

The Influence of Culture and Religion in Coping with a Mental Illness by the Residents of the Eastern Cape Province, South Africa.

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Abstract

Culture and Religion are significant constructs in the understanding, diagnosis, and treatment of mental illness, and acknowledging culture and religion is thus essential to effectively engage with all people seeking mental healthcare. This study sought to explore the role of culture and religion in coping with mental illness among people of the Eastern Cape Province in South Africa. The study employed a quantitative exploratory-descriptive approach, with 101 participants taking an online questionnaire as a convenience sample. Descriptive and inferential statistics were used to analyse the data. The findings suggested that there is a link between religion/culture and how people cope with mental illnesses. The study's findings highlight the importance of public education initiatives that recognise and appreciate people's cultural variety and collaboration between traditional and medical experts.

Keywords: culture; Eastern Cape; mental illness; perceptions; religion

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Introduction

Due to its diversity, including its cultures and religions, South Africa is renowned as "a rainbow nation". It has a rich cultural heritage and consists of diverse groups of people who differ in race, culture, religion, gender, and age (Sawe, 2019). The country's borders are home to various ethnic and religious groups, including the Xhosa, Pedi, Zulu, Ndebele, Khoisan, Tswana, Christian, Hindu, Muslim, and Afrikaner. (Statistics South Africa, 2016). The differences in cultural and religious beliefs create a multitude of knowledge, understandings and coping strategies that influence how individuals define and perceive mental illness and how they seek mental health services. The American Psychiatric Association (2013) notes that cultural differences need to be considered as cultural contexts significantly influence the expression and evaluation of the psychological ailments exhibited by individuals.

Many experts view the current practice and treatment of mental illness as being monocultural since it emerged from Western notions of knowledge, which are profoundly ingrained in Western culture. (Leichsenring et al., 2018). Considering other cultures that are different from Western culture, the Western framework has consequences when used in that context (Barker & Ukpong, 2020).

Because diverse cultures define mental health differently and mental illness, there are implications for the effectiveness of one model of treatment when applied to all cultures. Many factors need to be considered to effectively engage with all people seeking mental healthcare (Fernando, 2015). By the aim and objectives set, this study provides a detailed account of religion and culture's role as a coping strategy for mental illnesses. As indicated in the literature review, South African beliefs regarding mental illness are steeped in the influence of supernatural entities. This study is beneficial and relevant to South African psychological knowledge production as it considers indigenous knowledge systems currently excluded from mainstream theory and practice.

Mental Illness among the AmaXhosa

An example of the impact of culture on the expression and evaluation of ailment is seen in the *AmaXhosa*, who assert that mental illnesses may be ascribed to supernatural entities or spirits and ancestors. *Ukuthwasa* among the *AmaXhosa* (which encompasses symptoms that bear a resemblance to mental disorders, such as hallucinations and illusions) is believed to need cultural doctoring because it is an embodiment of both nature and the ancestral world (Mabona, 2004). As such, many individuals opt for traditional ways of treatment and view Western medicine as unhelpful (Mbanga et al., 2002). This is strongly tied to beliefs held on the causes of mental illness, which results in perceptions and coping strategies reflecting the belief in question.

Mental Illness among the AmaZulu

Similarly, traditional Zulu people construe mental illness from supernatural concepts and view them as a manifestation of magical, animistic and mystical elements

(Crawford & Lipsedge, 2004; Ngubane, 1977; van der Zeijst, 2020). The AmaZulu differentiates mental illness between *Umkhuhlane* (a physical illness that can be treated with indigenous herbs and biomedically with medicine) and *Ukufa-Kwabantu* which requires African, indigenous practices that usually require performing rituals (Ngubane, 1977). These rituals often include several cleansing practices or procedures such as purging (*ukuphalaza/ukugabha*), cleaning bowels with laxatives (*ukuchatha/ ukucima*), steam baths (*ukugquma/ukufutha*) or lighting incense (*impepho*) to get rid of evil spirits (Mpofu, 2011).

Mental Illness among the Muslims

On the other hand, the Muslim community also recognise the existence of spiritual taxonomies as a causal factor for mental illness and believes that the 'evil eye' leads to mental illness (Mohamed-Kaloo & Laher, 2014). When providing treatment for mental illnesses, Muslim faith healers recite certain passages from the Holy Qur'an. "...We put our palm on the patient's head, which is a type of good energy," a healer claimed. So, as we recite the Qur'an, you will notice that... the energy is transferred into them..." These passages are read and then blown into the client and/or onto natural ingredients, such as water, honey, sugar, salt, and olive oil, which the patient will use when cooking or consuming. In addition, the verses of the Qur'an are always worn and inscribed on a sheet of paper (Ally & Laher, 2008). Belief, according to faith healers, is a crucial part of treatment. Faith in the Almighty and that the Almighty's grace would heal the spiritual aspect causing the illness. This applies to Islam or any other religion, and faith in a higher power is required (Ally & Laher, 2008).

Mental Illness among the Hindu

Hinduism, another religion in South Africa, holds the notion that mental illness is a manifestation of one's imbalance in the world rather than a consequence of physiological or psychological dysfunction (Dein et al., 2020).

Treatment of Mental Illness in Indigenous Communities

Treatment for mental illness is commonly sought with the aid of traditional healers in African cultures due mainly to the notion that the underlying aetiology of mental illness is more cultural/religious than biological (Mkhize, 2004). In African cultures, the traditional healer determines the underlying cause, which the victim's behaviour may cause that angers the ancestors or the patient's relationship with the environment because it is considered that balance is maintained through relationships with the environment, fellow general public, and the ancestors (Saayman & Kriel, 1992). Traditional healers are not similar; they do not all play the same roles or fall into a similar categorisation. There are several traditional healers in the Xhosa culture, such as the Diviner (*Igqirha*) as well as the Herbalist (*Ixhwele*) (Mzimkulu & Simbayi, 2006).

In line with Atilola (2015), African religious pastors have become a modernised form of the traditional mental health care system. Pastors mainly treat mental illness through

faith healing and preaching faith in a superior being (Atilola, 2015). The churches arose from the blending of Christian beliefs with African culture. One of these churches is the Zion Christian Church, which blends Christianity and African philosophies. It permits Africans to practice their African traditions while becoming Christian (Afolayan, 2004). As shown by Abu-Raiya, Pargament and Exline (2015). The Christian Bible makes instances of spirit possession and exorcism. Mental illness was regarded to be demonic spirit possession, which required to be exorcised. Roman Catholic churches continue to employ exorcism, although the Church is increasingly cautious in distinguishing between the exceptional and regular need for exorcism (Abu-Raiya et al., 2015).

The Influence of Culture and Religion on Mental Illness

Literature has demonstrated that culture and religion are significant constructs in the understanding, diagnosis, and treatment of mental illness and that acknowledging culture and religion is thus important. It is crucial for this study that the terms culture and religion be defined.

Culture

Culture is defined as "shared learned behaviour passed down from generation to generation for individual and societal growth, adjustment, and adaptation: culture is represented externally as works of art, norms, and institutions, and it is symbolised internally as values, beliefs, attitudes, epistemology, attitudes, and biological functioning" (Fernando, 2015).

The sociocultural context in which behaviour occurs differentiates normal behaviour from aberrant behaviour, so determining what is aberrant is ultimately a social construct that may differ between social groups (Canino & Alegría, 2008). Therefore, their sociocultural background influences every aspect of an individual's sickness experience, including the specific perception of experiencing illness.

South Africa is defined by the diversity of its communities, and African people embrace a variety of social activities that define their identity as people and as a community (Mkhize, 2021). Therefore, to understand the conceptualisation of mental illness, it is critical to first review culture and its influence on the development of aberrant behaviour (Kometsi et al., 2020), as the diagnosis of a mental illness is given based on deviations from a culture and community's sociocultural norms.

Religion

Religion is a structured set of beliefs, practices, rituals, and symbols to bring people closer to the divine or transcendent, such as a God or a higher power (Moreira-Almeida et al., 2006).

The notion that religion and psychiatry have always been in opposition persists. Most people presently believe that most mental illnesses were/and are considered witchcraft

or demonic possession throughout the past centuries (Koenig et al., 2020). Admittedly, one of the founding mythologies of psychiatry is that determined and educated psychiatrists freed mankind from religious superstition (Moreira-Almeida et al., 2006).

Although several pieces of research reveal correlations between religious activity and mental well-being, few have investigated the possible determinants of this association (Behere et al., 2013). Many factors have been suggested to explain religion's effect on human well-being. Many illnesses are linked to behaviour and lifestyle; for example, the foods we eat, the drinks we drink, the sex we have, the drugs we use, the prescriptions we take, and the way we check ourselves for preventative measures all have a big impact on our health. (Behere et al, 2013). Religion teaches or forbids health-related practices, and the biblical instructions regarding nutrition, food handling, sanitation and purity, circumcision, and sexual conduct are vital for preventive measures (Bonelli & Koenig, 2013). The significance of the relationship between religion and mental illness should be acknowledged. The mentally ill may possess spiritual needs that ought to be identified and fulfilled. However, mental health professionals and other healthcare organisations are often reluctant to address them, and to incorporate spirituality into therapeutic practice, adequate training is required (Behere et al., 2013). Therefore, the practitioner should be well-versed in the cultural and religious milieu in which he or she works.

Methods

Study Area

One of South Africa's provinces, the Eastern Cape, has been chosen as the research study environment. Gqeberha (previously Port Elizabeth), one of its two main cities, is the researchers' residence and the location of their affiliated institution (Nelson Mandela University). On South Africa's east coast, the Eastern Cape is between the Western Cape and KwaZulu-Natal provinces. Inland shares borders with the Northern Cape, Free State, and Lesotho.

Black Africans comprise most of the province's population, and the Eastern Cape is primarily populated by Xhosa speakers, with Afrikaans and English speakers accounting for a significant population. The province is ranked as the third most populated in the country, primarily rural and one of the poorest provinces in the country (EC Provincial Website, n.d.). South African Census Survey (2016) revealed that the Eastern Cape has a geographical area of 168,966 square kilometres, with a population of approximately 6 996 976.

Individuals seeking mental healthcare are impeded by the general public's ignorance about the presence and management of various mental illnesses. People in the Eastern Cape often turn to traditional healers before visiting a mental health professional because of cultural misconceptions about mental illness, particularly among the Xhosa community (Strümpher et al., 2016).

Participants

The online survey was completed by 101 participants from the general population of Eastern Cape using a convenience sampling technique. Regarding racial demographics, 70.3% of these individuals were African, 17.8% White/Caucasian, 7.9% coloured, and 4% Indian. The sample was made up of 32.6% men and 67.4% women.

Data Collection Method

An online questionnaire from the QuestionPro online platform has been utilised as a research tool for the research study. Respondents were invited to participate in the study through various online social media platforms (Facebook, Instagram, LinkedIn), which provided a link to the research and took the user to the QuestionPro platform. Biographical information was collected. Participants were asked for the following biographical information for statistical purposes: age, gender, population group, home language, culture, and religious affiliation. The questionnaire thus consisted of biographical information, three open-ended questions, and 38-close-ended questions.

The questionnaire was designed using a Likert scale rating, allowing participants to rank the available answers to the questions on the scale of the given range of values. In a 5-point Likert scale rating system, respondents choose from a range of possible responses to a specific question or statement; responses typically include “strongly agree,” “agree,” “neutral,” “disagree,” and “strongly disagree.” Often, the categories of response are coded numerically, in which case the numerical values must be defined for that specific study, such as 1 = strongly agree, 2 = agree, and so on (Jamieson, 2017). Items were developed based on the literature review.

Procedure

Ethical clearance was received from the Research Ethics Committee (RECH) at Nelson Mandela University, with the number H21-HEA-PSY-007. The questionnaire was uploaded onto the online platform QuestionPro, and the researcher contacted the religious and cultural leaders who were gatekeepers to the study and acted as middlemen between the researcher and the participants. The information sheet inviting participants to participate was also shared broadly across and through various online platforms (Facebook, Instagram, Email, etc.). Participation was voluntary, and informed consent was a prerequisite before being admitted to complete the online questionnaire. The Questionnaire took approximately 16 minutes to complete. All data from QuestionPro was forwarded to the researcher on request as an Excel spreadsheet.

Data Analysis

After cleaning and sorting, the data was analysed using descriptive and inferential statistics. After cleaning the data, the statistical applications STATA (version 16.1) and SPSS Statistics were used to analyse the recorded data. The researcher sought statistical advice from a Biostatistician at Nelson Mandela University's Faculty of Health

Sciences. Data from open-ended questions were also deductively coded in pre-existing specified frames that evolved from the data. To ensure trustworthiness in the study, the researcher had to employ several measures to ensure credibility, dependability, transferability, and confirmability. Credibility was established through rigorous study design and valid measurement instruments, dependability was ensured by a consistent data collection method, transferability was facilitated by detailed descriptions of the sample and methodology, and confirmability was maintained through objective data analysis and transparent reporting.

Results

Demographic Characteristics

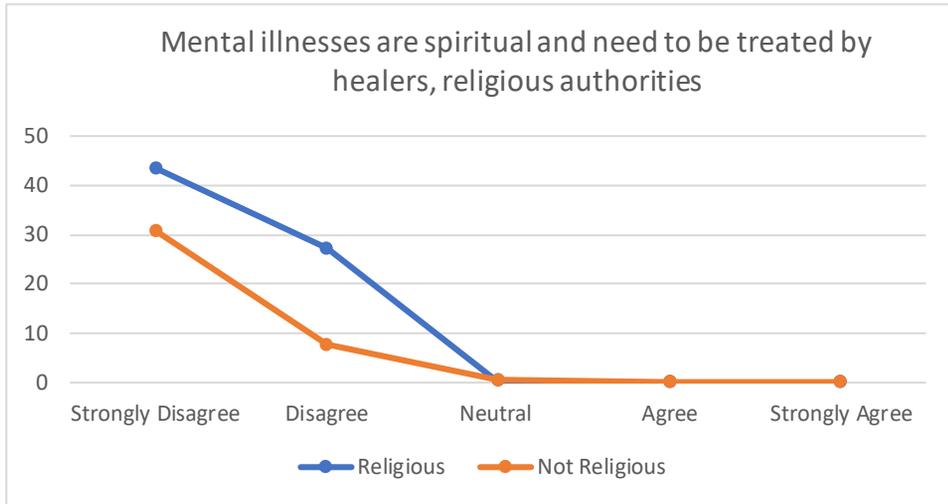
The results of the sample show that most $n=53$ (52.5%) of the study participants were between the ages 18 and 24 years. Many of the participants were females $n=64$ (67.4%), African $n=71$ (70.3%) and spoke IsiXhosa $n=60$ (59.4%) as a home language. About $n=88$ (87.1%) of the study participants indicated that they were religious, with the most participants being Christians $n=79$ (89.8%). Furthermore, the results indicated that most participants, $n=68$ (68.0%), are culturally inclined and participate in cultural activities.

Culture/Religion vs Mental Illness

Culture and Religion were cross-tabulated with all the participants' responses to the questionnaire items regarding mental illness. However, the researcher has only presented the Chi-square tests of variables with a relationship, i.e., variables with a statistically significant association (p -value <0.05).

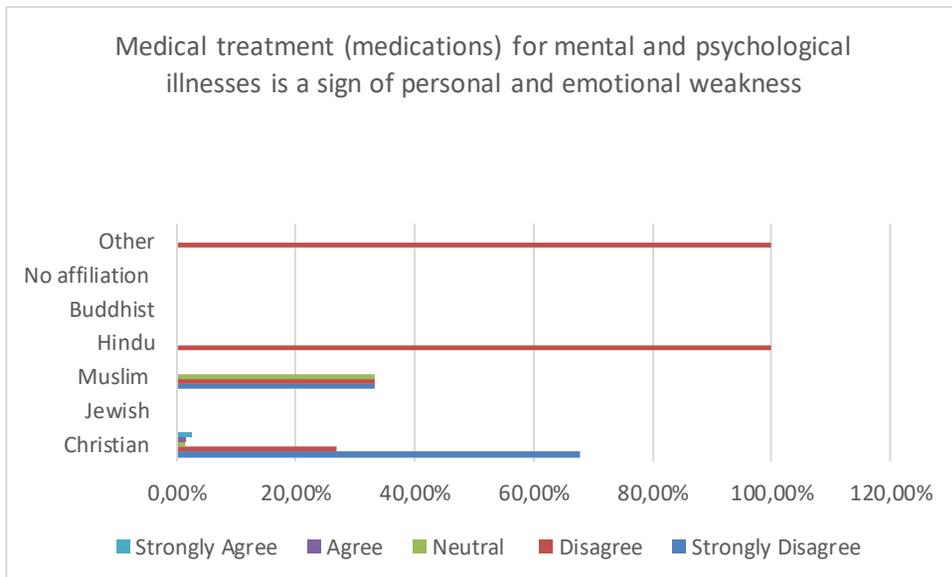
A Chi-square test of independence was performed to examine the relationship between Culture/religion and the responses to the questionnaire item: "*Mental illnesses are spiritual and need to be treated by healers, religious authorities*". The relation between these variables indicates that there was statistical significance, $p=0.029$.

Figure 1: Association between Mental Illness and Culture/ Religion



A Chi-square test of independence was performed to examine the relationship between religion and the responses to the questionnaire item: “*Medical treatment (medications) for mental and psychological illnesses is a sign of personal and emotional weakness*”. The relation between these variables indicates that there was statistical significance, $p=0.030$. Most participants, $n=53(67.9\%)$, who are Christian, indicated they strongly disagreed with this statement. This indicates a relationship between religion and the perception of mental illness.

Figure 2: Association between Item Responses and Religion



A Chi-square test of independence was performed to examine the relation between the population group and the responses to the questionnaire item: “Medical treatment (medications) for mental and psychological illnesses is a sign of personal and emotional weakness”. The relation between these variables indicates that there was statistical significance, $p=0.004$. Most participants, $n= 43(62.3\%)$, who are African by ethnicity, indicated strongly disagreeing with this statement.

Table 1: Association between Item Responses and Distribution Per Population Group

Variable	Questionnaire item					P-value (Chi-square test)
	<i>Medical treatment (medications) for mental and psychological illnesses is a sign of personal and emotional weakness</i>					
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	
Population group						
African	43(62.3%)	21(30.4%)	2(2.9%)	1(1.4%)	2(2.9%)	0.004
White	14(77.8%)	4(22.2%)	0(0.0%)	0(0.0%)	0(0.0%)	
Coloured	7(87.5%)	1(12.5%)	0(0.0%)	0(0.0%)	0(0.0%)	
Indian	0(0.0%)	2(50.0%)	2(50.0%)	0(0.0%)	0(0.0%)	
Other	0(0.0%)	0(0.0%)	0(0.0%)	0(0.0%)	0(0.0%)	
	64(64.6%)	28(28.3%)	4(4.0%)	1(1.0%)	2(2.0%)	99(100.0%)

Chi-squared test *Significant at $P<.05$

A Chi-square test of independence was performed to examine the relation between home language and the responses to the questionnaire item: “A mental illness is caused by angering the ancestors”. The relation between these variables indicates that there was statistical significance, $p=0.028$. Most participants, $n= 27(46.6\%)$, who speak IsiXhosa as a home language strongly disagree with this statement.

Table 2: Association between Item Responses and Distribution Per Home Language

Variable	Questionnaire item <i>A mental illness is caused by angering the ancestors</i>					P-value (Chi-square test)
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	
Home Language						
English	19(79.2%)	3(12.5%)	2(8.3%)	0(0.0%)	0(0.0%)	0.028
Afrikaans	9(100.0%)	0(0.0%)	0(0.0%)	0(0.0%)	0(0.0%)	
IsiXhosa	27(46.6%)	12(20.7%)	18(31.0%)	0(0.0%)	1(1.7%)	
Other	2(25.0%)	2(25.0%)	4(50.0%)	0(0.0%)	0(0.0%)	
	57(57.6%)	17(17.2%)	24(24.2%)	0(0.0%)	1(1.0%)	99(100.0%)

Chi-squared test *Significant at $P < .05$

Discussion

This study explored the influence of culture and religion in coping with mental illness by the residents of the Eastern Cape.

The data was analysed using descriptive statistics after it was cleaned and sorted. Descriptive statistics were used to describe the results, and the results were presented using frequency tables and graphs. After that, the inferential statistics that analysed associations using Chi-square tests were also performed to test whether there were relationships between the different variables.

The results of the study revealed that there is a relation between religion/culture and coping with a mental illness by the participants of the study.

General Findings

Examining the impact of culture and religion on how mental illness is perceived is crucial in the effort to comprehend how a society conceptualises mental illness. Indigenous perspectives on mental illness are grounded in a social context that differs significantly from Western perspectives.

Of the 101 research participants, most of the participants, $n = 88$ (87.1%), indicated yes - that they are religious. $n = 79$ (89.8%) of these participants are Christian, none of the participants are Jewish, $n = 6$ (6.8%) are Muslim, $n = 1$ (1.1%) participant is Hindu, none of the participants identified as Buddhist, $n = 1$ (1.1%) identified as to have no religious affiliation and $n = 1$ (1.1%) indicated that to identify as other religions. Of these participants, $n = 68$ (68%) indicated yes - that they are culturally inclined.

A Chi-square test of independence was performed, and the relation between these variables indicates statistical significance, $p < 0.05$. This indicates a relationship between culture, religion, and their perception of perception of mental illness. This suggests that individuals have some sort of knowledge about mental illness and the impact that culture and religion play in their perceptions. The fact that people differ in their cultural and religious values concurrently influences how they cope and seek treatment (Swartz, 1998). As assumed, participants who identified as being religious and cultural believe mental illnesses are spiritual and need to be treated by healers and religious authorities.

The people of South Africa embody various cultural traditions that reflect who they are as individuals and as a nation. South Africa is known for its diversity of cultures (Matsumoto & Juang, 2004). Health practitioners ought to be informed about and be able to recognise cross-cultural concerns to offer effective, culturally relevant, and precise mental healthcare treatments for everyone. Mental health professionals must be aware of the ways that stereotypes about culture and mental illness are founded on presumptions about African culture (Ogundare, 2020). It is obvious that South African populations are diverse. Thus, it is anticipated that various people will have diverse views on the causes and treatment of disease and diverse approaches to understanding and treating ailments (Matsumoto & Juang, 2004). In traditional healing, the treatment process looks for possible answers to what triggered the sickness, who or what entity is responsible for it, and why the particular individual was targeted for suffering (Crawford & Lipsedge, 2004). People frequently see traditional healers recognised as care providers in their communities who may seek reasons and treatments for various illnesses and grief (Moodley & West, 2005).

Additionally, religious beliefs influence the choices regarding the evaluation and treatment of mental illness. Several participants consider mental illnesses as created purposely by demons. Because of such firm beliefs, most participants seek redemption from religious leaders. Some indicated having become mentally sick due to not participating in religious activities that could assure that they received protection from God. This is corroborated by Bonelli and Koenig (2013), who reported that people with mental illnesses claim that their being sick is caused by a lack of protection due to their unwillingness to participate in religious activities. As a result, evil spirits have a part in the onset of their condition. The stigma towards people suffering from mental illness influences the way people view and seek treatment (Corrigan et al., 2014), and deferring treatment is tied with far worse consequences for a variety of illnesses. In the past, mental illness was frequently associated with superstition or religious beliefs, and the prejudice of mental illness has been observed in diverse groupings of people.

From the mental health standpoint, religion offers rules and standards that people may use to map a direction for their lives. Believers can more readily handle life's stresses, strains, and uncertainties. Therefore, an examination must consider some of these factors since improved mental health may be linked to social support, religious views,

emotions, experiences, attitudes, and lifestyle, as Bhugra and Osbourne (2004) believe that religion and science share similar normative and humanistic principles.

Limitations

All research studies will undoubtedly have shortcomings and weaknesses. It is critical to recognise these limitations since they allow for guidance in future research.

The research used an online questionnaire to collect data due to the consequences of the COVID-19 pandemic and people's careful interactions. The COVID-19 outbreak revealed several social and institutional constraints preventing and impeding the researcher from conducting in-depth interviews with the participants. Using an online questionnaire as a research tool for the study has posed a limitation. Using an online questionnaire in data collection often results in the dishonesty of the research participants when answering the questions.

However, despite these limitations, the findings are still meaningful and beneficial for suggesting future, in-depth research.

Conclusion

This study explored the influence of culture and religion in coping with mental illness by the residents of the Eastern Cape. The results of the study revealed that there is a relation between religion/culture and coping with a mental illness by the participants of the study.

The findings of this study emphasise the necessity of public education efforts that understand and respect people's cultural diversity and teamwork among traditional and medical professionals. Future studies should focus on using discourse analysis to better investigate indigenous groups' conceptions of mental illness and their views about its aetiology and treatment.

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