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Cultural Perspectives on Mental Illness: An Ethnopsychiatric Analysis in Traditional African Societies

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ABSTRACT

Background: The Western view of mental illness has traditionally been universalistic, neglecting cultural influences. Ethnopsychiatry challenges this, emphasizing how mental illness is shaped by social and cultural contexts.

Methods: This study examines representations of psychological suffering in traditional African societies, focusing on collectivity, spirituality, and family dynamics. Based on interviews with African cultural mediators, it explores local interpretations and management of mental illness, analysed through thematic analysis to compare with Western paradigms.

Results: The study found that interpretation of mental illness is often seen as having spiritual or social origins rather than a medical basis, diverging from the Western medical approach. Key themes include the family's role as a support system and the view of illness as punishment or spiritual imbalance, shaping healing practices through traditional healers and social reintegration.

Conclusions: Integrating ethnopsychiatry into therapy strengthens patient-provider relationships, reduces dropouts, and improves treatment outcomes.

Keywords: Ethnopsychiatry; Mental illness; Culture; Spirituality; Migration; Family

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Introduction

The ethnopsychiatric approach, with contributions from scholars who have explored the treatment of the cultural Other (Ellenberger, 2020; Caroppo et al., 2009; Cardamone e Zorzetto, 2000; Devereux, 1972; Nathan, 1993), has facilitated a gradual process of understanding within institutions and public mental health services. This process has highlighted the urgent need to modify and renew patient care practices in a constantly evolving social context.

Despite growing awareness of the critical issues within current systems and numerous studies conducted by research groups in Italy and other European countries (i.e. Van Aken, 2008; Farotti e Olivieri, 2011), no significant changes have been implemented, except in some isolated experiences within public healthcare or, more frequently, in the private sector.

The systematic adoption of an ethnocentric perspective in mental health care proves to be particularly risky, especially within public services. One of the fundamental objectives of psychological practice is to develop a non-judgmental listening approach in working with patients. To this end, it is essential to consider the biases that may shape thought and behavior in clinical relationships with patients from diverse cultural backgrounds. Reflecting on patient care in Western contexts, on the distinctive elements of the therapeutic setting and diagnosis, allows for the recognition of the deep and pervasive influence of ethnocentrism in psychological practice.

Illness as a Cultural Construct

A critical analysis of the concepts of illness, care, and healing - without attributing to them an absolute and universal meaning but rather considering them as cultural constructs - constitutes the first step of this experimental research. The primary objective is to investigate how psychological disorders manifest and are interpreted in non-Western, traditional cultures. Based on the premise that illness incorporates a cultural matrix of beliefs and meanings (Bragazzi & Del Puente, 2012; Devereux, 2007; Inglese, 2005; Nathan, 1995), it becomes essential to explore how the social and cultural system contributes to the construction of both illness and the figure of the patient. Individual suffering is embedded within a matrix of meanings and specific codes, which vary according to the cultural context of reference. Although understanding these dynamics is complex, questioning these concepts can represent a crucial first step toward the development of a more inclusive approach.

Analyzing representations of mental health among individuals born and raised in contexts significantly different from the European one allows for a greater awareness of the multiplicity of conceptions of illness and care. It is also necessary to consider that many of the notions and practices of Western psychology and psychiatry have become part of the knowledge repertoire of traditional societies since the colonial period, intersecting with local traditions of thought (Beneduce, 2019).

Focus on African Contexts

This study gave particular attention to African cultures for two main reasons. First, a significant portion of the immigrant population in Italy originates from the African continent: specifically, 22.25% of foreign residents in Italy are from African countries (ISTAT, 2021). Second, the high linguistic and cultural heterogeneity of the African community in Italy represents a crucial factor. Africa, the third-largest continent, is characterized by extraordinary linguistic fragmentation, with over 2,000 spoken languages, reflecting its internal cultural diversity.

Exploring representations of mental health through the narratives of individuals from different African countries has facilitated a meaningful comparison of diverse ways of interpreting psychological disorders. The objective of this study was not to identify a common denominator but rather to explore the differences between Western and non-Western conceptions, as well as among various African traditional societies themselves.

Method

The study was a preliminary qualitative investigation conducted through interviews and analysed using thematic analysis methodology.

Semi-structured interviews were employed, as they allow for a flexible exchange with interviewees while following a guide that directs the conversation according to the study's objectives. This approach also ensures reciprocal engagement between the participants, enabling a deeper exploration compared to structured interviews.

Furthermore, the use of a semi-structured methodology provided interviewees with the opportunity to express themselves more freely, discussing their experiences while maintaining a clear direction and addressing key topics as the conversation progressed.

The interviews took place at the Women and Girls Safe Space (WGSS), a facility established in 2020 for foreign women, girls, and their children in southern Italy, in the city of Palermo. Created through a collaboration between Center Penc, a clinical ethnopsychology

center based in Palermo, the International Rescue Committee (IRC), and UNICEF, WGSS serves as a secure refuge within a transcultural support initiative, offering legal and administrative assistance, literacy programs, training courses, and recreational activities to foreign women residing in Palermo.

The study focused on exploring the customs, histories, and memories of the participants, subsequently emphasizing the theme of mental illness.

Participants

For the purposes of this research, an initial analysis of the cultural landscape across Africa was conducted, with particular attention to the characteristics of traditional societies and the main themes of cultural anthropology.

Specifically, the study involved five cultural mediators from different African countries. Access to their knowledge and narratives regarding the customs and traditions of their respective communities proved to be highly valuable, as each participant belonged to a distinct ethnic group, as presented in Table 1.

No.	Age	Country of origin	Years in Italy
1	44	Nigeria	24
2	42	Mali	20
3	29	Nigeria	8
4	26	Nigeria	4
5	20	Mali	4
Total number (N=5)			

Most of the participants were originally from Nigeria, a federal state in West Africa and the continent's most populous country. While they shared some common languages, the mediators belonged to different communities and ethnic groups, each with its own unique cultural heritage and traditions. Other participants were from Mali, a landlocked West African country characterized by significant geographical and cultural diversity, with a northern region dominated by the Sahara Desert and a southern region within the Sudanese savanna.

Participants were selected through purposive sampling, as they were already engaged with the center where the research was proposed. Their role as cultural mediators made them particularly suited to provide insights into their respective cultural backgrounds.

After an initial contact, participants were asked whether they wished to take part in the study, ensuring full privacy and requesting permission to record the interviews. Once consent for audio recordings was obtained, a schedule for the interviews was established.

The interviews took place over the course of one month, accommodating the commitments of the cultural mediators, who were also engaged in other activities within the center. Due to variations in the conditions of the interviews - such as the presence of other mediators or professionals at the WGSS - the final sessions took the form of focus groups.

During the preliminary meeting, held before the interviews began, participants were provided with an outline of the interview questions, allowing them to review the content in advance. This approach created a more comfortable environment and encouraged greater spontaneity in responses during the interviews.

Interview Structure

The interview guide was written in Italian, as most participants were fluent in the language. However, for some, expressing themselves in English was more natural, necessitating simultaneous translation by one of the cultural mediators.

Table 1. Semi-Structured Interview Guide

General Section
<ul style="list-style-type: none"> • Who are you, where are you from, and what language do you speak? • What are your customs and traditions? What rituals mark the stages of life (birth, death, marriage, transition to adulthood)? • How does daily life function (individual, group, community)?
Experience of Illness
<ul style="list-style-type: none"> • Mental illness: How is it experienced, perceived, and represented? • Are there traditional stories about the origins of mental illness? • How is it treated? In what ways does the community take care of the individual affected?

As shown in Table 1, the questions in the interview guide were divided into two sections. The first was designed to facilitate an in-depth exploration of the participants' customs and traditions. It began with an introductory question aimed at gathering information on

personal identity, country of origin, and spoken languages. Subsequent questions explored aspects related to daily habits, traditions, and ceremonies practiced within their communities. Many of the responses referred to the participants' personal memories, describing events and rituals they had experienced, often imbued with strong emotional significance.

An additional question in the first section addressed daily life in their countries of origin, allowing for the reconstruction of fragments of their experiences before migrating to Europe. The interview guide was structured with simple yet open-ended questions to enable participants to share their narratives freely, without thematic constraints. The order of the questions was not rigid; rather, it was dynamically adapted using narrative prompts, allowing for a thematic rather than a strictly sequential approach.

The second section of the interview guide had a more directive focus, centering on the concept of mental illness. This phase was conducted in a group setting, although participants engaged with the topic to a lesser extent than in the first part. The decision to begin with a broader and less structured exploration was aimed at fostering greater openness in discussing more sensitive topics, such as difficult memories or culturally reserved issues. Despite some reluctance, the contributions that emerged were nonetheless meaningful.

During the interviews, numerous themes were explored - some directly linked to the predefined questions, while others arose spontaneously but were still relevant to the participants' lived experiences in their countries of origin.

Procedure and Measures

The interviews were conducted in May 2022, with a weekly schedule, for a total of four sessions. The cultural mediators participated based on their availability, dedicating approximately 30 minutes to each session.

The first interviews began with individual meetings with two participants, during which information was gathered on their countries of origin and cultural traditions. Subsequently, the group expanded to include additional mediators who expressed interest in participating in the research. This led to a natural transition to a focus group format, enabling a more dynamic and enriching exchange among participants.

During the sessions, participants shared narratives about ceremonies and customs within their communities. The discussion then shifted towards family and social dynamics, as well as the perception of mental illness in their countries of origin. Once data collection was completed, the interviews were manually transcribed. The material was then analyzed

using thematic analysis (Braun & Clarke, 2006) to identify and categorize recurring themes within the narratives.

Thematic analysis was conducted manually, following the six-phase framework proposed by Braun and Clarke (2006). After familiarization with the data through repeated readings of the transcripts, initial codes were generated inductively, based on the content of the narratives. These codes were then organized into potential themes, which were reviewed and refined through iterative comparison with the original data. Although no qualitative data analysis software was used, efforts were made to ensure consistency in coding by revisiting the data multiple times and discussing emerging categories with peer researchers involved in the study design.

Results

Through thematic analysis, a coding process was applied to the excerpts from the transcribed interviews. The resulting codes, listed in Appendix, were derived from a thorough analysis of the collected material.

Based on these codes, a synthesized analysis will be presented to identify the key emerging themes, with the goal of contributing to ethnopsychiatric research.

General Section

The name

From the analysis of the interviews, the first category that emerges is the concept of "name," a theme addressed by the interviewees immediately after describing wedding and funeral celebrations in Nigeria and Mali. In this context, a name is not just an individual identity, but a deeply community-related element linked to a person's social role. The name is assigned by the community and can be modified based on significant life events, such as marriage or the loss of a family member.

Unlike Western societies, where personal identity is seen as an individual and static construct, in the examined communities, identity is shaped by events and social recognition. In Mali, for instance, when a person loses a parent, they may receive a new name and assume a different role within the community while still being referred to by their original name.

During wedding ceremonies, specific names are given to the bride and groom to highlight their newly acquired status. Another significant aspect of the importance of names is seen in funeral rituals, where the deceased is no longer called by their name but identified as "the body," symbolically marking their departure from the community of the living.

Family and gender relations

Two key emerging themes are family structure and gender dynamics. In these communities, the family extends beyond the Western nuclear model, including multiple wives and elders who play a central role in decision-making. Major life choices, like marriage or migration, require family, especially elder, approval.

Marriage involves the groom's family investigating the bride's background, and if deemed suitable, her family may request a dowry ("bride price"), symbolizing the union between families.

Gender roles remain hierarchical, with men as decision-makers and heads of the family. Weddings reinforce this dynamic through symbolic gestures, such as the bride kneeling to offer wine. However, men are also responsible for their wives' well-being, with the bride's father entrusting his daughter to the groom as part of this duty.

The rules of polygamy

Polygamy, understood as the possibility for a man to have multiple wives, is a common practice in various African communities and is governed by specific cultural and legal norms.

The interviews reveal that polygamy is legally accepted in some parts of Africa, though regulations vary depending on the national and cultural context. In some North African countries, it is allowed only if the man can prove he has sufficient financial resources to support multiple wives, whereas in certain sub-Saharan communities, it requires the first wife's consent.

The management of polygamous relationships differs according to local traditions. In many communities, the man must follow a strict rotation in cohabiting with his wives, avoiding favoritism and ensuring fairness. However, some traditions dictate that all wives live together and serve their husband simultaneously, sometimes leading to competitive dynamics. The housing arrangements for the wives also vary: in some cases, each has her own residence, while in others, they share a house with designated living spaces. Some beliefs suggest that forced cohabitation among wives can create tensions that negatively impact the husband's health.

The concept of shame

The concept of shame emerges as a powerful tool of social control used to regulate individual and collective behavior. In these societies, shame is one of the most severe social sanctions, capable of irreparably damaging an individual's and their family's reputation.

The interviews highlight how the fear of community judgment influences many aspects of daily life, from career choices to personal relationships. Certain professions, such as being a hearse driver, may be considered dishonorable and lead to social isolation.

Premarital pregnancy is particularly stigmatized: in such cases, the woman risks being disowned by her family unless she agrees to marry the child's father or terminate the pregnancy before the community finds out.

Mental illness is also heavily stigmatized. Families tend to hide members suffering from psychiatric disorders to avoid being excluded from the community. Mental illness is not perceived merely as an individual problem but as a "stain" on the entire family, potentially compromising its social standing and the marital prospects of its members.

Rituals

Rituals are structured practices deeply embedded in cultural and religious traditions. Marriage is considered a fundamental rite of passage. One interviewee emphasized its significance: "*Of all traditions, marriage is the most important.*" Another participant from Nigeria highlighted the transformative nature of marriage, stating that it marks a crucial identity shift.

The interviews revealed the importance of symbolic rituals in major life events. For example, some women described a wedding tradition in which the bride drinks a cup of Panama wine and offers it to her future husband, a gesture that spiritually seals their union. If a couple later seeks divorce, a counter-ritual is required to formally dissolve the marriage; otherwise, any future children the woman bears would still be considered those of her former husband.

Beyond marriage, rituals also play a role in health-related beliefs. Traditional healers may prescribe rituals to cure mental illness, reinforcing the idea that ailments have spiritual origins. At the same time, some rituals—such as *vodou* practices—are perceived as potential causes of illness. As one participant explained, mental disorders may be attributed to spiritual forces, breaches of agreements, or external influences like drugs.

These insights illustrate the profound connection between rituals, identity, and well-being in these communities.

Experience of Illness

Spiritual illness

In many African cultures, mental illness is not seen as a psychological condition but as a spiritual phenomenon with causes rooted in the invisible world. This belief, passed down by village elders, shapes how illness is understood and treated. One participant described it as “*spiritual mental illness*”, emphasizing the need to distinguish between physical and spiritual afflictions.

Despite regional differences, interviewees shared similar perspectives, highlighting the role of oral tradition in transmitting knowledge (Nathan, 2001). When an illness is deemed spiritual, the affected person is taken to a traditional healer for treatment. As one mediator explained, “*If it is a spiritual illness, one must follow the appropriate rituals.*”

This view underscores the deep connection between spirituality, tradition, and mental health in these communities.

Illness as a punishment of the Spirits

Interviewees described how mental illness is often viewed as a spiritual affliction caused by offending spirits. In traditional villages, elders teach strict moral rules believed to be dictated by spirits, ensuring harmony within the community. Violating these rules—such as engaging in violence or breaking an oath—is thought to invite spiritual punishment, manifesting as mental illness.

“*If you don't respect the spirit, the spirit will leave you for the moment*” explains a girl who speaks English, commenting with disappointment on the immoral behavior of those who deliberately violate the rules of the community. They explain that the Spirits, following the offense suffered, abandon the person who betrayed their will, leaving them. This abandonment means that their future is doomed, since without their approval it is not possible to live peacefully.

One participant explained: “*When someone starts behaving as if they have a psychiatric disorder, we say they have offended a spirit, which then sends something harmful.*”

Despite this belief, some acknowledged that mental illness can have multiple causes, including drug use and traditional rituals like *vodou*. Younger generations, exposed to different perspectives, are increasingly questioning spiritual explanations. As one interviewee noted: “*Nowadays, seeing that these illnesses persist regardless of belief in spirits, people are realizing it's not just about them.*”

This shift highlights an evolving understanding of mental health within these communities.

Psychology as a taboo

Interviewees emphasized that in their home countries, psychology and mental health are often viewed with skepticism. Discussing mental illness is taboo, and Western psychological concepts are dismissed as *"the medicine of the whites."* While some African universities offer psychology courses, traditional beliefs remain dominant, leading many to distrust psychiatric treatments.

Access to psychiatrists is also extremely difficult. One woman described the struggle to find a mental health professional: *"It's easier to get an audience with the Pope in Rome than to see a psychiatrist in Africa."* As a result, families often turn to traditional healers, who are believed to have the ability to address spiritual ailments.

Mental illness is generally perceived through behavioral symptoms rather than medical diagnoses. Those considered "mad" exhibit unusual or frightening behavior, such as excessive talking or making strange predictions. These individuals are avoided by the community, as their affliction is seen as divine punishment. One participant explained: *"If someone is mentally ill, people assume they must have done something wrong."*

This perception reinforces reliance on spiritual healers rather than medical professionals. As another interviewee noted: *"Since the illness is spiritual, they believe only someone who sees the spiritual world can cure it."* Consequently, psychiatric treatment remains largely inaccessible and culturally rejected.

The Healer

Western medicine, introduced during colonial psychiatry, remains discredited among those most tied to tradition, particularly the elderly. Younger generations, while more open to psychiatry, struggle to access professionals, who are scarce and difficult to reach. Given this skepticism and the historical association of Western medicine with oppression, traditional healers remain the preferred choice for mental illness treatment.

Traditional healers are trusted figures within the community, easily accessible without appointments. Their role is to communicate with the spiritual world, identify offenses that triggered the illness, and prescribe rituals to restore balance. However, their services can be costly, especially if the illness is severe. Payment often extends beyond money, binding entire families to future obligations. One interviewee explained:

"If the healer cures your relative, you and your family owe him - even your children if they marry."

Despite their importance, healers often use harsh and violent methods. Mentally ill individuals are frequently beaten, yet families continue seeking their help, fearing social isolation if they refuse traditional treatment. The role of the healer is usually inherited, passed down from father to son, further cementing their influence within the community.

Discussion

Figure 1 illustrates how, starting from complex material and previously extracted codes, it is possible to define overarching themes.

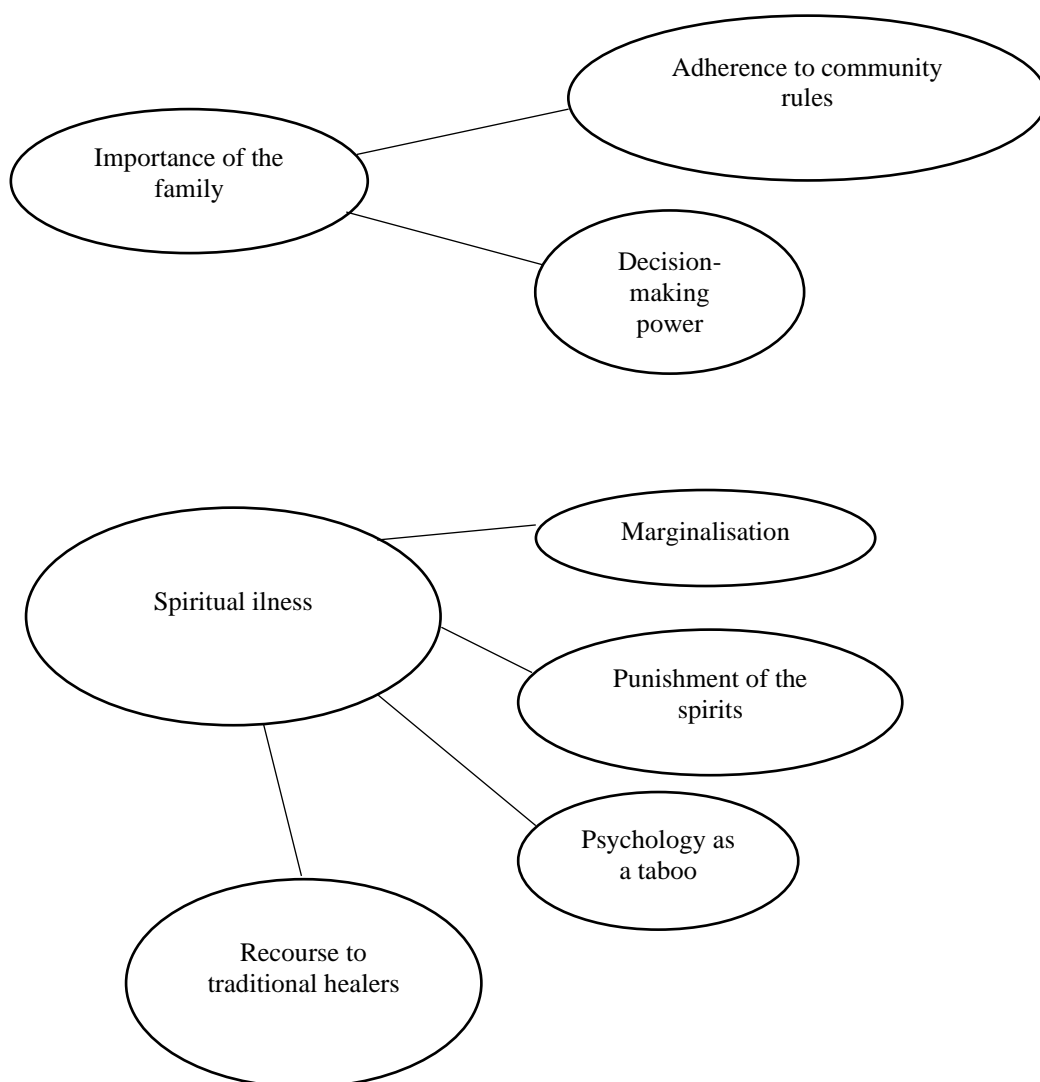


Figure 1: Mapping key themes

The generated map highlights two main concepts, synthesized from the obtained codes: the importance of family and the spiritual illness.

From these two fundamental themes emerge relevant and recurring sub-themes in the narratives of the interviewees. These sub-themes, closely connected to the main ones, pertain to various aspects of the structure of traditional societies and the relationship between culture and illness.

Specifically, "importance of the family" is strongly associated with the concepts of "adherence to community rules" and "decision-making power", which reflect the role of collective norms and hierarchical structures within traditional social systems. These elements emphasize how decisions about care and mental health are not taken individually, but rather within a framework of shared values and responsibilities.

On the other hand, the theme of "spiritual illness" is linked to a cluster of codes that express both explanatory models and cultural attitudes towards psychological suffering. These include "recourse to traditional healers", which indicates a culturally embedded system of care, and notions such as "punishment of the spirits", "psychology as a taboo", and "marginalisation", which suggest a complex interplay between spiritual beliefs and social responses to mental illness. The analysis of these themes aims to demonstrate how a reflection on them can provide a significant contribution to ethnopsychiatry and clinical care in Western contexts.

By recognizing these connections, it becomes possible to better understand how meaning is attributed to mental suffering and how culturally specific responses are activated. This can help clinicians and researchers develop more inclusive, context-sensitive approaches.

Family, community and power

The family plays the role of an "incubator" within which newborns learn the rules and values of the community. In this sense, it can be compared to the Western family structure. A distinctive element of the African family, as opposed to its Western counterpart, is its stability and constant presence throughout an individual's life. Unlike many European and American countries, where children tend to leave the family home at the age of eighteen to achieve independence and separate from their parents, in Africa, independence takes on a different meaning. Even the choice of a spouse is primarily a family decision. The head of the family is generally a paternal figure, but their role is mainly to embody a pre-established rule and order that must be respected.

The origin of mental disorders and their social significance

Another fundamental theme that emerged from the analysis of the interviews concerns the origin of illness, traditionally considered to be of a spiritual nature. Several sub-themes are connected to this topic, representing different facets of this interpretation of illness. The main sub-themes identified are:

- Punishment of the Spirits
- Marginalisation
- Psychology as a taboo
- Recourse to traditional Healers

Mental disorders are attributed to the realm of spirituality, a concept profoundly different from that characterizing Western medical disciplines, which interpret illness as an organic problem. In the West, the influence of 19th-century positivism on psychiatry led to the classification of mental illness within the corporeal domain, identifying the brain as the site of psychological distress and the physiological substrate of mental imbalance (Del Corno, Lang, 2013; Rossi Monti & Stanghellini, 1996). The integration of these findings into the medical field enabled psychiatry to establish itself as an autonomous scientific discipline.

However, this perspective reflects only the Western historical development of the concept of mental illness. While over time this condition has been interpreted as the result of passion overcoming reason (Lo Coco, Lo Verso, 2006), in other contexts, illness is often conceived as a deviation from moral law. In this regard, Coppo (2003) highlights that in some cultures, what animates human beings is not exclusively linked to the brain but also exists outside the individual, who is seen as a vessel and interpreter rather than the sole possessor of it.

The treatment of mental illness is not limited to following the prescriptions given by the healer, who, by establishing contact with the invisible world, offers a resolution to the conflict. Therapy also involves a process of social rehabilitation. Beneduce (2019) defines this approach as "healing through socialization."

Migration raises several issues, including land rights, the value of borders, the legitimacy of cultural norms, integration, and reception. This complex phenomenon affects society on multiple levels, making the commitment of governments and international organizations essential to ensuring the protection of migrants' rights and providing support for their integration into destination countries.

In recent years, Europe has become a major destination for increasing migratory flows from low and middle-income countries. This phenomenon is characterized by socio-environmental variables that can negatively impact mental health. Scientific literature has highlighted a rise in the incidence of common mental disorders among migrants (Bhugra et al., 2011). This risk is particularly high for first-generation migrants due to their geographical and cultural distance from their country of origin and the transition from rural contexts to metropolitan areas.

Among the primary risk factors for the mental health of migrants are the failure to achieve migration goals, transcultural stress, loss of social status, discrimination, and family separations (Mazzetti et al., 2006). The presence of compatriots can serve as a protective factor but, in some cases, may hinder the integration process and make long-term adaptation more challenging.

A crucial aspect concerns the limited access of migrants to mental health services in Europe, due to social, linguistic, cultural, and organizational barriers in host countries. In Italy, despite the presence of centers of excellence, structural challenges persist in mental health services, along with a lack of cultural competence among healthcare professionals.

The migration experience is characterized by multiple contradictions: migrants find themselves suspended between two worlds and two temporal dimensions, in a state of transition between the past and the future, between the "no longer" and the "not yet".

Conclusion

The analysis conducted highlights the necessity of moving beyond a two-dimensional and universalistic view of mental illness, characteristic of the Western approach, by directly listening to perspectives from different cultural contexts. Engaging with individuals born and raised in environments shaped by distinct social structures and value systems has provided deeper insight into customs, practices, and interpretations of phenomena that significantly diverge from those predominant in Italy and Europe.

Without aiming to establish a qualitative comparison between different conceptions of mental illness, it becomes evident that understanding alternative models of *presence* and the *crisis of presence* (De Martino, 1977) can enrich individual knowledge and promote greater methodological flexibility in clinical care. According to De Martino, the *crisis of presence* is a condition experienced by humans that can be mastered thanks to the reintegrating function of myths. For the anthropologist, it is a cultural phenomenon that occurs when a society loses its

sense of rootedness in the world and in its own history and faces a kind of 'existential vacuum'. In this sense, for De Martino the magical-ritual strategies of popular medical traditions become an important object of study, suitable to be analysed in order to understand how culture is used by peoples to overcome suffering. Ethnopsychiatry emerges as an approach that broadens the interpretative framework of psychopathological manifestations and treatment pathways, contributing to the integration of modern psychiatric and psychological knowledge.

Considering the consequences of colonial psychiatry - whose practices left profound scars on colonized populations and shaped common perceptions in post-colonial contexts - it is crucial to develop a critical awareness of the past and to radically rethink clinical approaches to migrant populations. As Beneduce (2019) has observed, psychiatry has evolved in ways that often fail to recognize the social and cultural nature of its diagnostic categories, disregarding the models of illness that influence the expression and public recognition of emotions, distress, and conflicts.

It is therefore essential to acknowledge that human suffering cannot always be classified through diagnostic categories developed within a single cultural system. An approach that considers the diversity of illness and healing models - moving beyond the tendency to impose a singular interpretative framework - could significantly improve access to adequate care for migrant populations.

Challenges related to compliance - understood as the patient's adherence to treatment - and therapeutic alliance - the collaboration between patient and therapist in achieving common goals - represent a significant barrier in the clinical care of migrants. These challenges often result in high dropout rates and reduced effectiveness of therapeutic interventions.

Thus, a clinical approach that prioritizes attentive and non-judgmental listening, one that does not merely categorize distress according to pre-established schemes but instead integrates diverse conceptions of human existence, proves indispensable. Mental health professionals' awareness of the existence of multiple ways of experiencing illness and healing - closely tied to one's cultural background - can foster a solid foundation of trust between migrant patients and clinicians, ultimately improving the effectiveness of therapeutic interventions.

Since the clinical care of migrants by mental health services is a very complex issue, which requires more attention, it is important to underline how much the competence of operators needs more investment in cross-cultural listening. The results obtained in this study could give an input to the realisation of training of health workers regarding migrants' culture

and language; to the financing of mental health programmes designed for those arriving from non-western realities; to the creation of support systems for migrants in need of assistance, in order to favour their integration possibilities.

In addition, it is important that migrants are encouraged to talk about their experiences and seek the support they need, and for this to happen, elements from the ethno-psychiatric clinic must be integrated into the care. Implementing and composing what Beneduce calls 'spurious care strategies' (Beneduce, 2019), taking into account the 'attachments' of patients, whether they are first- or second-generation migrants, could be a solution to many of the problems concerning the compliance of migrant patients.

Limit of the research and future prospective

This study offers an in-depth exploration of cultural mediators' perspectives on mental health within African migrant communities. However, some limitations should be acknowledged. The findings are context-specific and shaped by the experiences of the participants involved, all of whom were engaged in a particular setting and selected through purposive sampling. The deeply situated nature of the narratives, and their dependence on the local context of the center where the research took place, limits the extent to which the findings can be transferred to other populations or settings. While this qualitative approach provides rich and nuanced insights, it does not aim to produce broadly generalizable conclusions.

Moreover, challenges emerged in the cultural translation of the analytical categories used to interpret the data. Although thematic analysis allowed for an inductive approach, the interpretation of culturally specific narratives required constant reflexivity and awareness of the researcher's own cultural lens. The process of identifying and categorizing themes involved negotiating meanings that may not always align with Western conceptual frameworks, particularly when addressing sensitive topics such as mental illness or social dynamics.

Future research could further explore the topic by involving a wider range of stakeholders, including mental health professionals, community members, clinicians, migrant patients, and policymakers, to gain a more comprehensive and multidimensional understanding.

Additionally, studies focusing on specific cultural or national groups within the African

diaspora could help highlight intra-group differences and refine intervention strategies in a more culturally responsive manner.

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Authors' contribution

C.B. assisted with concept, study design, data analysis, manuscript preparation and manuscript editing; C.B. assisted with the generation of the initial draft of the whole manuscript, manuscript editing and data interpretation; C.B. and G. L. C. assisted with manuscript editing and study concept; C.B. and G.L.C. assisted with manuscript editing, data analysis, data interpretation, and study supervision. All authors contributed to and have approved the final manuscript.

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APPENDICES

Themes	Extracts
<p>“Centralità del Nome”:</p>	<p><i>“Il giorno che ti devi sposare, non sei più “****”, sei la “sposa””</i></p> <p><i>“Quando c’è un matrimonio, il nome della persona che si sposa cambia”</i></p> <p><i>“Quando muore qualcuno, non sei più chiamato col tuo nome. Il nome sparisce. [...] se ad esempio muore il marito, la donna</i></p>

	<p><i>è chiamata “fliyamusò”, per dire “donna vedova”.</i></p> <p><i>“I bambini (figli del genitore morto) non sono più chiamati col nome, ma vengono chiamati con un altro nome durante i giorni del funerale.”</i></p> <p><i>“La donna che ha partorito si chiama “juvatò”, ovvero persona che ha messo al mondo qualcuno”</i></p> <p><i>“Queste tradizioni fanno cambiare nome”</i> (P1)</p>
<p>“Ruolo della Famiglia”:</p>	<p><i>“L’uomo arriva a casa e comunica ai genitori di aver trovato una donna con cui intende passare la vita insieme. Allora la famiglia dell’uomo comincia ad indagare sulla famiglia della donna, per vedere se è una famiglia perbene, se hanno una brutta nomina, o se qualcuno della famiglia ha fatto qualcosa di grave”</i></p> <p><i>“Quando si indaga sulla famiglia e si vede che si tratta di una famiglia perbene, allora la famiglia dell’uomo si reca presso quella della donna”</i></p> <p><i>“La famiglia della donna accetta; alle volte anche la famiglia della donna indaga; [...] allora dice “dovete pagare la dote”</i></p> <p><i>“La famiglia dell’uomo si organizza”</i></p>

	<p><i>“E’ come se la donna andasse via dalla propria famiglia per fare parte di quella dell’uomo”</i></p> <p>(P2)</p> <p><i>“La famiglia a questo punto si chiede, dell’altra, che tipo di famiglia è questa?”</i></p> <p>(P3)</p> <p><i>“Se io so che tua sorella o tuo fratello o qualcuno di tuo è matto, nessuno ti parla più. Tutti ti isolano, isolano l’intera famiglia”</i></p> <p>(P2)</p> <p><i>“(del debito col guaritore) Sei in debito. Tu e tutta la tua famiglia, se quello si sposa anche i suoi figli, ecc.”</i></p>
<p>“La Vergogna”:</p>	<p><i>“Se qualcuno ha fatto una gravidanza al di fuori di una relazione matrimoniale, nessuno vorrà più sposare qualcuno in quella famiglia: è come se si fosse “sporcata”, non è più degna.</i></p> <p><i>Se la ragazza decide di tenere quella gravidanza, si sposano subito, prima che il villaggio venga a saperlo. Se non accade, la ragazza sarà negata dalla famiglia, perché avrà gettato “fango” sulla famiglia col suo sbaglio”</i></p> <p>(P2)</p> <p><i>“(su gravidanze in seguito a tradimenti da parte della moglie se il marito è lontano da</i></p>

oltre sei mesi) *Tale figlio verrà riconosciuto come figlio legittimo del marito. I giovani di oggi però non lo accettano; è comunque una vergogna per la donna se lo fa, ma in ogni caso non è peccato*”

“(sull’incenso profumato acceso dalla donna per un uomo) *Questo odore appartiene ad una donna sposata; quindi, dicono che quando lo senti da una ragazza (nubile) non ti sposa più, diventa zitella*”

(P1)

“*In Nigeria, mio fratello maggiore aveva una fidanzata che lavorava in un ospedale psichiatrico. Già lei, per il solo fatto di lavorare lì, era vista male dalle persone*”

(P2)

“(sul malato mentale) *sei più abbandonato a te stesso. Di solito stai fuori, vivi per strada, lontano. Non puoi fare una famiglia*”

(P1)

“*Quale genitore ti darebbe suo figlio o sua figlia se sei matto? Già nel villaggio questo viene visto male [...] Se una famiglia ha qualcuno matto in famiglia si “ammuccia”, si nascondono per far sì che la comunità non venga a saperlo.*”

	<p><i>“Se io so che tua sorella o tuo fratello o qualcuno di tuo è matto, nessuno ti parla più. Tutti ti isolano. Isolano l’intera famiglia”.</i></p> <p><i>“Diventa lo zimbello di tutti, ridono quando lo vedono e ridono anche di te. Perché immaginano che sei sporca, che non ti lavi...”</i></p> <p>(P2)</p>
<p>“Rapporto uomo-donna-famiglia”:</p>	<p><i>“Se un uomo vuole sposare una donna non chiede a lei, ma agli anziani della comunità”</i></p> <p><i>“Alla donna viene dato da suo padre un calice di vino di Panama e le dice “portalo all’uomo che vuoi sposare”</i></p> <p><i>“Lei deve inginocchiarsi per farlo bere; c’è un po' questo simbolo di sottomissione da parte della donna: deve inginocchiarsi per consegnargli qualunque cosa durante i rituali.”</i></p> <p><i>“L’uomo è la testa”</i></p> <p>(P3)</p> <p><i>“Pure da noi, quando tu fai dei figli con un altro e sei sposata con un uomo Igbo, questo figlio sarà dell’uomo che hai sposato”</i></p> <p>(P4)</p>
<p>“Rituali”:</p>	<p><i>“[...] le donne devono prendere la coppa di vino di Panama per l’uomo”</i></p>

“Il giorno del matrimonio, dopo che hanno fatto tutti i sacrifici e rituali, alla donna viene dato da suo padre un calice di vino di panama”

(P3)

“Deve inginocchiarsi per consegnargli qualsiasi cosa durante i rituali”

“(sul divorzio) Per realizzarlo sono necessari alcuni rituali: servono per spezzare quel calice col vino che quel giorno diede a quell'uomo, perché per tradizione è quello che li ha uniti [...] Fin quando non verrà messo in atto questo rituale che “spezza” il legame”

(P3)

“Si fanno degli incantesimi, si mettono i propri umori nelle preparazioni culinarie per realizzarli”

“Da noi nella camera da letto mettono a bruciare l'incenso, una serie di erbe che bruciando fanno buon odore. Quando il marito è fuori e la moglie mette a bruciare questo incenso, il marito torna subito”

“(sulla causa della malattia mentale) che è un matto, che gli hanno fatto vodù. È uno dei modi. La causa della malattia mentale può essere relativa a tanti fattori, tipo la droga, il vodù, ovvero i riti tradizionali (spirituali)”

	<p>(P1)</p> <p><i>“Una volta consultato, il medico (tradizionale) ti dirà cosa bisogna fare. Se è necessario fare un sacrificio o un rituale [...] l’atto che è necessario compiere per rimandare la malattia mentale nel mondo spirituale.</i></p>
<p>“Regole della poligamia”:</p>	<p><i>“Un marito con più mogli vive insieme a quella che in quei giorni cucina per lui; poi si sposta dall’altra che cucinerà; in genere due notti a testa. Se per caso il marito deve dormire da una moglie, nel suo turno, e dorme da un’altra, e da quell’incontro nasce una gravidanza, quel bambino è un bastardo. Non è legittimo, ma illegittimo, perché non era il turno di questa signora ma di un’altra. Non può essere riconosciuto, perché se il marito va a dormire dall’altra mentre una lo aspettava, ha peccato, non ha rispettato le regole, ed è come se avesse commesso un’infedeltà”</i></p> <p><i>“Coloro che sono più ricchi fanno costruire una casa per ciascuna moglie, ma ci sono anche quelli che pur avendo soldi, preferiscono che le donne vivano nella stessa casa. Anche su più piani, dove dividono le mogli”</i></p> <p>(P1)</p>
<p>“Malattia spirituale”:</p>	<p><i>“La malattia mentale non ha a che fare con la psicologia: non c’è da scoprire”</i></p> <p>(P1)</p>

“Ha più a che fare con qualcosa di spirituale. [...] quando una persona comincia a comportarsi come se avesse un problema psichiatrico, noi diciamo che ha offeso qualche spirito. Lo spirito allora gli ha mandato qualcosa di maligno che può andare via attraverso un sacrificio.”

(P2)

“In Mali la questione della salute mentale è vista malissimo: la psicologia non è un qualcosa che lì funziona tanto [...] Per dirti che prima di tutto è visto male ciò che riguarda la salute mentale. [...] o ti portano in questo ospedale o ti portano da un guaritore tradizionale.”

“La causa della malattia mentale può essere relativa a tante cose, tipo la droga, il voodoo, ovvero riti tradizionali, spirituali”

(P1)

“Noi pensavamo, prima, che la malattia mentale, (tutto quello che succede ora in realtà succedeva anche prima) veniva solo dal “maligno”: solo se aggredisci, se fai uso di droga, se violenti qualcuno”

“Quindi qualsiasi cosa succedeva ci facevano credere che era lo spirito che lo causava, per tenerci a bada”

“Essendo che nel villaggio sono tutti cresciuti con la mentalità tradizionale, non

	<p><i>credono nella medicina inglese (o medicina dei bianchi). [...] Perché secondo loro è una malattia spirituale; quindi, devono rivolgersi a qualcuno che vede il mondo spirituale per poter risolvere un problema spirituale”</i></p> <p>(P2)</p>
<p>“Psicologia come tabù”:</p>	<p><i>“La malattia mentale non ha a che fare con la psicologia: non c’è da scoprire”</i></p> <p>(P1)</p> <p><i>“In Africa si dice “medicina dei bianchi”. [...] Mi ricordo, in Nigeria, che mio fratello maggiore aveva una fidanzata che lavorava in un ospedale psichiatrico. Già lei, solo per il fatto di lavorare lì, era vista male dalle persone”</i></p> <p>(P2)</p> <p><i>“In Mali la questione della salute mentale è vista malissimo: la psicologia non è un qualcosa che lì funziona tanto”</i></p> <p><i>“L’idea della mente prima non era tanto sviluppata, non conoscevamo tante cose”</i></p> <p>(P1)</p> <p><i>“Essendo che nel villaggio sono tutti cresciuti con la mentalità tradizionale, non credono nella medicina inglese – o medicina dei bianchi [...] non si rendono conto che il guaritore tradizionale costa più dell’ospedale, e anche se vengono a saperlo</i></p>

	<p><i>non gli interessa perché non ci credono e non intendono rivolgersi ad un dottore”</i></p> <p>(P2)</p>
<p>“Malattia come punizione degli Spiriti”:</p>	<p><i>“Che è un matto, che gli hanno fatto vodù. È uno dei modi. La causa della malattia mentale può essere relativa a tanti fattori, tipo la droga, il vodù, ovvero riti tradizionali, spirituali, che si spiega in tanti modi. Facciamo un esempio: io ho bisogno di soldi, sono venuta da te e abbiamo fatto un accordo; tu non hai rispettato l’accordo”</i></p> <p>(P1)</p> <p><i>“In alcuni casi, soprattutto prima, la malattia mentale può avvenire quando tu non rispetti le regole del villaggio. Se per esempio nel villaggio in cui vivi c’è una determinata regola che tutti devono rispettare e tu non la rispetti, ti attaccano con la malattia mentale. La persona diventa matta. Ci sono molte regole. Per esempio, da dove vengo io, forse ora non lo fanno quasi più, ci sono alcuni uomini a cui piace avere rapporti con donne sposate o violentare le persone. Ce ne sono tanti, dipende dalla tua comunità. Ora succede di meno. Se tu non rispetti gli spiriti del villaggio, loro ti allontanano, ti lasciano (in ingl.) o se non ci credi. [...] Se tu segui le regole della comunità allora non avrai alcun problema con lo spirito della comunità; se invece tu aggredisci le regole dello spirito, allora avverrà questo.”</i></p>

	<p>(P3)</p> <p><i>“Inizialmente, noi africani, forse gli anziani lo sapevano e non ci dicevano niente, per farci avere paura, per farci rispettare le regole. Ci sono alcune regole messe lì dallo spirito antico (inudibile) di cui gli anziani hanno messo pure la loro, per proteggere il villaggio. Per non fare andare il villaggio troppo lontano dalle regole della comunità, per mantenerle salde. Quindi, qualsiasi cosa ci succedeva ci facevano credere che era lo spirito che lo causava, per tenerci a bada. Ma oggi – vedendo che a nessuno importa più niente di questi spiriti e le malattie ancora ci sono – allora la popolazione si è resa conto che non è un solo fatto di spiriti, ma che ci sono diverse cause che possono portare alla malattia mentale.”</i></p> <p>(P2)</p> <p><i>“Ti riferisce la causa della malattia, ovvero il peccato che ha commesso che lo ha condotto a sviluppare una malattia mentale”</i></p> <p>(P3)</p> <p><i>“Più grave è ciò che ha commesso la persona più ti costa la cura”</i></p> <p>(P2)</p>
<p>“La funzione del Guaritore”:</p>	<p><i>“Le cose sono due: o ti portano in questo ospedale o ti portano da un guaritore tradizionale”</i></p> <p>(P1)</p>

“Quindi se si tratta di uno che ha un problema riconosciuto di natura spirituale, lo si lega e lo si porta dal medico tradizionale. Ma per andare dal medico tradizionale si paga, ma anticamente non si pagava con denaro ma con beni di necessità (pollo, mucca) per consultare il mondo spirituale. Quindi si interroga sul perché sta accadendo questo e ti risponderà. Una volta consultato, dirà cosa bisogna fare. Se devi fare un sacrificio o un rituale; quindi, ti dice ciò che devi fare. Ti dice la causa della malattia, ovvero il peccato che ha commesso che lo ha portato a sviluppare una malattia mentale. Poi ti dice l'atto che è necessario compiere per rimandare la malattia mentale nel mondo spirituale.”

(P3)

“Sì, da noi dicono che la malattia si può rimandare indietro”

“I genitori o le famiglie che vogliono guarire una persona ma non hanno i mezzi lo portano dal guaritore tradizionale”

(P1)

“Non si rendono conto che il guaritore tradizionale costa più dell'ospedale, e anche se vengono a saperlo non gli interessa perché non ci credono e non intendono rivolgersi ad un dottore. Perché secondo loro è una malattia spirituale, quindi devono rivolgersi

a qualcuno che vede il mondo spirituale per poter risolvere un problema spirituale.”

(P2)

“Quando ti portano dal guaritore tradizionale ti fanno bere una bevanda (inudibile). Tu vieni legato, picchiato, messo in catene. È una vera e propria tortura. I matti vengono picchiati sempre”

(P1)

“Quindi preferiscono andare direttamente dal medico tradizionale. Perché ci conosciamo tutti, non c'è neanche bisogno di prendere appuntamento. Ci si arriva facilmente. E una volta che ci arrivi è facile. Più grave è ciò che ha commesso la persona e più ti costa la cura”

(P2)

“Guarire da una malattia mentale è raro. Quando tu guarisci, comunque non potrai guarire al cento per cento. Quindi, anche se lo si guarisce di un poco, tu devi tornare a pagare. Perché se la cura ha funzionato, diventa come un debito, e tu devi pagarlo al guaritore tradizionale”

(P1)

“Sì, anche se il guaritore ti dice che per guarirlo vuole delle cose specifiche, e tu gli porti ciò che ha chiesto; se riesce poi veramente a guarirlo, è come se fossi suo. Sei

	<p><i>in debito. Tu e tutta la tua famiglia, se quello si sposa anche i suoi figli, ecc. Potrebbe per esempio chiedere la mano della figlia.”</i></p> <p>(P2)</p> <p>“(su come si diventa guaritore) <i>Si tratta di un’eredità. Di padre in figlio”.</i></p> <p>(P1)</p>
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