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ABSTRACT

Beliefs and attitudes are essential in mental health discourse. However, cultural beliefs and attitudes towards mental health problems (ATMHPs) among the Berom people of Nigeria are under-researched. The present studies made original contributions using the cultural identity model (knowledge of tribal language and culture) as predictors to investigate ATMHPs, and semi-structured interviews to further examine the potential impact of cultural beliefs on mental health problems. In study 1, N=140 participants responded to questionnaire on ATMHPs and a 5-point Likert-type scale on knowledge of tribal language and culture. Data collated was analysed using multivariate multiple regression in RStudio. Study 2 interviewed N=13 participants (n=7 laypeople; n=6 Western-trained mental health practitioners). Interviews were recorded, transcribed and analysed thematically. Findings of study 1 showed cultural identity model non-significant predictor of ATMHPs. However, in study 2, four themes emerged: Cultural beliefs that MHPs are caused by spiritual forces; Berom indigenous preference for traditional healing; Christian religious healing in Berom communities; and Western-trained mental health practitioners' perception of lay service-users. The authors concluded that Knowledge of culture and tribal language has no impact on ATMHP; however, the Berom traditional and Christian religious healing could be harnessed as essential forms of indigenous mental healthcare provision.

Keywords: Attitudes, Berom-culture, Berom-language, beliefs, Christianity, traditions, healing, mental health.

INTRODUCTION

The term 'Berom' has dual meanings. It is used to (i) describe the community as a people, and (ii) their native language of communication. The Berom people are mostly farmers, located predominantly in Jos Plateau State of Nigeria, with a population of approximately 3.5 million (Olisaeke, 2012). They have a rich cultural heritage engrained with Christianity and religiously devout to worship *'Dagwi'* (Almighty God) (Tagurum et al., 2015). For example, 'wusal-Berom' is a popular annual cultural festival of traditional Berom Christian fellowship that attracts Berom and non-Berom people from all walks of life.

Before the advent of Christianity, the early Berom traditional religion had 'behwol' (shrines). The behwol is made up of gods' sacred order. Due to behwol psychological, and religious significance, people with mental health conditions and diviners prayed at behwol for healing and protection against any form of evil (Mwadkwon, 2010). Diviners are gifted Berom persons with special powers to heal mental health problems. Diviners are believed to harness spiritual powers and medicinal herbs for mental health healing and protect individuals, families, and the entire Berom community from malignant spirits or sorcerers (Mwadkwon, 2010).

There is an increasing cultural belief about the re-emergence of traditional healing systems in Nigeria. For example Jidong et al (2021a) used a qualitative method and explored the Nigerian cultural beliefs about MHPs and traditional healing. The study found that traditional healing is revered among Nigerians and shapes the current dynamics of the mental health care provision in the country. This includes the preference for traditional healing as the first treatment modality for MHPs in Nigeria. Jidong et al (2021a) also found that traditional healing is useful, effective, affordable, culturally and linguistically compatible with indigenous Nigerians. Similar findings were reported in (Takim, David, & Pefun, 2013), which showed that traditional healing was the preferable source of treatment for mental health conditions among Nigerians.

Furthermore, religion and spirituality dominate the Nigerian mental health discourse. Religious healing is believed to be compatible with the faith-based belief systems of the community. It is also considered as useful, affordable, reliable source of healing for mental health problems. For instance, Christian religious healing may involve praying and fasting with the aim of 'casting out' demons that might have caused the MHPs (Ebigbo & Tyodza, 2007). Similarly, a study involving 219 psychiatric patients recruited from a teaching hospital in Kano, Nigeria highlights that 59% attributed their MHPs to supernatural forces while 45% reported patient's initial resort to religious healings (Aghukwa, 2012). Over a decade ago, a community survey (the Nigerian Survey on Mental Health and Well-being) indicated that about 31% of the respondents adduced mental illnesses to supernatural causes (Gureje, Lasebikan, Ephraim-Oluwanuga, Olley, & Kola, 2005). This may account for the use of alternative practitioners notably priests, spiritualists and natural therapist as the first port of call by four in every five individuals seeking treatment for mental illnesses (Lasebikan, Owoaje, & Asuzu, 2012).

Cultural belief systems and traditional practices play essential roles in how people think, act or engage in mental health-seeking behaviours (Helman, 2007; Jidong et al., 2021b; Makgahlela et al., 2021). Mental health is subjective and could be defined in linguistic expression, community orientation, social expectation or cultural identity (Jidong, Kenneth & Tribe, 2020; O'Neill, 2005; Vaillant, 2012). The concept of cultural identity credited to Collier and Thomas (1988) opined that behavioural conduct rules are shaped by shared cultural beliefs, norms, values, and meanings. Thus, it further reflects aspects of cultural beliefs, values or behavioural tendencies to act in specific ways endorsed by the ethnic people (Schwartz, Zamboanga & Weisskirch, 2008; Unger, 2011). Cultural identity is a fluid and dynamic process that continuously evolves across one's lifespan (Bauman, 2001).

Cultural identity-oriented behaviours often manifest in people living in an ethnic community with a consensual and explicit agreement about their collective identity (Taylor & Usborne,

2010). In essence, ethnic people might consciously and deliberately engage in behavioural processes that are culturally motivated by shared history about mental health issues from family, community and societal responses. On this premise, it is apparent that individuals' cultural beliefs or self-knowledge of culture and tribal languages could be essential in understanding Attitudes Toward Mental Health Problems (ATMHP). More illustratively, McAdams (2006) examined the lived stories of native Americans and found that individuals' lived stories were significantly shaped by forces such as cultural norms, historical events and cultural assumptions or superstitions. However, McAdams' (2006) study was conducted in an American population, which may not reflect the behavioural tendency across other cultures. However, the study broadens our understanding of the relevance of cultural beliefs on mental health issues. The cultural identity model is operationalised in the present study as the knowledge of tribal language and culture. Knowledge of tribal language is further defined as understanding and speaking the Berom tribal language fluently. In contrast, the knowledge of culture is the ability to understand the Berom traditional practices and rituals associated with mental health issues.

The high dominance of Western psychiatric ideas on mental health across the globe has potentially undermined the cherished cultural beliefs and traditions of many low and middle-income countries like Nigeria (Shukla et al., 2012; Tribe, 2014). Of the over 206 million Nigerian population (Worldometers, 2020), an estimated ratio of access to psychological services is 50 psychologists to 150,000 citizens (1: 3000) (Mefoh, 2014a), with only 250 practising psychiatrists and 200 psychiatry trainees which result in the high shortage of mental health provision in the country (Association of Psychiatrists in Nigeria, 2020). Although a few studies in Nigeria had earlier highlighted the relationship between cultural beliefs and mental health (Gureje et al., 2005; Lasebikan, 2016). Specifically, a study by Lasebikan and Lasebikan (2017) in Nigeria showed the receipt of a culturally competent alcohol intervention program in

a native Yoruba language. This yielded a higher retention rate for clients in treatment for problem drinking than one run in the English language (Lasebikan & Lasebikan, 2017). However, these studies had been quantitative assessment and a review of literature which have greatly limited the depth of the exploration of the research question. Therefore, it is justifiable that assessing the role of culture on mental health issues using qualitative measures will add to the body of literature on the subject.

To the best of the researchers' knowledge, this is the first empirical study examining the Berom cultural beliefs, lay understandings, and attitudes towards mental health and well-being split into two studies. Hence, highlighting the study's originality, significance and contribution to the literature. Study 1 hypothesised that knowledge of culture and tribal language could predict ATMHP. Also, study 2 asked what are the cultural beliefs about MHPs and help-seeking behaviours? The study's prediction and research question reflect the theoretical underpinning of social constructionism which states that human beliefs and perceptions are shaped by their shared history, language and social space (Burr, 2015).

This paper contribute to the body of knowledge and literature from two perspectives. Firstly, the study hypothesised that a cultural identity model based on knowledge of tribal language or culture does not predict ATMHP among the Berom ethnic people. Secondly, our findings showed the existence of cultural beliefs, and that MHPs are caused by spiritual forces and potential preferences for the Berom traditional and Christian religious healing. The paper's implication for clinical practice is to design care provision that accommodates cultural beliefs and spiritual practices. The authors argued that findings of the present study had set a foundation for future research to build evidence-based effectiveness of the Berom traditional and Christian religious healings for potential incorporation into the broader mental health care system.

METHOD

Design

The paper employed a mixed methods research design incorporating quantitative and qualitative methods. In essence, There is an increasing trend in using mixed methods for health research (Coyle et al., 2018; Wisdom, Cavaleri, Onwuegbuzie, & Green, 2012). Mixed methods harmonises both quantitive and qualitative data, increasing rigour and robustness and improving confidence in the findings. Our approach to mixed method was underpinned by Morgan's (1998) mixed methods explanatory parallel design. The study used the cultural identity model (knowledge of tribal language and culture) as predictors to investigate ATMHPs, and semi-structured interviews to further examine the potential impact of cultural beliefs on mental health problems.The qualitative component of the present study complements the quantitative research in three perspectives: Firstly, it addressed cultural beliefs about mental health that were otherwise unable to be captured in the questionnaire used. Secondly, questionnaires used were not culturally validated, and therefore, unable to identify nuances and salience features of participants' defined meanings and lived experiences of their indigenous mental health discourse. Thirdly, the qualitative component allowed for self-expression of beliefs about mental health in the participants' own words beyond the Likert-type restriction of the questionnaire used in study 1. The qualitative element built and complimented on the quantitative part of the present study.

Study 1: Participants, questionnaire and data collection

In study 1, 140 participants responded to a demographic measure of knowledge of culture and tribal language. Participants were each self-assessed on a scale of 1-5 (1 less to 5 high knowledge) alongside an ATMHP scale (Gilbert et al., 2007). ATMHP is a 35-item scale adapted because it tapped on the various aspects of shame on MHP. The scale is divided into

five sections that measured (i) individual's perception of how their families and communities see MHP, (ii) the person's perception of how their family members and community would see them if they had MHP, (iii) negative evaluation and internal shame of having MHP, (iv) beliefs and reflected shame about how one's family would be seen should one had MHP, (v) fears and reflected shame on self - associated with a close relative who suffers from MHP. Although the ATMHP scale adapted for study 1 was not culturally validated; however, the various sections of the questionnaire highlighted relevant culturally transferable themes applicable to the Berom people and context.

Study 1 recruitment and mode of data analysis

The quantitative arm employed an opportunity sampling technique for participants' recruitment. The response time for each questionnaire was approximately 10 minutes. Multivariate multiple regression was conducted in RStudio version 0.99.896 for the data analysis. Gilbert et al (2007) initially validated the ATMHP scale with Asian and non-Asian female students and found all subscales to have had good Cronbach's alphas of 0.85 and 0.97.

Study 2: Interview questions, data collection and analysis

A semi-structured interview schedule was used to ask questions about participants' cultural beliefs on mental health issues. To ensure rigour, an iterative method was employed to develop the interview schedule among the research team to allow for robustness and appropriateness of the interview questions to the target populations. The questions asked include; (a) What do you understand by a mental health condition (MHP) from the Berom cultural perspectives? (b) How would you tell when someone is having a MHP? (c) What are your views or the Berom cultural perspectives about the causes of MHPs within the community? (d) How do you think people from the Berom community think about people with MHPs? (e) Where do you think the Berom

people get help/support/treatment if they are experiencing any MHPs? Other interview topics included questions on available treatment options for MHP within their local communities.

The experiences of Western-trained mental health practitioners of working with 'lay' service-users were also explored. The rationale for including Western-trained mental health practitioners is to explore variances or similarities concerning their views on the health-seeking behaviours of laypeople experiencing MHPs. Some of the questions practitioners were asked include (a) What do you think are the common narratives about MHPs in the Berom community? (b) What do you think are the dominant cultural beliefs about the causes of MHPs? (c) Do these cultural/traditional beliefs affects their help-seeking behaviours for MHPs or your practice as a Western-trained mental health practitioner? Some interviewed laypeople and mental health practitioners also participated in the survey.

Study 2 recruitment and mode of data analysis

Purposive and snowball sampling techniques were adopted to recruit 13 participants who underwent semi-structured interviews that lasted approximately 55 minutes each. Interviews were audio-recorded and transcribed verbatim. Of the 13 participants, n=7 laypeople (Male = 4; Female = 3) while n=6 Mental health practitioners (Male = 3; Female = 3). Data saturation was reached after interviewing the 7th lay participant and the 6th Western-trained mental health practitioner when data verbatim showed no new information was being generated. Lay participants are referred to members of the public who were self-identified as not having any form of Western professional training in mental healthcare. However, the lay participants recruited had other experiences, such as public civil service, self-employed entrepreneurs and educational study experiences at different levels.

Thematic analysis was adopted from a socio-constructionist theoretical perspective to analyse the interview transcripts (Burr, 2015; Harper, 2011; Willig, 2013). NVivo v12 was also used

to organise the interview transcripts for the data analysis. The data was analysed thematically according to the guidelines recommended in Braun & Clarke (2013; 2006), which include familiarising with data transcripts, coding, generating themes, reviewing themes, defining and naming themes, and writing up. Finally, identified vivid expression was used as supporting extracts for the emerging themes in the results section.

Participants and location of data collection

All participants in studies 1 and 2 lived in the Berom communities of Jos, Plateau State Nigeria at the time of data collection with an age range between 18 and 65 years.

Ethics

Ethical approvals were granted for studies 1 and 2 from the University of East London, UK and the Jos University Teaching Hospital, Nigeria. Informed consent was sought and granted by all participants in both studies and were also self-identified as members of the Berom ethnic people.

RESULTS

Study 1: Quantitative findings

The levels of cultural knowledge and tribal language were recorded with a Likert-type scale of 1-5 (1 less to 5 high knowledge). Scores were recorded for the Attitudes towards Mental Health using the Gilbert et al (2007) ATMHP scale. Means and standard deviations can be viewed in Table 1. ATHM1: individual's perception of how their families and communities see MHP; ATMH2: the person's perception of how their family members and community would see them if they had MHP; ATMH3: negative evaluation and internal shame of having MHP; ATMH4: beliefs and reflected shame about how one's family would be seen should one had MHP; ATMH5: fears and reflected shame on self - associated with a close relative who suffers from MHP.

Table 1 showing descriptive statistics, reliability and correlations between cultural identity predictors and the subscales of attitudes towards mental health

	Descriptive Statistics			Zero Order Correlations					
	Alpha	Mean	Standard Deviation	Knowledge of Culture	Knowledge of Tribal Language	ATMH 1	ATMH 2	ATMH 3	ATMH 4
Knowledge of Culture	-	-	-	-					
Knowledge of Tribal Language	-	-	-	0.70***	-				
ATMH 1	0.85	15.2	5.66	0.02	-0.05	-			
ATMH 2	0.9	21.3	7.93	-0.03	-0.09	0.64***	-		
ATMH 3	0.87	12.7	5.37	0.06	-0.01	0.57***	0.69***	-	
ATMH 4	0.89	15.5	6.17	-0.04	-0.04	0.54***	0.64***	0.67***	-
ATMH 5	0.87	11.8	5.01	0.03	-0.02	0.45***	0.48***	0.52***	0.62***

*Note: N = 128; *p < 0.05; **p < 0.01; ***p < 0.001*

Multivariate multiple regression was conducted with all five Attitudes towards mental health subscales as outcome variables and "Knowledge of Culture" and "Knowledge of Tribal Language" as predictors. Overall, the multivariate model was not significant (*Knowledge of Culture:* $V^{(s)}(1)=0.03$, $F(5,121)=0.64$, $p=0.67$; *Knowledge of Tribal Language*: $V^{(s)}(1)=0.02$, $F(5,121)=0.39$, $p=0.86$).

No individual regression model reached significance for ATMHP subscale 1 ($F(2,125)=0.50$, $R^2=0.01$ $p=0.61$), ATMHP 2 ($F(2,125)=0.59$, $R^2=0.01$, $p=0.56$), ATMHP 3 ($F(2,125)=0.60$, $R^2=0.01$, $p=0.55$), ATMHP 4 ($F(2,125)=0.10$, $R^2=0.002$, $p=0.91$), ATMHP 5 ($F(2,125)=0.17$, $R^2=0.002$, $p=0.84$) where Knowledge of Culture and Knowledge of Tribal Language were predictors. Individual weightings of predictors can be viewed in table 2.

Table 2 showing predictor weightings for each Attitudes Towards Mental Health Subscale

Outcome	Predictor	*B*	Std. Error	*β*	*t*	*p*
Attitudes 1	Knowledge of Culture	0.60	0.73	0.10	0.82	0.42
	Knowledge of Tribal Language	-0.83	0.85	-0.12	-0.98	0.33
Attitudes 2	Knowledge of Culture	0.48	1.02	0.06	0.47	0.64
	Knowledge of Tribal Language	-1.22	1.18	-0.13	-1.03	0.31
Attitudes 3	Knowledge of Culture	0.75	0.69	0.13	1.09	0.28
	Knowledge of Tribal Language	-0.69	0.80	-0.12	-0.86	0.39
Attitudes 4	Knowledge of Culture	-0.13	0.7952	-0.02	-0.16	0.88
	Knowledge of Tribal Language	-0.18	0.93	-0.02	-0.19	0.85
Attitudes 5	Knowledge of Culture	0.05	01	0.07	0.54	0.59
	Knowledge of Tribal Language	-0.05	0.11	-0.06	-0.47	0.64

There was no significant interaction for knowledge of culture and tribal language as predictors for ATMHP subscales 1, 2, 4, & 5. This statistical outcome suggests that the individual awareness of cultural practices and traditions or the ability to speak the native language fluently and relate with people amicably has no implication for ATMHPs.

Study 2: Qualitative findings

The data analysis captured four key themes from the qualitative arm of the present study, which includes (i) Cultural beliefs that MHPs are caused by spiritual forces; (ii) Berom indigenous preference for traditional healing; (iii) Christian religious healing in Berom communities; and (iv) Western-trained mental health practitioners' perception of lay service-users. Note, direct extracts from the data verbatim in the interview transcripts are used to support the identified themes.

Cultural beliefs that MHPs are caused by spiritual forces

The first theme elaborated on beliefs about spiritual causes of MHPs in the community. Thus, gods, spirits or the devil are believed to cause MHP or individuals who have access to spiritual powers can bewitch others and cause MHPs of any kind. A lay interviewee said:

> *"You will find out in the Bible, there was this mad man of 'gagara' and we learned that he was possessed actually with demons, but Jesus commanded the demons and they left. So, really and truly, there are psychological conditions that could be demonic, and there are those that came as a result of natural occurrence"* [Lay participant, 5].

As depicted in the above extract, the interviewee believes in the spiritual causes of MHPs from a Biblical perspective and acknowledged the chances of naturally occurring MHPs. A possible explanation for this might be the participant's background as a Christian. This might have impacted how they construe religious doctrine as representing a strong basis for inferring psychological conditions influenced by spiritual forces. However, an interviewed mental health

practitioner contradicted the conventional lay narrative on spiritual manipulation to cause mental illness in other people by suggesting that such acts are not common among the Berom ethnic people except for the cases of witchcraft:

> *"[Spiritual manoeuvring to cause mental illness in others] is not actually something that is obvious in this [community], the Berom man, apart from the issue of witches and witchcraft- the issue of making other people mad is not actually a big issue in Berom land, I don't actually believe in such things, I am yet to see somebody who believes in such"* [Mental health practitioners, 9].

Although, the above extract suggested that the participant does not believe in the spiritual causes of MHP. This explanation might be attributed to the interviewee's training background – it appears evident that Western-trained mental health practitioners are likely to dissociate from their beliefs on spiritual causes of mental illness. Despite the above notion, the beliefs about spiritual causes of MHPs is not limited to laypeople. For instance, another interviewed mental health practitioner argued that laypeople and service-users in their facilities believe in the spiritual causes of MHPs. As such, the participant further stated that:

> *"[service-users] believe that some forms of mental illnesses are witchcraft, or being possessed, so it takes a lot of effort to convince them that is not all forms of mental illness that can be seen as being possessed due to witchcraft, and because of this beliefs, the illness behaviour is different that affects the health-seeking behaviour, people go to seek for help and in places where actually help is not there actually, but they still go there, so their beliefs determine what the patient gets in terms of therapy, so this is a very, very serious believe"* [Mental health practitioner, 9].

As depicted in the above extract, service-users' beliefs shaped their healthcare-seeking behaviours. This may also imply that, because the people believed in spiritual causes of MHP,

they are likely to seek help from spiritual sources such as traditional or religious healing. This notion is further elaborated upon in the following theme.

Berom indigenous preference for traditional healing

Interviewees were asked where they think most people often access reliable and effective mental health services. The overall response to this interview question suggested that traditional and religious healing services are used more often than Western mental healthcare. For instance, the following two lay interviewees have this to say:

> *"The traditional healers are doing well to some extent. Yes! Because they know more about the culture; they are like the bridge between culture and the Berom man"* [Lay participant, 7].
>
> *"There are people who go there [to traditional healers and sacred places with MHP] with the belief that they will be better, their children will be better, their relatives will be better, and it works"* [Lay participants, 2].

These extracts, which are representative of the data set, depicts the overwhelming beliefs about the efficacy of traditional healing for MHP. These beliefs appeared to be directly linked to the usage of traditional healing services. Thus, due to the preference for traditional healing, another lay interviewee equally suggested for the incorporation of traditional healing into formal healthcare and possible collaboration between traditional healers and Western mental healthcare practitioners in the following extract:

> *"We have some herbalist that can just help you and give you herbs that you can take and will sustain you or to heal [MHPs]. I think that is a good idea, if the government would incorporate them [traditional healers] to work with them [Western trained mental health practitioners]. Because other herbs are very vital*

so that they would put all hands together, I think the hospitals too can even use it [herbs]" [Lay participant, 3].

The above extract further suggested that indigenous herbs could be refined, used or prescribed in hospitals for service-users who suffer from any forms of MHPs.

Christian religious healing in Berom communities

Christian religious healing is well-cherished among the Berom people. Some members of the Berom community consult their clerics in the quest for getting spiritual healing for their MHPs in the form of religious counselling, praying and fasting, depending on the prescription given by their religious leader. Both lay participants and mental health practitioners expressed confidence in the efficacy of Christian religious healing for MHPs. An interviewed lay participant said:

"Yeah! Prayers do help them to get better actually because healing comes from God and when you believe in God, when you receive prayers [from a pastor], and God decided [to heal], you would definitely be healed" [Lay participant, 3].

Similarly, mental health practitioners perceived the role of Christian religious healing with prayers as useful in complimenting their treatment intervention. For instance, one of the interviewed mental health practitioners said:

"Studies have shown that with prayers and medication, the clients do better. Most of the times, it is just to satisfy the curiosity of the patient. Also, we educate the Imams or the Pastors and create an avenue to have one-on-one interaction with them [religious leaders] and tell them what to do when they come across cases like that [mental illness]. So, sometimes they don't just come [to the facility] and pray, they usually interact with us [the mental health practitioners]. Well! There are no doubts that there are so many mental health cases, so many mental illness cases

that have been attended to by traditionalists and they are doing well, yes they are doing very well" [Mental health practitioners, 8].

The above extract revealed the usefulness of religious prayers in healing MHP. It also demonstrated the possibility of harnessing and adopting religious prayers side-by-side with psychotherapy to foster recovery.

Western-trained mental health practitioners' perception of lay service-users

Mental health practitioners acknowledged the usefulness of cultural sensitivity, such as cultural orientation and native language, to strengthen rapport and trust between service-users and providers. For example, an interviewed mental health practitioner said:

In the hospital, once they discover you are their language [same ethnic group], you speak the same language with them, they tend to come closer to you, and they ask you a lot of questions. This is very, very helpful because I'm a Berom person, I know the culture and those things that I feel would affect their consent to their treatment, I explain to them, and I try to disabuse their minds or make them understand the cultural aspect is different from the medical aspect and try to make them relate it so that it would help them in the treatment" [Mental health practitioner, 10].

The excerpt demonstrated that service-users feel secure whenever they meet a practitioner from the same ethnic group, with the same cultural orientation and speak the same native language. It also showed in the data set that most people used traditional and religious healing because it is affordable and cost-efficient compared to Western mental health service. Another interviewed mental health practitioner said:

"There are people who till today they cannot afford their medical bills who don't even visit the hospital in the first place, just like I told you there are herbalists

around, you would hear that if you plug this tree leaf, cook it and drink it and actually, you will sleep off, it helps, it cures, like till today I know that there are people who use guava leaves for diarrhoea and for some it stops. There are people who for typhoid I know a powder from a particular tree, the tree leaves are pounded and brought into powder form, and they drank. You hear them saying that is what cure them after all" [Mental health practitioner, 13].

The above extract made specific examples of the usefulness of indigenous herbs in treating some biological illness. However, similar narratives could be extended to the beliefs about using herbs and traditional healing for MHP.

DISCUSSION

Our study aimed to use the cultural identity model (knowledge of tribal language and culture) as predictors to investigate ATMHPs, and semi-structured interviews to explore perspective concerning the potential impact of cultural beliefs on mental health problems. In study 1, findings on whether knowledge of culture and tribal language could predict ATMHP showed no main or interaction effects. Thus, levels of individuals' awareness of their cultural practices and traditions or the ability to speak the native language fluently and relate with other community members amicably have no impact on ATMHPs. Findings of study 1 are not congruent with the cultural identity approach which opined that the behavioural tendencies to act in specific ways are endorsed by cultural meanings and shared values or language (Collier & Thomas, 1988; Jidong et al., 2021c; Schwartz et al., 2008; Unger, 2011). An alternative explanation for why there were no significant effects on knowledge of culture and tribal language on ATMHP could be partly because the Gilbert et al (2007) ATMHP scale was initially validated for Asian and non-Asian female students and not culturally standardise for the indigenous Berom people. In addition, study 1 findings contradict the social constructionist

theory, which argued that social realities are shaped by shared history, language and social space (Burr, 2015).

Anticipated outcomes and the preliminary findings from the quantitative study 1 with the potential tendency of showing no main or interaction effects triggered the need for the follow up qualitative study 2. Study 2 showed that there are cultural beliefs that MHPs are caused by spiritual forces and a potential trajectory between the Berom cultural beliefs and the indigenous preference for traditional and religious healing for MHPs.

A recurrent pattern from the qualitative findings was the perceived belief system that reflects the theoretical assumptions of the spiritist etiologic theory of MHP. A previous study found a strong link between spiritism and MHP among indigenous people of Brazil (Moreira-Almeida & Neto, 2005). The theory support spirits' survival after death and a continuous exchange of knowledge between the disincarnated and incarnated spirits.

The present findings also showed that spiritualists or individuals who have access to supernatural powers could invoke evil spirits to inflict MHPs on any person of their choice. This also extends to the infliction of MHPs by some spirits or gods. Similarly, Opare-Henaku and Utsey (2017), in a study that examined culturally prescribed beliefs about mental illness among the Akan people of Ghana, found that mental illness is predominantly seen as a spiritual illness or punishment from the gods. Similarly, in a survey study conducted by (Ramkissoon, Donald, & Hutchinson, 2017) in Trinidad, they assessed 158 tertiary-level students' perception of the causes of mental illness and help-seeking behaviours. 32.3% attributed symptoms of mental illnesses to supernatural causes, 27.8% believed that someone else inflicted it, and 24.1% were attributed to evil spirits. These findings are not surprising as both Ghana and Trinidad seem to share similar cultural beliefs and traditions.

Furthermore, qualitative findings showed an indigenous preference for traditional and Christian religious healing for MHPs. This could be partly due to the cultural beliefs about the causes of MPHs. These similar findings were long reported in Goldstein (1981) who claimed that people who deeply identify with their linguistic and cultural heritage have higher chances to follow their traditional healing and health practices believed to enhance general well-being. Although, Goldstein (1981) findings are over three decades ago, it also showed the long history of preference for traditional or spiritual healing for MHPs. The choice for traditional healing of MHPs is theoretically underpinned in the heritage consistency model which opined that the construction of health and illness is significantly influenced by the person's ethnocultural and religious backgrounds (Zitzow & Estes, 1981). In another study, Ramkissoon et al (2017) confirmed that people are willing to seek religious and medical intervention even for mental illnesses believed to be either supernatural or medical in nature. However, the present findings did not establish if the high preference for traditional and religious healing were due to the high shortage of Western-trained mental health practitioners (e.g. psychiatrists, clinical psychologists or therapists) in their communities.

The present study is limited in some ways. For instance, the ATMHP scale of measurement used for survey data collection in study 1 was not culturally validated for the Berom population. Therefore, the study's findings should be treated with caution. Several culture-bound syndromes and cultural expression of mental illnesses greatly differ across different cultures. Also, the number of participants (N=140) recruited was not based on a particular sample size formula and is not representative of the entire Berom community.

For study 2, it is important to caution that interview extracts reported in the qualitative arms of the study are statements made by interviewees, and thus, represents their perspectives and understandings of MHPs within their locality. This may not necessarily represent an objective view or dominant opinion of the general Berom population. Also, interviewees, especially

mental health practitioners, are seen as an elite group who are highly educated. Their views may not coincide with those of rural, uneducated persons described in the dataset. More so, issues of traditional and religious healing resonated consistently across the datasets. However, traditional and religious healers were not included in the data collection.

This study has established some understandings of mental health issues with the potential transferability of the present findings among Berom ethnic people. The applicability of the present study is supported in its epistemology. For instance, social constructionism would suggest that cultural and linguistic interactions create realities and shared history of common values or traditions are essential aspects of mental health (Burr, 2015; Harper, 2011; Willig, 2013).

Finally, future studies could endeavour to validate all measurement scales to ensure that research tools are all culturally appropriate. The magnitude of actual access to mental health facilities could also be examined, such as a survey of referrals with an audit of Western mental healthcare facilities, traditional and religious healing in the Berom communities.

CONCLUSION

The quantitative component (study 1) examined knowledge of culture and tribal language which showed no impact on ATMHPs. This was an unanticipated finding. However, the follow-up qualitative component (study 2) revealed cultural beliefs that MHPs are spiritually caused and potential preference to seeking traditional and Christian religious healing by the indigenous Berom people. This study has addressed significant socio-cultural issues that have practical implication for mental health among the Berom people. In essence, the study recommends that traditional and Christian religious healing should be harnessed as essential forms of indigenous mental healthcare provision in Nigeria. Although, the knowledge of tribal language showed no significant impact, the native Berom language could be utilised as a useful

means of communication to facilitate mental health provision in the Berom communities. Finally, future research could investigate the perspectives of traditional and religious healers on mental health issues in Berom communities.

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