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Schizophrenia, Culture, and Help-Seeking in Kenya: Toward Culturally Responsive Assessment and Care

Sheila Gavuha Mugwe*
School of Psychology, Daystar University, Nairobi, Kenya

***Abstract*: Schizophrenia in Kenya should be understood as both a clinical condition and a culturally embedded experience. Globally, the World Health Organization estimates that schizophrenia affects approximately 23 million people, or about 1 in 345 people, equivalent to 0.29% of the population; among adults, the estimate is about 1 in 233 people, or 0.43% (World Health Organization (WHO), 2025). Applied cautiously to Kenya's estimated population of 50–60 million people, this suggests that approximately 145,000–174,000 Kenyans may be affected by schizophrenia. This figure should be distinguished from broader psychosis estimates: Kenya's Ministry of Health reports the probable prevalence of psychosis at about 1% of the population, which would translate to approximately 500,000–600,000 people (Ministry of Health Kenya, 2024). These estimates highlight the importance of addressing schizophrenia and related psychotic disorders not only through biomedical diagnosis and treatment, but also through culturally responsive care that considers local beliefs, stigma, family caregiving systems, pluralistic help-seeking, and barriers to accessing mental health services. In Kenya, traditional health practitioners have been identified as important actors in mental health care pathways, particularly because many individuals and families seek support outside formal psychiatric services before or alongside biomedical treatment (Okonji et al., 2008). More broadly, research on psychotic disorders in Africa emphasizes the need to explore synergy between biomedical, traditional, and faith-based systems of care while protecting patient safety, dignity, and access to evidence-based treatment (van der Zeijst et al., 2023).**

***Keywords*: Schizophrenia, pluralistic, psychosis, help-seeking, culture.**

1. Introduction

Schizophrenia is a severe psychiatric condition commonly associated with disturbances in perception, thought, behavior, emotion, and functioning. When active, symptoms may include hallucinations, delusions, disorganized speech, difficulties in thinking, and reduced motivation. However, the experience of schizophrenia is not only clinical; it is also shaped by the cultural meanings attached to unusual behavior, voice-hearing, social withdrawal, and altered perception. In Kenya, where families often play a central role in caregiving and where religious and traditional healing systems remain influential, schizophrenia must be understood through both biomedical and sociocultural-spiritual lenses.

This paper focuses on schizophrenia among Kenyan communities and examines how culture shapes symptom interpretation, stigma, help-seeking, treatment engagement, and family caregiving. It proposes culturally responsive clinical recommendations for psychologists, psychiatrists, counsellors, and mental health services working with individuals experiencing schizophrenia or psychosis in Kenya.

2. Literature Review

Schizophrenia is a severe psychiatric disorder characterized by disturbances in thought, perception, emotion, behavior, and functioning. The World Health Organization estimates that schizophrenia affects approximately 23 million people globally, or about 1 in 345 people, equivalent to 0.29% of the population; among adults, the estimate is about 1 in 233 people, or 0.43% (World Health Organization (WHO), 2025). Applied cautiously to Kenya's estimated population of 50–60 million people, this would suggest approximately 145,000–174,000 Kenyans may be affected by schizophrenia. However, this figure should be distinguished from broader psychosis estimates. Kenya's Ministry of Health estimates the probable prevalence of psychosis at approximately 1% of the population, equivalent to roughly 500,000–600,000 people, and reports that about 25% of outpatients and 40% of inpatients in Kenyan health facilities have a mental condition (Ministry of Health Kenya, 2024). These figures show that schizophrenia and psychosis-related conditions represent an important clinical and public health concern in Kenya.

Genetic factors play an important role in the aetiology of schizophrenia, as demonstrated by family, twin, and adoption studies. Early research showed clear familial aggregation, with higher risk among biological relatives of affected individuals (Kety et al., 1968; Gottesman & Shields, 1976). Twin studies further support the genetic contribution, showing higher concordance rates among monozygotic twins than dizygotic twins, which suggests a strong hereditary component (Sullivan et al., 2003; Hilker et al., 2018). Adoption studies also strengthen this conclusion by showing that individuals with biological parents diagnosed with schizophrenia remain at

*Corresponding author: sgmugwe@gmail.com

elevated risk even when raised in adoptive environments without schizophrenia (Kety et al., 1968; Gottesman & Shields, 1976). However, the genetic basis of schizophrenia is not explained by a single gene. Contemporary evidence supports a polygenic model, in which multiple genetic variants of small effect contribute cumulatively to vulnerability (Owen et al., 2023). This model better explains the complex inheritance patterns observed in schizophrenia and moves the field away from earlier single-gene explanations. Importantly, genetic vulnerability does not determine illness on its own; rather, it interacts with environmental, social, cultural, and structural factors that shape symptom expression, help-seeking, treatment engagement, and recovery.

Specific biological mechanisms have also been investigated. Sekar et al. (2016) identified complex variation in the complement component 4 gene, known as C4, as associated with schizophrenia risk, suggesting a possible link between immune-related genetic pathways and synaptic pruning during brain development. This is significant because schizophrenia commonly emerges in late adolescence or early adulthood, a period associated with ongoing brain maturation. In addition, immune and inflammatory models have expanded biomedical explanations of schizophrenia. Khandaker and Dantzer (2016) review evidence suggesting that immune-to-brain communication may contribute to schizophrenia, while Khandaker et al. (2017) describe immuno-psychiatry as an emerging field linking inflammation and autoimmunity with depression and psychosis. These findings are important, but they should not be treated as single-cause explanations. Instead, they support a multidimensional understanding of schizophrenia in which biological vulnerability interacts with psychological, social, cultural, and structural conditions.

Kenya-specific research also highlights the importance of early identification of psychosis-risk symptoms, particularly among young people. Mamah et al. (2021) studied 9,564 Kenyan adolescents and young adults aged 15–25 and found that psychotic-like experiences were relatively common, although most were mild and not functionally impairing. More clinically significant risk was lower, with 4.6% categorized as high risk for psychosis and 30.6% as medium risk based on symptom scores. The study also found that greater psychotic-like experience severity was associated with mood impairment, stress, poverty, lower educational attainment, underemployment, and substance use history. More recent Kenyan research by Sæle et al. (2024) similarly examined DSM-5 psychiatric disorders among Kenyan youth aged 15–25 and found that psychiatric disorders were more common among those at high psychosis risk. These studies are important because schizophrenia and related psychotic disorders often emerge during adolescence or early adulthood. They also show that early psychosis-risk symptoms may occur alongside depression, anxiety, stress, poverty, and social disadvantage, making culturally informed early assessment and intervention especially important in Kenya.

Although biomedical research is essential, schizophrenia cannot be understood only through biological explanations. Culture shapes how symptoms are interpreted, how families respond, where help is sought, and whether formal psychiatric care is accessed early. In many Kenyan communities, unusual behavior, hallucinations, social withdrawal, or disorganized speech may be interpreted through spiritual, moral, relational, or traditional frameworks. Amunga's (2020) study of selected communities in Western Kenya shows that cultural beliefs can influence how mental distress is understood and managed. Importantly, culture may have both harmful and supportive effects: some beliefs may increase fear, shame, or delayed treatment, while rituals and culturally meaningful practices may provide psychological comfort, belonging, and social restoration. This balanced view is important because culturally responsive care should avoid treating culture only as a barrier. Instead, clinicians should identify which beliefs worsen stigma or risk and which cultural resources can support coping, family involvement, and recovery.

Spirituality is especially relevant to psychiatric care in contexts where religious and spiritual beliefs shape meaning-making and coping. Peteet (2019) argues that spirituality requires conceptual, clinical, and research attention in psychiatry, rather than being dismissed as irrelevant. In Kenya, this is important because psychotic symptoms may be interpreted through religious or spiritual frameworks, and families may seek support from pastors, prayer groups, traditional healers, or other community figures before or alongside formal psychiatric services. A culturally responsive clinician must therefore assess spiritual beliefs respectfully while also distinguishing between culturally meaningful beliefs and symptoms that indicate clinical risk, distress, or functional impairment. This requires cultural humility, careful assessment, and ethical attention to patient safety and dignity.

Help-seeking for schizophrenia and psychosis in Kenya is often pluralistic. Families may move between hospitals, psychiatrists, psychologists, churches, prayer camps, herbalists, traditional health practitioners, and community elders. Okonji et al. (2008) found that traditional health practitioners are important actors in Kenyan mental health care pathways, particularly because many individuals and families seek support outside formal psychiatric services. More broadly, van der Zeijst et al. (2023) reviewed traditional and faith-based healthcare in the management of psychotic disorders in Africa and emphasized the need to explore synergy between biomedical, traditional, and faith-based systems. This does not mean that all traditional or faith-based practices are clinically safe or effective. Rather, it suggests that clinicians should understand the patient's actual pathway to care and, where appropriate, engage community systems in ways that protect patient rights, avoid coercion or harm, and support access to evidence-based treatment.

Stigma remains a major barrier to schizophrenia care in Kenya. Mental health conditions may be associated with shame, dangerousness, unpredictability, moral weakness, curses, witchcraft, demonic possession, or social failure. Such stigma can lead to concealment, delayed treatment, social isolation, exclusion from education or employment, and family burden. Local advocacy sources such as Basic Needs Basic Rights Kenya describe stigma as a force that silences people with

mental health conditions and limits community inclusion. Although such sources are not peer-reviewed, they provide useful local practice-based context that aligns with academic literature on pluralistic help-seeking and community-based mental health support. In schizophrenia care, stigma reduction should therefore be treated as a clinical and equity issue, not merely as a public-awareness concern.

Structural barriers further complicate schizophrenia care in Kenya. The Ministry of Health reports that 75–85% of people with mental illness may be misdiagnosed or untreated when they visit health facilities, and that general healthcare workers diagnose only a small proportion of mental illnesses (Ministry of Health Kenya, 2024). A National Academies workshop summary on sustainable mental and neurological health care in Ghana and Kenya also identifies stigma, workforce shortages, poor infrastructure, limited medicines, inadequate funding, and low diagnostic capacity as major challenges in Kenya's mental health system (National Academies of Sciences, Engineering, and Medicine, 2016). These barriers are especially important for schizophrenia because delayed diagnosis and treatment can worsen outcomes, increase relapse risk, intensify caregiver burden, and deepen social exclusion.

Taken together, the literature supports a biopsychosocial and culturally responsive approach to schizophrenia care in Kenya. Biomedical studies show that schizophrenia involves genetic, neurodevelopmental, and possibly immune-related vulnerabilities. Kenyan youth studies show that psychosis-risk symptoms are clinically relevant and often linked to social disadvantage and comorbid distress. Cultural and spiritual literature shows that patients and families interpret symptoms through multiple explanatory frameworks, while Kenya-specific health-system literature shows that access to formal mental health care remains limited. Therefore, effective schizophrenia care in Kenya should not reject biomedical psychiatry or romanticize cultural explanations. Instead, it should integrate evidence-based diagnosis and treatment with cultural formulation, family psychoeducation, stigma reduction, respectful engagement with patients' belief systems, and attention to structural barriers that shape access to care.

3. Method

This paper used a practice-based integrative review approach to synthesize literature on schizophrenia, psychosis, culture, spirituality, help-seeking, stigma, and mental health service barriers in Kenya and wider African contexts. The review drew on peer-reviewed journal articles, global health sources, Kenyan policy documents, and local mental health practice sources. Sources were selected if they addressed at least one of the following areas: biomedical understandings of schizophrenia, genetic or immune-related explanations of psychosis, psychosis risk among Kenyan youth, cultural interpretations of mental illness, traditional and faith-based help-seeking, stigma, or mental health service access in Kenya.

Literature was identified through academic databases and online repositories, including PubMed, ScienceDirect, Google Scholar, NCBI Bookshelf, World Health Organization resources, Kenya Ministry of Health publications, and selected Kenyan mental health organization websites. Priority was given to peer-reviewed studies, clinical guidelines, and Kenya-specific sources. Non-peer-reviewed sources, such as local advocacy or mental health awareness websites, were used only to provide contextual examples of stigma and public mental health education.

The literature was analysed thematically. Sources were grouped into six major themes: biomedical and genetic understandings of schizophrenia, immune and inflammatory perspectives, psychosis risk among Kenyan youth, cultural and spiritual explanatory models, pluralistic help-seeking pathways, and structural barriers to care. These themes were then used to develop culturally responsive clinical recommendations for assessment, formulation, intervention, supervision, and equity-oriented practice.

4. Results

A. Theme 1: Schizophrenia has Biological and Genetic Foundations

The reviewed literature shows that schizophrenia has significant biological and genetic dimensions. Classic family, twin, and adoption studies support the role of inherited vulnerability in schizophrenia risk (Gottesman & Shields, 1976). More recent twin-study evidence shows that schizophrenia is influenced by both genetic and environmental factors, supporting a gene-environment model rather than a purely hereditary explanation (Imamura et al., 2020). Contemporary genomic research further shows that schizophrenia is highly polygenic, involving many common genetic variants of small effect as well as rare copy number and coding variants (Owen et al., 2023). Additional research has examined possible biological mechanisms, including C4-related synaptic pruning and immune-to-brain communication pathways (Sekar et al., 2016; Khandaker & Dantzer, 2016; Khandaker et al., 2017).

B. Theme 2: Psychosis Risk Among Kenyan Youth is Clinically Important

Kenya-specific studies highlight the importance of early identification of psychosis-risk symptoms among adolescents and young adults. Mamah et al. (2021) found that psychotic-like experiences were common among Kenyan youth aged 15–25, although most were mild and not functionally impairing. More clinically significant psychosis risk was lower, with 4.6% categorized as high risk. Sæle et al. (2024) further found that psychiatric disorders were more common among Kenyan youth at high psychosis risk. These findings suggest that early psychosis-related symptoms in Kenya may occur alongside depression, anxiety, stress, poverty, substance use, and other forms of social disadvantage.

C. Theme 3: Cultural and Spiritual Meanings Shape Interpretation of Symptoms

The literature also shows that schizophrenia and psychosis are interpreted through cultural, spiritual, and social frameworks. In Kenyan communities, symptoms such as hallucinations, disorganized speech, unusual behavior, or social

withdrawal may be understood through explanations involving witchcraft, curses, spirit possession, divine punishment, or spiritual calling. Amunga (2020) shows that cultural beliefs can shape how mental distress is understood and managed in Western Kenya. Peteet (2019) further argues that spirituality is clinically relevant in psychiatry and should be approached thoughtfully rather than dismissed. These findings suggest that culturally responsive care must explore the patient's and family's explanatory models rather than assuming that biomedical explanations are the only meaningful framework.

D. Theme 4: Help-seeking is Pluralistic

The reviewed literature indicates that help-seeking for psychosis in Kenya and wider African contexts is often pluralistic. Individuals and families may seek help from hospitals, psychiatrists, traditional health practitioners, herbalists, pastors, prayer groups, or community elders. Okonji et al. (2008) identify traditional health practitioners as important actors in Kenyan mental health care pathways. van der Zeijst et al. (2023) similarly emphasize the need to explore synergy between biomedical, traditional, and faith-based systems in the management of psychotic disorders in Africa. This suggests that clinicians should assess previous and ongoing help-seeking pathways, including traditional and faith-based care, while protecting patient safety and access to evidence-based treatment.

E. Theme 5: Stigma and Structural Barriers Affect Care

Stigma and service barriers emerged as major themes. Schizophrenia and psychosis may be associated with shame, dangerousness, social failure, witchcraft, demonic possession, or incurability. These beliefs can contribute to concealment, delayed treatment, social exclusion, and family burden. Kenya's Ministry of Health reports that probable psychosis prevalence is approximately 1% of the population and identifies major mental health treatment gaps, including misdiagnosis and limited detection in general health settings (Ministry of Health Kenya, 2024). The National Academies of Sciences, Engineering, and Medicine (2016) also identify stigma, workforce shortages, poor infrastructure, limited medicines, inadequate funding, and low diagnostic capacity as major barriers to mental health care in Kenya.

5. Discussions

The findings suggest that schizophrenia care in Kenya requires more than symptom-based diagnosis. Biomedical literature supports the role of genetic, neurodevelopmental, and immune-related vulnerability in schizophrenia, but Kenyan and African literature shows that the recognition and management of psychosis are shaped by culture, spirituality, family systems, stigma, and access to care. This means that schizophrenia should be approached through a biopsychosocial-spiritual responsive framework. Such a framework recognizes the clinical reality of psychosis while also taking seriously the meanings that patients and families attach to symptoms.

The originality of this review lies in bringing together biomedical schizophrenia literature with Kenyan and African literature on culture, spirituality, help-seeking, and structural barriers. Rather than presenting biomedical and cultural explanations as opposing views, the review argues that both are necessary for effective clinical care. In practice, this means that clinicians should assess symptoms, risk, and functioning while also asking about cultural explanations, religious beliefs, family interpretations, and previous pathways to care.

These findings have direct clinical implications. Assessment should include both psychiatric screening and cultural formulation. Formulation should consider biological vulnerability, symptom presentation, family response, cultural meaning, stigma, and structural barriers. Intervention should combine evidence-based treatment with family psychoeducation, relapse planning, stigma reduction, and culturally sensitive engagement with spiritual or traditional beliefs. Supervision should help clinicians reflect on their assumptions and manage ethical tensions, especially when cultural or religious practices may either support recovery or increase risk.

6. Conclusion

This integrative review shows that schizophrenia in Kenya is both a clinical condition and a culturally embedded experience. Biomedical literature identifies genetic, neurodevelopmental, and immune-related vulnerabilities, while Kenya-specific and African literature shows that culture, spirituality, stigma, family caregiving, pluralistic help-seeking, and health-system barriers shape how psychosis is recognized and managed. The review concludes that culturally responsive schizophrenia care in Kenya should integrate evidence-based psychiatric treatment with cultural formulation, family psychoeducation, stigma reduction, ethical engagement with traditional and faith-based systems, and attention to structural barriers. Such an approach can improve early identification, strengthen therapeutic alliance, reduce treatment delays, and promote dignity and equity for people living with schizophrenia and related psychotic disorders.

7. Recommendations

A. Clinical Recommendations

Clinicians should assess both symptoms and cultural meanings by asking patients and families how they understand the problem, what forms of help they have already sought, and what beliefs or fears may affect treatment engagement.

B. Family Recommendations

Mental health services should include family psychoeducation because families are central to care in Kenya. Psychoeducation should explain symptoms, relapse signs, medication, coping strategies, and ways to reduce stigma.

C. Service Recommendations

Mental health care should be integrated into primary care and community health systems, with training for general healthcare workers to identify psychosis-risk symptoms and make appropriate referrals.

D. Ethical Recommendations

Collaboration with traditional or faith-based systems should be approached carefully. Clinicians should respect patients' beliefs while ensuring safety, consent, dignity, and access to evidence-based treatment.

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