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Literature Review on Psychosis in Sub-Saharan Africa

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Abstract: The scoping review explores the prevalence, diagnosis, and treatment of psychosis in Sub-Saharan Africa, highlighting the unique cultural and systemic challenges faced in the region. Despite an estimated global psychosis prevalence of 3%, Sub-Saharan Africa experiences a disproportionate burden, exacerbated by poverty, under-resourced healthcare systems, and cultural stigmas. Studies report a varying prevalence of psychotic symptoms across different countries, such as Kenya (8%) and Tanzania (3.9%). However, due to minimal mental health resources, psychosis often remains undiagnosed or untreated, particularly in rural areas. The review emphasizes the cultural lens through which psychosis is viewed, with many communities attributing symptoms to witchcraft, spiritual possession, or divine punishment. Consequently, individuals frequently seek care from traditional healers before accessing formal psychiatric services. The stigma surrounding mental illness further deters timely medical intervention, often leading to prolonged untreated psychosis and poor health outcomes. Diagnosis of psychosis in Sub-Saharan Africa faces additional barriers due to the reliance on Western diagnostic tools, such as the DSM-5 and ICD-10, which may not align with local cultural norms. Behaviors considered psychotic in Western contexts might be interpreted as spiritual experiences in African settings. As such, the absence of culturally adapted diagnostic instruments complicates accurate diagnosis and treatment. The treatment landscape is similarly complex, with limited access to psychotropic medications and mental health professionals. The scarcity of community-based mental health services results in long treatment delays and high relapse rates. The review calls for developing culturally appropriate diagnostic tools, expanding mental health services, and addressing stigma to improve psychosis care in Sub-Saharan Africa. Addressing these issues is essential to reducing the burden of untreated mental illness and enhancing mental health outcomes in the region.

Keywords: Psychosis; Sub-Saharan Africa; mental health; diagnosis; Treatment.

Introduction

Psychosis is characterized by symptoms such as hallucinations, delusions, and cognitive disorganization and it has a significant global impact (Morgan et al., n.d.).While it is estimated that psychosis affects approximately 3% of the population worldwide, regional variations exist due to socio-economic and cultural factors (Morgan et al., 2008). In Sub-Saharan Africa, the burden of psychosis is particularly acute due to the intersection of poverty, limited healthcare

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infrastructure, and widespread cultural stigmatization of mental illness (Collins et al., 2011). In rural Kenya, the prevalence of single psychotic symptoms is 8%, with only 0.6% experiencing two symptoms (Jenkins et al., 2012). In urban areas of Tanzania, 3.9% of individuals reported experiencing one or more psychotic symptoms (Jenkins et al., 2010). A study in northern Benin found a lifetime prevalence of psychotic syndrome at 30.18% (Tognon-Tchégnonsi et al., 2020). Another study observed that traumatic events are common, with individuals with psychosis in Ethiopia reporting higher exposure to trauma compared to controls (Girma et al., 2022).

Incidentally, the prevalence of psychosis in the Sub-Saharan Africa has increased mental health burden in this region significantly, maybe, due to minimal resources to tackling the menace. Sub-Saharan Africa allocates minimal resources to mental healthcare, with mental health services often accounting for less than 1% of national health budgets (World Health Organization, 2015). The lack of investment in healthcare leads to inadequate infrastructure, a shortage of mental health practitioners, and restricted access to services, especially in rural regions (Eaton et al., 2011). For example, numerous countries in Sub-Saharan Africa report having fewer than 2 mental health professionals for every 100,000 individuals, with the majority of these professionals concentrated in urban centers (World Health Organization, 2015). This uneven distribution of resources results in rural communities, where a significant portion of the population resides, being greatly underserved (Eaton et al., 2011).Moreover, factors such as poverty, civil unrest, and the high prevalence of infectious diseases like HIV/AIDS further contribute to the region's mental health challenges, with psychosis often being undiagnosed or untreated due to these competing health priorities (Collins et al., 2011). Mental health care is primarily hospital-based, with limited outpatient or community-based services, contributing to long treatment delays and high relapse rates (Saraceno et al., 2007).

Another important aspect of psychosis research is its cultural perceptions, interpretations and stigmas. Generally, there is evidence that cultural interpretations of mental illness in Sub-Saharan Africa are heavily influenced by traditional beliefs. Psychotic symptoms such as hallucinations and delusions are often attributed to spiritual possession, witchcraft, or divine punishment in many communities (Abbo, 2011). As a result, individuals with psychosis frequently seek help from traditional healers before turning to formal health services (Abbo, 2011; Patel & Prince, 2010). Studies suggest that up to 80% of people with mental illness in the region first seek care from traditional or spiritual healers (Burns, 2011). Moreover, the stigma surrounding mental illness further complicates the situation. People with psychosis often face social ostracization, discrimination, and human rights abuses, such as forced confinement or violence (Alem et al., 1999; Burns, 2011). This stigma deters families from seeking timely medical care and exacerbates the social and economic burden on those affected by psychosis (Burns, 2011). Thus, there is significant diagnostic and treatment challenge, which further increases the burden of psychosis in the region.

The absence of culturally relevant diagnostic instruments has been identified as a significant concern in Sub-Saharan Africa, as noted in earlier research. The majority of

diagnostic standards for psychosis, including the DSM-5 and ICD-10, are founded on Western conceptions of mental health, which may not be suitable for application within African cultural settings (Becker & Kleinman, 2013). For example, behaviors interpreted as psychotic symptoms in Western contexts, such as talking to oneself or experiencing visions, may be considered culturally acceptable or even spiritual in certain African communities (Alem et al., 1999). Efforts are being made to develop culturally adapted diagnostic tools, but progress is slow (Patel et al., 2007). Training healthcare professionals to recognize culturally specific symptoms of psychosis remains a challenge, as many professionals are not adequately equipped to differentiate between culturally normative behaviors and clinical symptoms of mental illness (Alem et al., 1999).

Hence, the treatment of psychosis in Sub-Saharan Africa is severely constrained by the limited availability of psychotropic medications and mental health services. In many countries, psychiatric medications, such as antipsychotics, are unavailable or prohibitively expensive for most patients (Sorsdahl et al., 2009). According to the WHO, essential psychiatric medications are available in less than 30% of healthcare facilities in many parts of the region (World Health Organization, 2015). In addition, most psychiatric care is hospital-based, with very few community-based services available. This model of care limits access for people living in rural areas, who make up a large proportion of the population (Nadkarni et al., 2024; Thornicroft et al., 2016, 2019). Even when patients can access treatment, follow-up care is often inconsistent, leading to high rates of relapse and discontinuation of treatment (Ventevogel, 2014). The mental health landscape in Sub-Saharan Africa presents significant challenges for the diagnosis and treatment of psychosis. Cultural interpretations, stigma, inadequate diagnostic tools, and poor access to mental health services all contribute to a high burden of untreated mental illness. Addressing these challenges requires a multifaceted approach, including the development of culturally appropriate diagnostic tools, expansion of mental health services, and efforts to reduce the stigma associated with psychosis.

Method

This scoping review followed the framework outlined by Arksey and O'Malley (2005), with enhancements suggested by (Levac et al., 2010). The chosen methodology aimed to provide a inclusive understanding of the existing literature on psychosis in Sub-Saharan Africa, with specific attention to its socio-cultural and healthcare dimensions. The review involved five key steps: (1) identifying the research question, (2) identifying relevant studies, (3) selecting studies based on predefined inclusion and exclusion criteria, (4) charting the data, and (5) collating, summarizing, and reporting the results. An optional consultation with stakeholders and experts was considered but not implemented in this review.

Step 1: Identifying the Research Question

The primary research question guiding this scoping review was: "What is the current state of knowledge regarding the prevalence, diagnosis, treatment, and cultural perceptions of psychosis in Sub-Saharan Africa?"

This question was designed to capture a broad overview of the literature on psychosis, focusing on four sub-themes: 1) The prevalence of psychosis across different Sub-Saharan African countries. 2) Diagnostic challenges and the utilization of culturally appropriate tools. 3) Treatment approaches, including pharmacological and non-pharmacological interventions. 4) The role of cultural beliefs, traditional healing practices, and stigma in managing psychosis. The research question was formulated to reflect the diverse experiences of psychosis across the region, acknowledging the varying cultural and healthcare contexts.

Step 2: Identifying Relevant Studies

A inclusive search strategy was implemented to identify relevant peer-reviewed and grey literature. The following databases were searched: 1) Peer-reviewed literature: PubMed, Scopus, PsycINFO, Embase, and Web of Science. **2)** Grey literature: Google Scholar, WHO Library, and African Journals Online (AJOL).

In addition, reference lists of included articles and previous reviews were manually searched to identify studies that were not captured through the database search. A combination of keywords and medical subject headings (MeSH terms) was used to maximize the retrieval of relevant studies. The keywords included: Psychosis, schizophrenia, bipolar disorder with psychotic features, Sub-Saharan Africa, Africa South of the Sahara, traditional healing, mental health diagnosis, mental health treatment and stigma. Furthermore, Boolean operators (AND, OR) and truncations were applied to refine search results. No date restrictions were imposed to allow for the inclusion of older studies that provided historical insights.

Step 3: Study Selection

The study selection process involved two stages: an initial title and abstract screening, followed by a full-text review of potentially relevant articles. The inclusion and exclusion criteria were applied as follows:

Inclusion Criteria: 1) Studies conducted in countries classified as Sub-Saharan Africa by the World Bank. 2) Studies reporting on psychosis or psychotic disorders, including schizophrenia and bipolar disorder with psychotic features. 3) Studies discussing diagnostic tools, treatment modalities, or cultural perceptions related to psychosis. 4) Peer-reviewed journal articles, reports, dissertations, and theses.

Exclusion Criteria: 1) Studies focusing on neurological disorders or psychiatric conditions other than psychosis. 2) Studies not available in English or without accessible full-text versions. 3) Studies conducted outside of Sub-Saharan Africa or on African immigrant populations outside the region.

Two reviewers independently screened titles and abstracts, and disagreements were resolved through discussion or consultation with a third reviewer. Studies that met the inclusion criteria proceeded to full-text review, and those that did not meet the criteria were excluded.

Step 4: Data Charting

Data were extracted from the included studies using a structured data extraction form, which captured the following information: 1) Study characteristics: Author (s), publication year, country/region, study design, sample size, and population characteristics. 2) Prevalence: Reported prevalence rates of psychosis or schizophrenia. 3) Diagnostic tools: Instruments used for diagnosis, including culturally adapted or locally developed tools. 4) Treatment: Types of treatment reported (e.g., pharmacological, traditional healing, psychosocial support), access to mental health services, and availability of psychotropic medications. 5) Cultural perceptions and stigma: The role of traditional beliefs, stigma, and the involvement of traditional healers in psychosis care. 6) Outcomes: Key findings, including reported barriers to diagnosis, treatment, or management of psychosis.

The extraction form was piloted with a small sample of studies to ensure consistency. Data extraction was conducted by two reviewers independently, and discrepancies were discussed and resolved in regular meetings.

Step 5: Collating, Summarizing, and Reporting Results

The results were collated and summarized using narrative and tabular formats. A thematic analysis was conducted to identify recurring patterns across the included studies, with a focus on the following themes: 1) Differences in the prevalence of psychosis across Sub-Saharan Africa. 2) Diagnostic challenges, especially in the use of Western diagnostic tools in culturally diverse settings. 3) The influence of traditional healing and stigma on psychosis management. 4) Access to treatment, the role of psychotropic medications, and the availability of community-based care.

The findings were summarized to highlight key gaps in the literature and suggest areas for future research, particularly the need for culturally appropriate diagnostic tools and interventions for psychosis in Sub-Saharan Africa.

Ethical Considerations

Since this scoping review did not involve primary data collection or human participants, ethical approval was not required. However, all efforts were made to maintain transparency and proper attribution of included studies throughout the review process.

Data Analysis

The data analysis for this scoping review was conducted in several stages to ensure a complete synthesis of the available literature on psychosis in Sub-Saharan Africa. The approach focused on both quantitative and qualitative data, aiming to identify trends, gaps, and recurring themes related to the prevalence, diagnosis, treatment, and cultural perceptions of psychosis across the region.

Quantitative Data Analysis

Quantitative data, such as reported prevalence rates of psychosis, sample sizes, and demographic information, were extracted from the included studies and analyzed descriptively. Frequencies and proportions were calculated to summarize key variables, including: 1) The prevalence of psychosis in different Sub-Saharan African countries. 2) The distribution of studies by country, year of publication, and study design (e.g., cross-sectional, cohort, case-control). 3) The types of diagnostic tools used across the studies, including both Western-based and culturally adapted instruments.

The prevalence rates of psychosis were synthesized to explore variations across regions and countries. Where possible, data were stratified by factors such as age, gender, urban versus rural settings, and socio-economic status. These variables were compared to identify patterns or discrepancies in the reported rates of psychosis. For example, studies conducted in rural areas or those utilizing community-based samples were compared with those focusing on clinical populations in urban settings.

Qualitative Data Analysis

Qualitative data were derived from studies that explored cultural beliefs, traditional healing practices, stigma, and the lived experiences of individuals with psychosis. A thematic analysis was employed to identify common themes and sub-themes across the included studies. The following steps were followed during the qualitative analysis: 1) Familiarization with the data: The reviewers read and re-read the included studies to gain an in-depth understanding of the content and context of each study. 2) Coding: The key themes from each study were identified and coded. These included themes related to traditional perceptions of psychosis, the involvement of traditional healers in the treatment process, the role of families and communities in managing psychosis, and the stigma associated with mental illness. Cultural and social factors that influenced diagnosis and treatment-seeking behaviors were also coded. 3) Theme identification: After coding, similar codes were grouped into broader themes. These themes included: a) Cultural beliefs and explanations of psychosis: Many studies highlighted the role of supernatural beliefs, ancestral spirits, or witchcraft in explaining psychotic symptoms. These beliefs influenced how individuals and communities perceived the illness and shaped their approach to seeking care. b) The role of traditional healers: Several studies reported that individuals with psychosis often sought help from traditional healers before, or in conjunction with, formal healthcare providers. The review explored how this reliance on traditional healers impacted access to psychiatric services and the integration of biomedical and traditional treatment approaches. c) Stigma and discrimination: Stigma emerged as a significant barrier to help-seeking and treatment adherence in many studies. The thematic analysis captured the different forms of stigma experienced by individuals with psychosis, including social exclusion, discrimination in healthcare settings, and internalized stigma. 4) Reviewing themes: Once the initial themes were identified, they were reviewed and refined to ensure they accurately reflected the data across the studies. This step involved cross-checking the themes with the original studies to verify their relevance and consistency. 5) Defining and

naming themes: The final themes were defined and clearly named to reflect the key insights drawn from the qualitative data. These themes were then used to inform the narrative synthesis of the results.

Narrative Synthesis

The results of the data analysis were presented through a combination of narrative and tabular formats. The narrative synthesis brought together the findings from both the quantitative and qualitative analyses, highlighting key trends and recurring patterns related to the prevalence, diagnosis, and treatment of psychosis in Sub-Saharan Africa.

The quantitative data provided an overview of the epidemiology of psychosis, while the qualitative data added depth and context by exploring how cultural factors shaped the understanding and management of psychosis in different communities. This combined approach allowed for a holistic view of psychosis in Sub-Saharan Africa, emphasizing the importance of culturally sensitive diagnostic tools and treatment approaches.

Data Integration

In the final stage of data analysis, the results from the quantitative and qualitative analyses were integrated to identify key gaps in the literature and suggest areas for future research. The review particularly focused on the following: 1) The need for more epidemiological studies on the prevalence of psychosis in rural and under-researched regions of Sub-Saharan Africa. 2) The challenges of using Western-based diagnostic criteria in culturally diverse settings and the need for locally adapted diagnostic tools. 3) The role of traditional healers and community-based care in managing psychosis, and the potential for integrating these approaches with formal psychiatric care. 4) The impact of stigma on access to care and treatment adherence, highlighting the need for anti-stigma interventions tailored to the specific cultural contexts of Sub-Saharan African communities.

Result

Summary of Findings

The table provides data on various studies examining the prevalence of psychosis in African countries, highlighting differences in sample sizes, prevalence rates, settings (urban or rural), and diagnostic criteria used.

In Nigeria, (Jack-Ide et al. (2013) conducted a study with 50 participants in an urban setting but did not specify the prevalence rate, using DSM-5 or ICD-10 as diagnostic criteria. Olugbile et al. (2009) studied 500 individuals, noting a significant but unspecified prevalence rate, while Gureje et al. (2010) found a prevalence of 2.1% across mixed urban and rural populations using ICD-3/DSM-5 criteria. Kenya is represented by two studies from (Jenkins et al. (2012, 2015), both involving rural populations and using the Psychosis Screening Questionnaire. The 2012 study, with 1,000 participants, reported an 8% prevalence, while the 2015 study of the same size reported a higher rate of 13.9%. In Tanzania, Jenkins et al. (2010) studied 899 individuals

from mixed urban and rural settings, finding a prevalence rate of 3.9%, also using the Psychosis Screening Questionnaire.

Table 1
Prevalence of Psychosis in Sub-Saharan Africa by Region

Study	Country	Sample Size	Prevalence Rate (%)	Urban/Rural	Diagnostic Criteria
Jack-Ide et al., (2013)	Nigeria	50	Not specified	Urban	DSM-5 or ICD-10 mentioned)
(Jenkins et al., 2012)	Kenya	1000	8%	Rural	Psychosis Screening Questionnaire.
Jenkins et al. (2015)	Kenya	1000	13.9%	Rural	Psychosis Screening Questionnaire
Jenkins et al. (2010)	Tanzania	899	3.9%	Rural/Urban	Psychosis Screening Questionnaire
Lund et al., (2010)	South Africa	1,500	4.3%	Urban	ICD-10
Abbo (2011)	Uganda	387	16.3%	Rural	ICD-10/DSM-5
Olugbile et al. (2009)	Nigeria	500	Significant, but Not specified	Not specified	DSM-5
Burns (2011)	South Africa	2,000	3.8%	Mixed	DSM-5
Gureje et al. (2010)	Nigeria		2.1%	Mixed	ICD-3/DSM-5

In South Africa, two studies were conducted. Lund et al. Lund et al. (2010), with a sample of 1,500 from urban areas, reported a 4.3% prevalence using ICD-10 criteria, while Burns, (2011) studied 2,000 people in mixed settings, finding a prevalence rate of 3.8% using DSM-5. Finally, in Uganda, Abbo (2011) conducted a study with 387 participants in rural areas, reporting the highest prevalence rate at 16.3%, using ICD-10/DSM-5.

In addition, in northern Benin, the lifetime prevalence of psychotic syndrome is 30.18% (Jenkins et al., 2010). Limited data on psychotic disorders in low- and middle-income countries, including sub-Saharan Africa, due to lack of formal health care service (Veling et al., 2019).

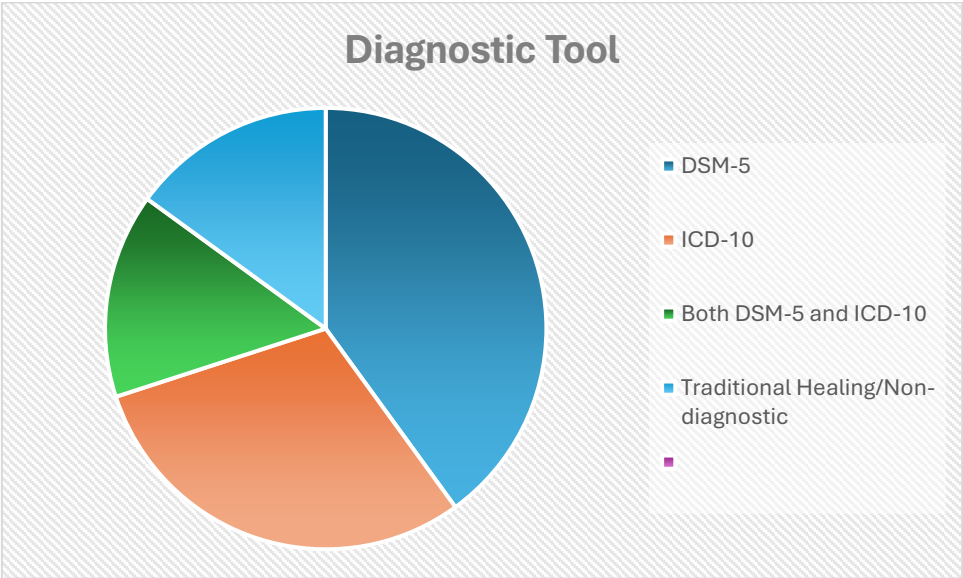

Figure 1. Diagnostic Approaches to Psychosis in Sub-Saharan Africa

There was a significant reliance on Western diagnostic criteria like DSM-5 and ICD-10, but there was also a notable gap in using culturally adapted diagnostic tools.

Detection and Treatment

In South Africa, a study found that traditional health practitioners (THPs) can play a crucial role in identifying and referring individuals with recent-onset psychosis. However, the accuracy of THP referrals varies, and collaboration with formal psychiatric services is beneficial (Veling et al., 2019). First contact with THPs is associated with longer durations of untreated psychosis (DUP) (Tomita et al., 2015). Another study in Uganda observed that cultural norms favoring alternative and complementary therapies contribute to longer DUP, with many patients going without antipsychotic medication for extended periods (Mwesiga et al., 2019). Also, a study in rural South Africa found that traditional health practitioners (THPs) were open to identifying and referring individuals with possible psychosis, suggesting collaboration with THPs as a promising approach to improve detection of individuals with recent-onset psychosis (Veling et al., 2019).

Cultural Beliefs and Stigma

Many communities in sub-Saharan Africa attribute psychosis to supernatural causes, which can lead to higher levels of self-stigma among individuals with psychosis (Makanjuola et al., 2016). This belief system is prevalent across different cultural groups, influencing treatment choices and pathways to care (Ayinde et al., 2023). In Ethiopia, exposure to traumatic events is common, with individuals diagnosed with psychosis reporting higher rates of trauma compared to controls (Girma et al., 2022). A study across Nigeria, Ghana, and Kenya found a greater tendency for individuals with high levels of self-stigma to ascribe supernatural attribution to their experience of severe mental health conditions (Makanjuola et al., 2016).

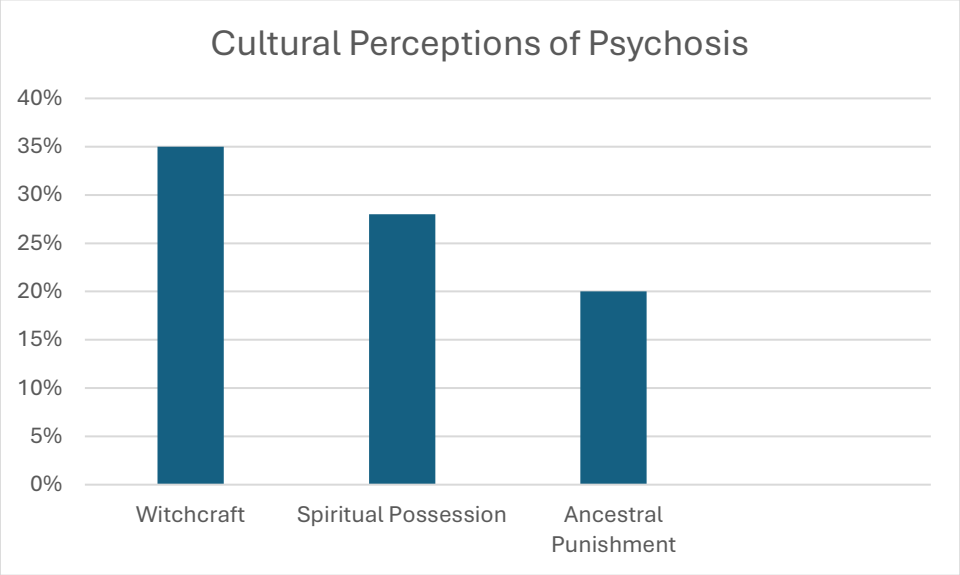

Figure 2. Cultural Explanations for Psychosis in Sub-Saharan Africa

Cultural beliefs, including witchcraft and spiritual possession, were prevalent explanations for psychosis in many regions. Approximately 35% of studies reported that psychosis was attributed to witchcraft, while 28% associated it with spiritual possession or ancestral punishment. These cultural interpretations significantly influenced help-seeking behaviors, with many individuals initially seeking help from traditional healers rather than formal psychiatric services (Atilola, 2015).

Discussion

The findings of this scoping review offered a nuanced understanding of psychosis in Sub-Saharan Africa, revealing critical gaps in the literature, challenges in diagnosis, culturally embedded treatment practices, and the pervasive impact of stigma. These insights have several implications for mental health practice, policy, and research in the region.

Prevalence of Psychosis and Epidemiological Gaps

The review identified a wide variability in the reported prevalence of psychosis across Sub-Saharan Africa, with studies reflecting differing rates depending on the population and region studied. Higher prevalence rates were typically reported in urban areas, where access to psychiatric services might have contributed to better detection. Conversely, rural regions were underrepresented in the literature, and prevalence estimates from these areas were likely lower, possibly due to underreporting or reliance on traditional beliefs that reframed psychotic symptoms in supernatural terms (Jack-Ide et al., 2013).

This finding underscored a significant gap in population-based epidemiological studies across Sub-Saharan Africa. Much of the existing research relied on clinical samples, which might not reflect the true community-level burden of psychosis. These gaps in epidemiological data suggested a need for more robust, large-scale studies in rural and marginalized regions to

ensure that mental health interventions and resources are appropriately allocated (Lund et al., 2013). Without inclusive data, it remained challenging to establish region-wide prevalence rates or to understand the socioeconomic and environmental factors contributing to disparities in mental health.

Challenges in Diagnosing Psychosis in Diverse Cultural Contexts

One of the most prominent themes emerging from this review was the challenge of diagnosing psychosis in culturally diverse settings. The reviewed studies emphasized that the standard diagnostic tools, such as the DSM-5 and ICD-11, were often unsuitable for use in many African contexts due to their Eurocentric assumptions. Psychotic symptoms were frequently explained in terms of spiritual beliefs, ancestral intervention, or witchcraft, which did not align with the criteria outlined in Western diagnostic systems. This misalignment could lead to underdiagnosis or misdiagnosis of psychosis in Sub-Saharan Africa (Abbo, 2011).

The need for culturally adapted diagnostic tools was a crucial implication of this review. Without tools that resonate with local cultural and spiritual frameworks, mental health practitioners may struggle to accurately diagnose psychosis in their patients (Jenkins et al., 2010). Culturally adapted tools that incorporate local understandings of mental illness would likely improve diagnosis accuracy and treatment outcomes (Patel & Prince, 2010). Moreover, involving local communities and traditional healers in the development of these tools could help bridge the gap between biomedical and traditional approaches to psychosis, enhancing their acceptance within communities.

Treatment Approaches: Biomedical and Traditional Healing Practices

The review revealed a duality in treatment approaches for psychosis in Sub-Saharan Africa, with many individuals oscillating between formal psychiatric services and traditional healing practices. Biomedical treatments, including the use of antipsychotic medications, were commonly prescribed in clinical settings, yet many patients also sought help from traditional healers, reflecting a pluralistic approach to mental healthcare (Burns, 2011). This duality often led to delays in seeking formal psychiatric care, especially when traditional treatments were preferred or viewed as more culturally appropriate.

The role of traditional healers in treating psychosis cannot be understated, as they often serve as the first point of contact for individuals experiencing mental health issues. Traditional healers employed spiritual rituals, herbal remedies, and counseling, based on the belief that psychosis stemmed from supernatural forces or spiritual disturbances (Collins et al., 2011). Although some traditional methods were reported to have positive outcomes, concerns were raised about their efficacy in treating severe psychotic disorders and the potential for delays in accessing biomedical treatment.

The implications for policy and practice are clear: integrating traditional healing practices into formal healthcare systems may improve treatment outcomes for patients with psychosis. Collaborative models of care that recognize the role of traditional healers could enhance patient engagement and adherence to treatment plans. However, this integration would require

mutual respect and understanding between biomedical practitioners and traditional healers, as well as educational programs that promote evidence-based practices within traditional healing contexts (Becker & Kleinman, 2013).

Impact of Stigma on Help-Seeking and Treatment Adherence

Stigma emerged as a significant barrier to effective diagnosis and treatment of psychosis in Sub-Saharan Africa. Individuals with psychosis were often subject to social exclusion, discrimination, and dehumanizing attitudes, which discouraged help-seeking behaviors and contributed to poor treatment adherence. The reviewed studies indicated that cultural beliefs linking psychosis to supernatural causes, such as witchcraft or possession, amplified the stigma associated with the disorder (Atilola, 2015). As a result, many individuals delayed seeking formal psychiatric care, fearing they would be labeled as "mad" or ostracized by their communities (Eaton et al., 2011).

Stigma not only influenced initial help-seeking but also impacted long-term treatment adherence. Patients who began psychiatric treatment often faced additional stigma from their communities and even within healthcare settings. Fear of social rejection frequently led to non-compliance with prescribed medications and disengagement from mental health services. Addressing the issue of stigma was therefore crucial for improving the management of psychosis in Sub-Saharan Africa (Lund et al., 2010).

To combat stigma, culturally tailored anti-stigma campaigns that involved community leaders, traditional healers, and individuals with lived experiences of psychosis were essential. These campaigns should aim to challenge negative beliefs about mental illness and promote greater understanding of psychosis as a medical condition, rather than a supernatural affliction. Additionally, training healthcare providers to adopt stigma-reducing practices within clinical settings could foster more inclusive and supportive environments for individuals with psychosis.

Implications for Policy and Future Research

The findings of this scoping review had several important implications for mental health policy and future research. First, there was an urgent need for policies that prioritized the development of culturally appropriate diagnostic and treatment tools for psychosis. Health ministries and policymakers across Sub-Saharan Africa should invest in the creation of diagnostic systems that account for local cultural contexts and promote the use of community-based mental health services (Saraceno et al., 2007).

Additionally, mental health policies must address the chronic underfunding of psychiatric services in Sub-Saharan Africa. Many of the studies reviewed reported significant challenges in accessing mental health services, particularly in rural and underserved areas. Investments in mental health infrastructure, training of healthcare professionals, and the integration of mental health services into primary care would be critical steps toward improving the management of psychosis across the region (Patel et al., 2007).

Future research should also focus on exploring the intersections between traditional healing practices and formal psychiatric care, with the aim of developing collaborative care models that reflect the pluralistic nature of mental health treatment in Sub-Saharan Africa. Furthermore, longitudinal studies on the impact of stigma-reducing interventions, both at the community and healthcare levels, are necessary to evaluate their effectiveness in improving treatment adherence and patient outcomes.

Conclusions

This scoping review has provided a comprehensive overview of psychosis in Sub-Saharan Africa, highlighting the significant gaps in prevalence data, diagnostic practices, treatment approaches, and the profound impact of cultural beliefs and stigma. It has been established that psychosis is a prevalent mental health concern in the region, but there is wide variation in how it is diagnosed and treated. While biomedical approaches, including the use of antipsychotic medications, are common, traditional healing practices continue to play a crucial role in the management of psychosis. This duality in treatment reflects the cultural complexity of mental health in the region.

One of the most critical findings is the inadequacy of existing diagnostic tools to address the unique cultural contexts of Sub-Saharan Africa. Psychosis is often attributed to supernatural forces such as witchcraft or ancestral punishment, which poses significant challenges for formal diagnosis and treatment. Stigma associated with psychosis further exacerbates the problem by delaying help-seeking behaviors and reducing adherence to treatment.

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