

## RELIGIOUS BELIEFS, SPIRITUAL PRACTICES, AND MENTAL HEALTH HELP-SEEKING BEHAVIOUR AMONG ADULTS IN UGANDA: EXAMINING BARRIERS AND FACILITATORS TO PROFESSIONAL MENTAL HEALTHCARE UTILISATION

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### ABSTRACT

Mental health disorders represent a significant public health challenge in Uganda, where access to professional mental healthcare remains constrained by limited resources, inadequate mental health literacy, and persistent stigma. Religion plays a central role in Ugandan society and substantially influences health beliefs, coping strategies, and healthcare-seeking behaviours. However, the relationship between religious beliefs, spiritual practices, and professional mental health help-seeking remains underexplored. This study examined how religious beliefs and spiritual practices shape attitudes toward professional mental health help-seeking among individuals in Uganda and identified the religious, social, and structural factors that function as barriers and facilitators to mental healthcare utilisation. The study employed a qualitative secondary data review design within an interpretivist paradigm. A comprehensive search of peer-reviewed and grey literature published between 2000 and 2025 was conducted using PubMed, Scopus, PsycINFO, Web of Science, Google Scholar, African Journals Online, and relevant policy repositories. Data were synthesised thematically following the principles of qualitative evidence synthesis and guided by the Network-Episode Model of help-seeking behaviour. The review identified five interrelated themes: religious interpretations of mental illness; faith-based coping and pathways to care; stigma and social norms within religious communities; the role of religious leaders as gatekeepers and referral agents; and opportunities for collaboration between faith-based organisations and formal mental health services. Findings indicate that religious beliefs function as both barriers and facilitators to professional help-seeking. Spiritual explanations of mental illness, including beliefs in witchcraft, demonic possession, and divine punishment, may delay access to professional care. Conversely, faith communities provide emotional support, strengthen resilience, reduce social isolation, and facilitate referrals when religious leaders possess adequate mental health literacy. The study concludes that faith-sensitive mental health interventions and stronger partnerships between mental health providers and religious institutions are essential for reducing stigma, improving mental health literacy, and enhancing access to professional mental healthcare.

**Keywords:** Mental health help-seeking; Religious beliefs; Spirituality; Faith-based organisations; Mental healthcare utilisation; Uganda; Network-Episode Model; Stigma

### 1.0 INTRODUCTION

Mental health disorders constitute a predominant contributor to global disability, significantly affecting morbidity, quality of life, and socioeconomic challenges (World Health Organization [WHO], 2022). Despite an increasing acknowledgement of mental health as a critical public health concern, a pronounced treatment gap persists, especially in low- and middle-income countries (LMICs), where as many as 75% of individuals experiencing mental health disorders do not receive suitable care (Patel et al., 2018).

Investigations within African contexts reveal that explanatory frameworks for mental illness often exhibit pluralism, amalgamating biomedical, spiritual, and traditional viewpoints (Mendenhall et al., 2019). Individuals frequently pursue assistance from a variety of sources, either concurrently or in succession, including familial networks, spiritual leaders, traditional healers, and healthcare professionals (Ae-Ngibise et al., 2010). Although this pluralistic methodology may furnish culturally relevant support, it also has the potential to hinder timely access to professional care when spiritual or traditional interpretations predominantly shape understandings of mental illness. In sub-Saharan Africa, inadequate mental health infrastructure, a dearth of trained professionals, persistent stigma, and entrenched cultural beliefs continue to obstruct access to mental healthcare services (Sankoh et al., 2018).

Uganda confronts a substantial mental health challenge exacerbated by elements such as poverty, rapid urbanization, unemployment, infectious diseases, population displacement, and exposure to trauma related to conflict (Kigozi et al., 2010). Notwithstanding the Ugandan government's efforts to formulate policies aimed at the integration of mental health into primary healthcare systems, access to these services remains hindered by insufficient funding, a lack of specialized personnel, and enduring social stigma surrounding mental health issues (Kigozi et al., 2010; Ministry of Health Uganda, 2020). Consequently, numerous individuals experiencing psychological distress depend on informal support systems, including familial structures, traditional healers, and religious organisations (Abbo et al., 2008).

Religion serves as a pivotal aspect of Ugandan society, profoundly shaping health beliefs, coping mechanisms, and healthcare-seeking behaviours. Uganda is distinguished by elevated levels of religious affiliation, with Christianity and Islam being the predominant faith traditions, in addition to indigenous spiritual beliefs and practices (Uganda Bureau of Statistics [UBOS], 2024). Religious institutions frequently offer emotional support, social cohesion, moral direction, and practical aid, thus becoming significant sources of assistance for individuals confronting mental health difficulties (Leavey, 2010). As a result, religious beliefs and practices significantly influence the comprehension, interpretation, and management of mental illness.

The interplay between religion and the pursuit of mental health assistance is intricate and multifaceted. Empirical evidence indicates that engagement in religious practices can foster positive mental health outcomes through the enhancement of resilience, the cultivation of social support, and the promotion of adaptive coping strategies (Koenig, 2012). Religious leaders and faith-based communities may also facilitate access to professional mental health services by mitigating stigma and providing referrals to formal care (Leavey, 2010). However, certain religious interpretations may obstruct the pursuit of professional assistance when mental illness is predominantly attributed to supernatural phenomena such as demonic possession, witchcraft, curses, divine retribution, or spiritual deficiencies (Ae-Ngibise et al., 2010; Ventevogel et al.,

2013). Such beliefs may foster reliance on prayer, faith healing, or traditional remedies instead of evidence-based mental health interventions.

Ugandans frequently conceptualise mental health challenges through culturally specific frameworks, such as the notion of spirit possession, which may result in individuals seeking assistance from traditional healers rather than from medical practitioners (Asiimwe, 2023; Duijl et al., 2014). The stigma associated with mental health issues is widespread, leading individuals to experience discrimination rooted in cultural and religious values, which may dissuade them from pursuing help (Mugayo, 2015; Quinn & Knifton, 2014). Theological conservatism influences perceptions of mental health support, with individuals often preferring religious guidance over secular alternatives (Moreno et al., 2022). Religious convictions can offer a contextual framework for interpreting mental health, prompting individuals to seek assistance from faith-based organisations or spiritual leaders (Mugayo, 2015). Numerous individuals initially consult traditional healers and frequently report positive outcomes, underscoring the significance of integrating traditional practices within mental health care (Duijl et al., 2014). The path to recovery typically encompasses multiple help-seeking phases, illustrating a complex interaction between cultural beliefs and personal experiences (Duijl et al., 2014).

Research investigating mental health service utilisation in Uganda has predominantly concentrated on obstacles such as stigma, inadequate mental health literacy, geographical barriers, and limited resources (Kigozi et al., 2010; Ssebunnya et al., 2009). Nevertheless, insufficient attention has been directed toward comprehending how religious convictions and spiritual practices shape attitudes regarding professional mental health help-seeking. Existing literature has not adequately scrutinised the dual function of religion as both a potential enabler and impediment to mental healthcare utilisation, nor has it sufficiently investigated the impact of religious leaders and faith communities on help-seeking behaviours.

Addressing this lacuna in knowledge is of paramount importance, given the significant influence of religion in shaping health behaviours within Ugandan societies. A deeper understanding of the interplay between religious beliefs and mental health help-seeking may contribute to the development of culturally attuned interventions that enhance collaboration between mental health practitioners and faith-based organisations. Such strategies hold the potential to mitigate stigma, elevate mental health literacy, and promote timely access to appropriate care. Consequently, this study aims to explore how religious beliefs and practices influence attitudes toward seeking professional mental health assistance among Ugandans and to identify the religious, social, and structural factors that serve as barriers or facilitators to the utilisation of mental healthcare services.

## 2.0 METHODOLOGY

This study employed a qualitative secondary data review design to investigate the influence of religious beliefs and spiritual practices on mental health help-seeking behaviours among individuals in Uganda. Qualitative secondary data review entails the systematic identification, selection, analysis, and synthesis of existing literature and documentary evidence to generate novel insights into a research phenomenon (Johnston, 2017). This methodological approach was deemed appropriate as it facilitated an in-depth exploration of the intricate relationships between religion, culture, and mental healthcare utilisation without necessitating primary data

collection. The study adopted an interpretivist paradigm, which posits that health-seeking behaviours are socially and culturally constructed and shaped by individuals' lived experiences, belief systems, and social contexts (Creswell & Poth, 2018). Given the prominence of religion in Uganda, an interpretivist approach afforded a nuanced comprehension of how religious worldviews inform perceptions of mental illness and decisions regarding the utilisation of professional mental healthcare services.

Ethical approval was deemed unnecessary as the investigation utilised solely publicly accessible secondary data and did not entail direct engagement with human subjects or the acquisition of identifiable individual information. Nonetheless, ethical standards concerning intellectual integrity, transparency, and the precise representation of findings were rigorously maintained throughout the review process (Johnston, 2017). All references were duly acknowledged and cited in accordance with APA (7th edition) standards. The investigation was subject to various limitations. Primarily, the dependence on published literature may have resulted in the exclusion of pertinent unpublished studies and non-English sources. Additionally, the quality and comprehensiveness of the synthesis were contingent upon the methodological robustness of the studies included.

### **3.0 REVIEW FINDINGS AND DISCUSSION**

The qualitative synthesis brought to light five interconnected themes that elucidate the manner in which religious convictions and spiritual practices influence mental health help-seeking behaviors among individuals in Uganda: (1) religious interpretations of mental illness, (2) faith-based coping mechanisms and pathways to care, (3) stigma and social norms prevalent within religious communities, (4) the role of religious leaders as gatekeepers and referral facilitators, and (5) opportunities for collaboration between faith-based organizations and mental health services. Collectively, these themes illustrate that religion serves a dual function, acting as both an impediment and a catalyst to the utilisation of professional mental healthcare services.

#### **3.1 Religious Interpretations of Mental Illness**

The review indicated that conceptual frameworks for mental illness in Uganda are frequently shaped by religious and spiritual beliefs. Mental health disorders are often understood through a pluralistic perspective that amalgamates biomedical insights with spiritual interpretations, encompassing notions such as demonic possession, witchcraft, ancestral displeasure, curses, divine retribution, and spiritual assaults (Abbo et al., 2008; Ventevogel et al., 2013). Such interpretations are profoundly entrenched within local cultural and religious paradigms, significantly impacting how individuals identify symptoms, ascribe meaning to psychological distress, and ascertain suitable sources of care.

In alignment with findings from other sub-Saharan African contexts, the literature suggests that spiritual interpretations of mental illness may postpone the pursuit of professional assistance by prompting individuals to prioritise prayer, exorcism, fasting, and traditional healing methods before seeking formal mental healthcare services (Ae-Ngibise et al., 2010; Mendenhall et al., 2019). Within the framework of the Network-Episode Model (Pescosolido, 1992), these findings imply that religious beliefs shape help-seeking trajectories by influencing how social networks interpret symptoms and advocate for treatment alternatives.

Nevertheless, the findings also suggest that religious and biomedical explanations are not inherently contradictory. Numerous individuals concurrently engage with various treatment modalities, seeking assistance from religious leaders, traditional healers, family members, and healthcare practitioners. This trend reflects a pragmatic strategy for healthcare utilisation wherein individuals navigate diverse care sources based on perceived efficacy, accessibility, and cultural acceptability (Abbo et al., 2008).

### **3.2 Faith-Based Coping and Pathways to Care**

The analysis delineated religious practices as significant coping mechanisms for individuals confronting mental health challenges. Activities such as prayer, participation in worship services, reading of scriptures, pastoral counselling, and engagement in faith-based communities were frequently cited as vital sources of solace, hope, and emotional sustenance (Koenig, 2012). These practices augment resilience by instilling meaning during episodes of psychological turmoil and nurturing a sense of belonging within supportive social networks.

Faith-oriented coping may exert a favourable influence on mental health outcomes by alleviating social isolation and fostering adaptive responses to stressors. In Uganda, where formal mental health services are persistently under-resourced and unevenly disseminated, religious institutions frequently function as accessible and cost-effective sources of psychosocial assistance (Kigozi et al., 2010). As a result, faith communities often serve as the initial point of contact for individuals grappling with emotional or psychological distress.

However, the review revealed that an overreliance on religious coping strategies can obstruct professional care when spiritual interventions are perceived as substitutes rather than complementary to evidence-based treatments. Research conducted within African contexts suggests that individuals who conceptualise mental illness primarily as a spiritual affliction may defer seeking professional assistance until symptoms escalate in severity or become chronic (Ae-Ngibise et al., 2010). This finding accentuates the necessity of promoting integrated approaches that acknowledge the significance of spiritual coping while simultaneously advocating for timely access to professional mental healthcare.

### **3.3 Stigma and Social Norms Within Religious Communities**

Mental illness continues to be highly stigmatised in numerous Ugandan communities, with religious beliefs possessing the capacity to both reinforce and mitigate this stigma. The review identified that negative interpretations of mental illness as indicative of weak faith, moral failing, sinfulness, or divine retribution contribute to feelings of shame, self-stigmatisation, and social exclusion (Leavey, 2010; Ventevogel et al., 2013). Individuals facing mental health challenges may refrain from disclosing symptoms or seeking professional care due to apprehensions regarding judgment from family members, religious peers, and community leaders.

The effect of stigma aligns with the Theory of Planned Behaviour, which underscores the significance of subjective norms in shaping intentions related to help-seeking (Ajzen, 1991). Within tightly-knit religious communities, dominant beliefs concerning mental illness can profoundly affect individuals' choices about whether, when, and where to pursue assistance. Conversely, the review also uncovered evidence that faith communities can alleviate stigma by

fostering compassion, social inclusion, and collective accountability for the support of vulnerable individuals (Koenig, 2012). Religious tenets that emphasise empathy, dignity, and care for those enduring suffering may stimulate help-seeking behaviours and enhance treatment adherence. Consequently, the influence of religion on stigma is heavily contingent upon how mental illness is contextualised within specific faith traditions and local environments.

### **3.4 Religious Leaders as Gatekeepers and Referral Agents**

One of the most salient themes that emerged from the comprehensive review pertains to the pivotal role of religious leaders in the facilitation of mental health help-seeking pathways. Clergy, pastors, imams, and other figures of faith frequently occupy positions of significant trust within their communities and often act as informal counsellors for individuals grappling with psychological distress (Leavey, 2010). Their accessibility, cultural legitimacy, and spiritual authority render them critical gatekeepers within the mental healthcare continuum. The review posits that religious leaders are capable of enhancing access to professional mental healthcare services when they possess sufficient mental health literacy and acknowledge the efficacy of biomedical interventions. In these instances, faith leaders extend emotional support while simultaneously referring individuals to mental health professionals for specialised care (Ssebunnya et al., 2009).

Nevertheless, the findings also reveal that limited understanding of mental health disorders among certain religious leaders may lead to delays in referrals and an overreliance on spiritual interventions (Ae-Ngibise et al., 2010). The lack of formal collaborative frameworks between faith-based organisations and mental health providers further constrains opportunities for coordinated care. From the lens of the Network-Episode Model, religious leaders serve as influential agents within social networks that shape illness recognition, treatment choices, and navigation through various healthcare systems (Pescosolido, 1992). Therefore, enhancing their capacity to identify mental health issues and facilitate appropriate referrals may significantly improve access to professional services.

#### **Opportunities for Collaboration Between Faith-Based Organisations and Mental Health Services**

The review has identified considerable potential for collaboration between faith-based organisations and established mental health systems in Uganda. Given the extensive reach and societal influence of religious institutions, partnerships between mental health professionals and faith communities could augment mental health awareness, diminish stigma, and enhance service utilisation.

Empirical evidence from sub-Saharan Africa indicates that equipping religious leaders with fundamental mental health literacy, symptom recognition skills, psychological first aid techniques, and referral protocols can fortify pathways to care and promote early intervention (Sankoh et al., 2018). The integration of faith leaders into community-based mental health programs may also enhance the cultural relevance and acceptability of mental health services. Collaborative methodologies should recognise the significance of religious beliefs and spiritual practices while underscoring that spiritual support and professional treatment serve as complementary rather than competing modalities of care. Such alliances may cultivate trust in mental health services, particularly in marginalised communities where formal healthcare

infrastructure is deficient. However, the success of such collaborations necessitates clear referral frameworks, mutual respect between healthcare providers and religious leaders, and continuous dialogue regarding the delineation of roles and responsibilities within each sector. Policies that endorse faith-sensitive mental healthcare could assist in bridging the divide between community-based support systems and established mental health services.

#### **4.0 DISCUSSION**

Overall, the empirical evidence elucidates that the behavioural patterns associated with seeking mental health assistance in Uganda are influenced by a dynamic interaction of religious ideologies, social connections, cultural conventions, and systemic limitations. In alignment with the Network-Episode Model (Pescosolido, 1992), the decisions to seek help arise from interactions among diverse stakeholders, including individuals, families, spiritual leaders, and healthcare entities, rather than being solely a product of individual agency.

Religion exerts an influence on help-seeking behaviours through several distinct mechanisms. The interpretation of mental illness is profoundly affected by religious convictions; faith-based communities contribute to the establishment of social standards related to the disclosure of mental health issues and the pursuit of treatment, and spiritual leaders significantly affect the selection of suitable care options. The dualistic nature of religion, serving both as a conduit and an impediment, underscores the necessity for sophisticated strategies that transcend simplistic interpretations of faith's role in mental health contexts.

The evidence suggests that enhancing the utilisation of mental healthcare services in Uganda necessitates interventions that are both culturally attuned and sensitive to religious frameworks. Mental health policies ought to acknowledge the pivotal influence of faith communities and prioritise partnerships with religious organisations to fortify referral systems, elevate mental health literacy, and mitigate stigma. Such initiatives possess the capacity to diminish the treatment gap and augment accessibility to professional mental healthcare while honouring the religious principles and lived experiences of Ugandan populations.

#### **5.0 CONCLUSION**

This qualitative secondary data review scrutinised the impact of religious beliefs and spiritual practices on the mental health help-seeking behaviours of individuals in Uganda. The findings reveal that religion occupies a multifaceted and intricate role in shaping perceptions regarding the utilisation of professional mental healthcare services. Informed by the Network-Episode Model (Pescosolido, 1992), the review elucidated that decisions to seek help are situated within expansive social, cultural, and religious networks wherein family members, faith communities, traditional healers, and spiritual leaders exert substantial influence.

The review delineated five interrelated themes: religious interpretations of mental illness, faith-oriented coping strategies and pathways to care, stigma and social norms prevalent within religious communities, the function of religious leaders as gatekeepers and referral conduits, and potential collaborative opportunities between faith-based organisations and formal mental health services. These findings suggest that religious beliefs may serve as impediments to professional mental healthcare when mental illness is solely attributed to supernatural phenomena, such as demonic possession, witchcraft, divine retribution, or spiritual frailty (Ae-

Ngibise et al., 2010; Ventevogel et al., 2013). Such beliefs may lead to procrastination in seeking help, reinforce stigma, and promote dependence on spiritual remedies as substitutes for evidence-based interventions.

Conversely, the review accentuates the considerable capacity of religion to facilitate mental health help-seeking. Religious institutions offer accessible networks of social support, cultivate resilience through faith-centred coping mechanisms, and create trustworthy environments where individuals confronting psychological distress can seek counsel and emotional assistance (Koenig, 2012). Religious leaders, when endowed with adequate mental health knowledge, can assume a pivotal role in fostering mental health literacy, alleviating stigma, and enabling timely referrals to professional services.

By showing that the relationship between faith and seeking professional care is neither intrinsically good nor bad, the study adds to the expanding corpus of research on religion and mental health in sub-Saharan Africa. Instead, how mental illness is seen and dealt with in certain religious and societal contexts determines its impact. The results highlight the need for faith-sensitive and culturally sensitive mental health interventions that promote access to evidence-based treatment while acknowledging the significant role that religion plays in Ugandan society.

### 5.1 Recommendations

1. To enhance community-based mental health support and referral systems, the Ministry of Health, district health authorities, and mental health service providers should formally engage with religious organisations. Structured collaboration can enhance trust in professional services and ensure that spiritual support complements rather than replaces evidence-based mental healthcare (Sankoh et al., 2018).
2. To help clergy, pastors, imams, catechists, and other religious leaders better grasp mental health disorders, symptom recognition, psychological first aid, and referral channels, specific training programs should be created. Given their influence within communities, religious leaders are strategically positioned to challenge misconceptions and encourage timely help-seeking (Leavey, 2010).
3. Public health campaigns should integrate culturally and religiously relevant messages that address harmful beliefs about mental illness while promoting accurate information regarding prevention, treatment, and recovery. Collaboration with religious institutions can facilitate the dissemination of mental health information through sermons, religious gatherings, and faith-based media platforms.
4. In underprivileged rural areas where access to specialised care is still restricted, the Ugandan government should improve the integration of mental health services into primary healthcare systems (Ssebunya et al., 2009). To increase service acceptability and accessibility, community-based treatments should integrate pre-existing social and religious support systems.
5. Standardised referral protocols and channels of contact between religious communities and mental health specialists should be created by health authorities. In addition to ensuring continuity of care while honouring people's spiritual preferences and beliefs, clear referral procedures can help identify mental health issues early.

6. Future studies should use primary qualitative, quantitative, and mixed-methods approaches to investigate differences in mental health help-seeking among Uganda's many faith traditions, age groups, genders, and geographic locations. To investigate how shifting social and religious circumstances affect the use of mental health services over time, longitudinal research is required.
7. Mental health education should be incorporated into the curricula of seminaries, theological colleges, Islamic training facilities, and other faith-based educational establishments. Giving aspiring religious leaders a solid understanding of mental health can boost community support networks and enhance cooperation with medical professionals.

## 5.2 Funding

There was no outside funding for this research.

Conflict of interest/competing interests

There were no financial and non-financial competing interests for the analysed data.

Availability of data and material for data transparency

This study did not produce or analyse any primary data. The study only used secondary data from publicly accessible sources, such as reports, policy papers, peer-reviewed journal publications, and grey literature that was gathered from institutional archives and internet databases. This article's reference list includes citations for every data source utilised in the review. To guarantee transparency and reproducibility, the methodology section describes the search strategy, eligibility requirements, and data extraction techniques. On reasonable request, the appropriate author will provide more details about the search procedure and sources that were included.

## Declaration

I certify that the data in this journal article have not been offered for publication anywhere.

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