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Culture and clinical social work. Reflections from Zimbabwe, Ghana, Chile, and Indonesia

Kultúra és klinikai szociális munka. Reflexiók Zimbabwéből, Ghánából, Chiléből és Indonéziából

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Abstract
Social workers, who have recently joined a master's level course with a specialization in clinical social work were asked to reflect about mental health issues in their own sociocultural contexts. Questions targeted the perceptions of mental health problems, social norms on help-seeking behaviour and available resources. Reflections highlight the role of cultural competence in clinical social work and inform the readers about some contemporary challenges of clinical social work in an international context.

Keywords: clinical social work, reflective professional, mental health, cultural competency, transition

Absztrakt
Klinikai szociális munkára szakosodott, a mesterképzésre nemrég felvett szociális munkásokat arra kérték, hogy reflektáljanak a mentális egészség kérdéseire – saját szociokulturális kontextusukban. A kérdések a mentális egészséggel kapcsolatos problémák megítélésére, a segítségkérésre vonatkozó társadalmi normákra és a rendelkezésre álló erőforrásokra irányultak. A reflexiók rávilágítanak a kulturális kompetencia szerepére a klinikai szociális munkában, és informálják az olvasókat a klinikai szociális munka néhány aktuális kihívásáról a nemzetközi színtéren.

Kulcsszavak: *klinikai szociális munka, reflektív szakember, mentális egészség, kulturális kompetencia, átmenet*

Introduction

Reflections on the difficulties clinical social workers encounter in the different countries yield an invaluable insight into the cultural aspects of clinical social work and mental health development. Cultural competence is a core issue in clinical social work (Cooper & Lesser, 2008; Erdos et al., 2021): what works well in one culture cannot be interpreted by the service users in another context. When designing and implementing prevention and intervention programmes, these aspects often become the decisive factors of success. Students in clinical social work answered three questions related to help-seeking behaviour and the risks of stigmatization related to mental health problems, and to substance use more specifically. Questions targeted the open communication of one's emotions, and the specific difficulties men may face in these societies when they are impacted by stressful or traumatizing situations, parallel to the expectations to be "strong" among all adversities.

Cultural reflections

Zimbabwe

The family is prioritized over the individual. Decisions, such as education, marriage, or career are often made with the family's needs and reputation in mind, and young people are expected

to support extended relatives. This reflects a collectivist orientation as the family's needs can take precedence over purely individual desires which can become a burden for the individual (Mhlanga & Manyumwa, 2022). Collective success and community harmony are valued more than individual achievement; for example, at funerals or weddings, neighbours contribute labour and resources (*zunde raMambo spirit*) to support each other. While personal success is celebrated, it is usually framed in terms of how it benefits the family or community. For example, securing employment is often seen not only as a personal success, but also as a contribution to the family's wellbeing. As regards temporal orientation, traditional Zimbabwean culture tends to balance between the past and future orientations. Respect for elders, traditions and ancestral wisdom demonstrates the importance of the past. At the same time, daily life and community interactions are rooted in the future, for example, modern urban life is pushing more people to think about their future in terms education, savings, and migration. Future planning is interpreted in the context of the community and family continuity, rather than individual ambition alone. As for the locus of control, many people believe that both human efforts and external forces (God, spirits, or fate) shape life events. This can make Zimbabwean people more accepting of external circumstances and seek spiritual or communal solutions to their problems. This dual perspective encourages resilience while maintaining humility and respect for the forces beyond human control.

In the Zimbabwean culture, the image of the "ideal man" is traditionally linked with toughness, self-control, and emotional endurance. Openly showing distress and seeking help is frequently interpreted as a sign of weakness, especially regarding psychological pain, which is often described in terms of *kufungisisa* (thinking too much) or *kusuruvara* (deep sadness) rather than a health condition requiring treatment (Mhlanga & Manyumwa, 2022). Consequently, men experiencing psychological trauma in Zimbabwe often do not seek professional help. Instead, they can consult respected elders, visit traditional healers, or participate in traditional ceremonies like *bira* to seek help and guidance on how to heal and solve their problem. Therefore, although traditional Shona ideas of manhood emphasize stoicism and self-control, the culture also provides accepted ways for men to seek support through elders, rituals, and community-based programmes.

In the Zimbabwean culture – today, mostly in rural or traditional settings – emotions and personal problems are often seen as private family matters. People are encouraged to first discuss sensitive issues within the family, with elders, or with a trusted relative (Mhlanga & Manyumwa, 2022). Elders or family heads are believed to have the wisdom to guide and mediate: taking matters outside the family may be viewed as betrayal or lack of trust. However, in urban areas, and among the younger generations, it is more and more common and acceptable to speak to friends, church leaders, teachers, or even professional counsellors about one's emotions, especially if the family is not supportive, or if the issue involves the family itself.

In many parts of Zimbabwe, mental disorders are still seen as a stigma. People with conditions such as depression, psychosis, or epilepsy are sometimes labelled as "crazy" or "bewitched," assumed to be under a spiritual curse. This can lead to social exclusion, name calling, or even hiding the person from public view (Marimbe et al., 2016). The stigma does not only affect the patient. Families may also be blamed, mocked, or avoided by neighbours and relatives. For example, a parent might be told they failed to raise their child properly, or a family may be excluded from social events or marriage negotiations because someone in the household has a mental illness. Families may avoid seeking help early because they fear the judgements.

Public attitudes to psychoactive substance use depend on the type of substance and the circumstances. Legal substances, such as alcohol and tobacco, are widely used and socially accepted at gatherings, weddings, and traditional ceremonies – in that sense, use is a norm. However, when the use of any substance leads to dependence, violence, deteriorations in health, or disruptions in the family and community life, it is treated as a pathology and a public-health concern requiring education, counselling, and rehabilitation. At the same time, the possession or use of illegal drugs such as cannabis (*mbanje*), crystal meth (*mutoriro*), or cocaine is classified as a criminal act under Zimbabwean law, and people caught with these substances can be prosecuted or imprisoned (Marandure et al., 2023).

In conclusion, while Zimbabwean culture values family and elders, support may also come from friends, church leaders, or professionals. The key to today's problems, however, would be prioritizing the person's safety and emotional wellbeing over keeping issues strictly within the family. If trust is missing, or the family is not supportive enough then relying on external resources is necessary. Preserving family privacy can reduce help-seeking behaviour and deepen isolation, but external disclosure is acceptable only when it is handled with discretion. Prevention, treatment, and community education are equally important alongside law enforcement. Steps towards a healthier environment include challenging the harmful myths and creating safe spaces where both the individuals and the families can get support without risking stigmatization and shame.

Ghana

In the traditional Ghanaian culture, collaboration and group success are more important than individual achievements. A common saying, *"a single tree cannot make a forest",* is indicative of this view: you need everyone to make real progress. Personal goals and achievements are acceptable but cannot be a source for arrogance. Individuals should use their achievements to help the family and the community. Accordingly, in the Ghanaian culture, the family takes precedence over the individual. Major life decisions (e.g., marriage, education, occupation) often involve consultation with family elders or parents. An individual's actions are viewed as a reflection of the family's reputation. Even in urban settings, many people feel bound to familial expectations, and this affects career choices, religious life, and behaviour. In the traditional settings, cooperation and collective success are highly valued. In rural communities, farming, festivals, funerals, and rites are all communal. Success is often measured not only by personal wealth but by how much one gives back to the family and community. However, in more modern, urban areas, competitive ambition (especially in education, politics, or business) is increasingly accepted, and even celebrated.

Traditionally, ancestral heritage, lineage, and family history are central. Cultural practices such as naming ceremonies, puberty rites (*Dipo* among the *Krobo*), and funerals strongly reflect the importance of the past. Planning for the future is also valued (especially through education, and among the youth) – but not at the expense of honouring tradition. In many cases, spiritual or ancestral guidance is consulted for future decisions. The idea of learning from history and honouring ancestors to guide the future is captured as *sankofa* in the local parlance, meaning looking back to move forward.

In daily life, relationships are more important than strict schedules. Finishing a conversation or helping someone is often valued more than being exactly on time. This is not rudeness; it is a cultural priority on people over clocks.

In traditional Krobo and Ghanaian belief systems, life outcomes are often attributed to spiritual forces (God, ancestors, witchcraft), destiny, or God's will, with the curses or blessings passing through the family line. Good fortune is seen as a blessing, while bad luck or sickness might be explained by a curse, or by ancestors' unhappiness. This indicates a strong external locus of control. People often believe they have limited personal control over their life events. However, with recent advances in education, urbanization, and exposure to Western thinking, there is a growing belief in self-determination and agency, especially among the youth.

Traditionally, men in Krobo society and in Ghana are expected to be strong, composed, and self-reliant, positioned in a provider role and keeping everyone safe in the family. Emotional vulnerability, especially in public, is often discouraged as this could undermine their authority. An "ideal man" is expected to endure hardships quietly, relying on his own strength or on ancestral wisdom and prayer. Ghanaian culture values dealing with tough times without complaining. Seeking help, especially for psychological trauma, may be seen as a sign of weakness or "not being man enough." However, there is a growing awareness, especially among the young, the more educated, and in urban communities that mental health problems do exist and seeking help is a responsible act. Some churches, NGOs, and community leaders encourage men to open up, though this shift is gradual, and met with resistance from the older generations. However, there is an increasing public awareness due to media messages, NGO-based projects, and educational institutions, and the society is slowly moving from the perceptions of "being weak" towards seeing help-seeking as "being wise."

In Ghanaian societies, an individual's problem is a family problem. In Krobo and many other Ghanaian cultures, the family is the safest place for personal matters. Talking about emotional or psychological struggles outside the family might be seen as inviting shame to the family. It is seen as "washing your dirty linen in public". Nobody wants to show others the family's weak spots. Some may believe that talking about problems makes a person open to harmful spiritual influences or intentions. In addition, there is the fear that outsiders will gossip, or use the personal struggles against the individual or their family. Emotional issues are usually kept private or spiritualized, handled through prayer, assistance from the elders, or traditional rites. Speaking with a trusted elder, a pastor, or traditional priest (*okomfo*) outside the family might be acceptable, especially if they are respected members of the community. These leaders are not seen as outsiders because they, as spiritual guides, can be trusted to keep the issue confidential. Professional therapy or counselling is still not common in many Krobo communities, though it is slowly gaining ground, especially in Accra and other major cities.

Mental disorders are heavily stigmatized. Mental illness is often misunderstood to be associated with spiritual attacks, witchcraft, curses, demonic possession, or moral failure, as one's personal weakness. Some may think that this is "in the genes", a problem that "runs in the family". A person showing signs of mental illness may be labelled "crazy". The entire family may face stigma, especially if the person behaves erratically in public. This can affect marriage prospects, social respect, and community standing. Awareness campaigns and radio/TV programs in local languages have been introduced to educate people about mental health issues. Some churches and schools assist the efforts to destigmatize therapy and introduce emotional openness. However, in rural areas, traditional views still dominate.

Stigma affects not only the individual but the entire family. If a family is known to "have madness", it can be difficult for the siblings to get married, as the potential in-laws may fear that the condition is hereditary or that the family is spiritually troubled. The family may be gossiped about. They may feel ashamed and try to hide the affected member away from the public eye to protect the family's reputation. The level of stigma varies. Conditions like

depression and anxiety are more accepted in urban areas, especially when it is called "stress". However, psychotic disorders and other severe conditions, the mental disorders with salient symptoms carry the heaviest stigma.

Psychoactive substance use (such as marijuana, tramadol, cocaine, heroin, or alcohol abuse) is seen in three overlapping ways, depending on context:

1) As a criminal act

Legally, most psychoactive substances (except for alcohol and tobacco) are criminalized in Ghana. Marijuana (*wee*), although used by some people traditionally for rituals, is still illegal, though debates about decriminalization have been continued. Police crackdowns on drug users are common and caught with substances can lead to imprisonment or harassment.

2) As a pathology (medical view)

Substance abuse is increasingly perceived as a public health concern, especially among the youth. Ghana's Mental Health Authority and several NGOs are fighting for the right to rehabilitation over punishment. However, the health system has limited resources, and fundings form mental health support are scarce.

3) As a social taboo, a form of deviant behaviour

Culturally, in Krobo society, and with many Ghanaian cultures, psychoactive substance use, especially by the youth, is perceived as immoral, disrespectful, and a disgrace to the family. Users may be stigmatized, ostracized, or even blamed for bringing spiritual or social ruin to the household. Alcohol, though legal, is frowned upon when consumed excessively, especially by women or "respectable" men.

Chile

In Chile, the family is the fundamental basis of society, and family well-being is a priority over individual interests. It is common for families to stay united in the face of adversity and to serve as the primary source of emotional and financial support for the individual members, even for adults. Respect and solidarity for older generations is an important norm. Traditionally, an ideal man was expected to possess all the tools to cope with trauma and mental health issues on his own, without anyone's help. If he did not, he was considered weak and was stigmatized. However, among the new generations there is a growing belief that an ideal man knows his own limitations and chooses to seek help in overcoming his traumas, not only to help himself but also to avoid affecting those closest to him: his partner, children, and friends.

In the society, collaboration has been favoured over competition, due to the foremost importance placed on community life and the individual's participation in the society. Working together to achieve common goals within the neighbourhoods and cities is a salient aspect of daily life, reflecting the priorities of the domestic culture – although there are always exceptions to this rule. As for temporal orientation in Chile, everyone is moving fast, always thinking about the future without pausing to focus on the present. This might be associated with several stress-related problems, for example, the anxiety over situations that have not happened yet but could happen in the future. People seek to control everything, even the outcomes of events that are impossible to control. This attitude generates panic and low frustration tolerance when the results do not correspond to the expectations.

Mental health problems are a stigma not only for the person who suffers from it but for the entire family. For example, if a child has a mental disorder, it is immediately assumed that there was something wrong with the way the parents raised the child. The parents are blamed, criticized, and are held "responsible" for the problem; also, for not being able to handle the situation on their own. As for psychoactive substance use, alcohol, caffeine, nicotine, and even cannabis use is considered normal, and socially acceptable. The use of other drugs is considered a pathology from the moment addiction sets in.

There is a persistent belief that emotional problems should be resolved within a closed circle of trusted individuals, that is, within the family sphere. Only in extreme cases should one turn to people who are not close to them – or to professionals. The idea of turning to others who can provide balanced professional perspectives and appropriate tools has been gaining more and more acceptance lately, especially since the pandemic.

Indonesia

In Indonesia, mental disorders are considered a stigma for both the patient and the entire family. The patient might be excluded from the society since the traditional culture believes that having a mental disorder is the result of spiritual or moral failings. The patients are perceived as dangerous individuals, due to their unexpected behaviours. The family might also be subject to judgment and social exclusion. The community blames them for having missed to prevent the patient's moral or spiritual failings; thus, the individual's problem impairs their family "honour".

Psychoactive substance use is considered a criminal act. The government enforces extremely strict anti-narcotics laws through the Badan Narkotika Nasional (BNN, National Narcotics Agency). Possession, use, or trafficking of drugs (such as marijuana, methamphetamine, ecstasy, heroin) can lead to heavy prison sentences, rehabilitation orders, or even the death penalty in severe narcotrafficking cases. However, there is a parallel medical perspective in health and social work professional fields. Substance use disorders are increasingly recognized as health issues requiring treatment and rehabilitation, not just punishment. Rehabilitation centres (*panti rehabilitasi narkoba*) are available, but social stigma towards the users and their families remains extraordinarily strong. At the same time, not all psychoactive substances are treated equally. For example:

- Alcohol is legal, but use is a culturally sensitive issue. In many Muslim-majority areas, alcohol consumption is discouraged or even prohibited, while in other regions (e.g., Bali, North Sulawesi, Batak areas) drinking alcohol is normalized.
- Traditional psychoactive plants (like betel nut or certain herbal tonics) may be used in local rituals, and their use is not considered a criminal act.

As for informal support systems, it is acceptable to discuss one's emotions with someone outside of the family, as long as these are considered "light" emotions, in the sense that they are common to everyone, such as anger or sadness. However, the traditional Indonesian culture considers complex emotions and states potentially indicative of symptoms of a mental disorder a taboo. These should never be discussed with anyone outside the family. An "ideal man" demonstrated strength and fitness, has stamina and emphasizes masculine appearances (no excessive jewelleries, no makeup, etc.). Traditional intellectual and emotional traits include

rationality (emotional control, logical thinking) and stoicism (emotional restraint and enduring hardships). Therefore, they should not ask for help, as in the possession of their good endurance, logical thinking, and problem-solving skills, they are expected not to show any signs of weakness, especially in the cases of psychological trauma.

Reflections on transitioning to another country

International authors of the reflections participate in a cultural journey from the national to the transnational context. Their experiences and insights directly mirror the emphasis on multicultural practice in a globalized world. The need emerges not only to understand one's own culture but using one's new experiences as a *link between cultures*. Continuously reflecting on this mission is the core of becoming a humble, thoughtful, and effective social worker.

Psychiatric patients were historically seen as "alienists" for violating social norms (Szasz, 1995). Living in a different country grants subjective experiences on becoming an "outsider." Further, transitioning may involve a shift from the majority group enjoying its advantages to a minority group facing new challenges. Experiencing both sides of this divide can be confusing. This learning is an invaluable resource for empathy. When working with clients who are migrants, refugees, or anyone who feels marginalized and misunderstood by the mainstream society, practitioners can draw on their own impressions of navigating in a foreign culture, understanding the stresses of language barriers and the longing for cultural familiarity. A further result is the deepening person-in-environment perspective (Ornellas et al., 2018): to experience the reality of macrosystem factors (global migration, EU education policies), directly affecting a person's life. In addition, we have developed a comparative lens on social work systems. This unique position helps explore the diverse ways each country provides care, runs its social services, and handles tough decisions. These insights are a resource for new, creative ideas for the development of social work.

There is a clash between theory and reality. The social work theories based on a European context may seem disconnected from the urgent, everyday needs of people in other countries. The advanced social work methods assume that there are plenty of resources and that social workers have an elevated level of autonomy. These conditions often do not exist in the domestic systems. It can be even frustrating to learn about the ideal methods that are distant, and not feasible in the domestic systems, and adaptation is necessary. To prevent separation from the domestic practices, it is worth asking: "How can I use this idea back home? How do I make it work in my own setting?".

Conclusions

The goal of this professional reflection was to give a more detailed view on the traditional differentiation and on the implications of collectivistic versus individualistic cultural frames in social work. Perceptions on mental health, help-seeking, disclosure, stigma, and substance use are embedded in a broader cultural context. Strong family orientation and community-based anchors explain why mental health issues are often managed privately and disclosure to outsiders can be seen as risky, inappropriate, or dishonouring. Stigma is frequently described as collective: mental illness can affect family reputation, marriage prospects, and community standing. Across the reflections, stigma is consistently described as the negative labelling and exclusion of the person (Goffman, 2014), and reputational "spillover" that negatively affects

the family. The cultural *code of honour* prioritizing loyalty and rank as described by Philipsen (1992) is a recurring element. All these make confidentiality, family engagement, and culturally sensitive framing central to professional practice. Stigmatization affects one's willingness to seek help and openly share psychosocial or mental problems. Interventions should reduce shame, engage families without reinforcing blame, and acknowledge culture-specific explanatory models. Practitioners need to understand whether the family is a safe and competent support context, assess confidentiality fears and reputational risk, and consider authentic cultural bridges (e.g., elders, religious leaders, community mediators, or professional services framed as socially acceptable).

Every culture has its deep traditions concerning substance use, and these longstanding cultural constructions are not determined by the risky or non-risky nature of the substance. The reflections reveal how the social construction of legal or illegal psychoactive substance use varies in the different contexts: alcohol, cannabis, and other psychoactive substances can function as social norm, moral taboos, medical pathologies, or criminal acts depending on legal context, religion, class, gender, and community traditions. In social work practice, stigma and criminalization can block help-seeking and harm-reduction approaches, while normalization can conceal problematic use until it becomes severe. Interventions must be calibrated to local legal boundaries and cultural traditions concerning confidentiality, reputational risk, and the practical consequences of law enforcement for the individual and the family.

Explicitly or implicitly, these reflections demonstrated the role of globalisation in the diverse cultures: for example, traditional norms of masculinity are changing for a contemporary, health-supportive redefinition of responsibility and strength, especially in the younger cohorts and in the urban populations. Here, the question is not only "Does he ask for help?" but also "Which culturally acceptable forms of help exist, and how can helpers frame support in ways that do not trigger shame or loss of status?".

Reflections demonstrate why culturally responsive practice is not optional: the same symptom, coping strategy, or help-seeking pathway can have quite different meanings and social risk, depending on the person's cultural context.

References

Badan Narkotika Nasional. https://bnn.go.id/profil/

Cooper, M. G., & Lesser, J. G. (2008). *Clinical social work practice: An integrated approach*. Pearson/Allyn& Bacon.

Erdos, M. B, Endre, Sz., & Kárpáti, T. (2021). *Social work with psychiatric patients* (Fedor, A., Ed.). University of Debrecen.

Goffman, E. (2014). Stigma. In I. Marsh, R. Campbell, & M. Keating (Eds.), *Classic and contemporary readings in sociology* (pp. 108–113). Routledge.

Mhlanga, S., & Manyumwa, E. (2022). Making sense of depression within the Shona culture: Perceptions of tertiary students in the Midlands Province of Zimbabwe. *The Dyke*, *16*(1), 1–27.

Marandure, B. N., Mhizha, S., Wilson, A., & Nhunzvi, C. (2023). Understanding the nature of substance use in Zimbabwe: State of the art and ways forward: A scoping review protocol. *PLoS One, 18*(3), e0272240.

Marimbe, B. D., Kajawu, L., Muchirahondo, F., Cowan, F., & Lund, C. (2016). Perceived burden of care and reported coping strategies and needs for family caregivers of people with mental disorders in Zimbabwe. *African Journal of Disability*, *5*(1), 1–9.

Ornellas, A., Spolander, G., & Engelbrecht, L. K. (2018). The global social work definition: Ontology, implications and challenges. *Journal of Social Work*, *18*(2), 222–240.

Philipsen, G. (1992). *Speaking culturally: Explorations in social communication*. Suny Press.
Szasz, T. (1995). The origin of psychiatry: The alienist as nanny for troublesome adults. *History of Psychiatry, 6*(21), 001–019. https://doi.org/10.1177/0957154X9500602101