Exploring How Cultural Narratives Shape Recovery: Insights from Substance-Induced Psychosis Outpatients in Harare, Zimbabwe.

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ABSTRACT

Substance-Induced psychosis (SIP) imposes an incrementally significant clinical challenge in Zimbabwe. While biomedical models focus on neurobiological mechanisms, culturally constructed narratives' influence on the psychological experience of recovery remains critically underexplored, creating a gap in competent care.

Objective: This qualitative study aimed to explore the prevalent cultural narratives held by men recovering from SIP and to examine how these narratives function as psychological determinants of the recovery processes and therapeutic engagement.

Method: Utilising a phenomenological design, in-depth semi-structured interviews and a focus group discussion were conducted with eight male SIP outpatients of a central hospital in Harare to collect data. The data was analysed using thematic analysis.

Results: Findings revealed six key cultural narratives which included (1) supernatural attribution (including the "prophetic gift"), (2) attitudes surrounding substance use i.e. normalisation, medicinal and taboo, (3) stigmatisation, (4) collectivism, (5) masculinity concepts, (6) peer influence. These narratives function as internalised cognitive schemas that shape identity, dictate help-seeking behaviour, create psychological conflicts (e.g cognitive dissonance, internalised stigma). Participants navigated a therapeutic double bind between collectivist familial control and masculine self-reliance, which both individually and collectively directly influenced treatment adherence. A culturally sensitive treatment model that recognises explanatory frameworks, a multi-disciplinary approach, leverages community support and challenges stigma, was suggested based on feedback from participants.

Conclusion: Recovery from SIP is psychologically mediated through a powerful ecosystem of cultural meaning-making systems. The findings advocate for the development of responsive healthcare policies, services and culturally sensitive, collaborative care models that integrate study insights into clinical practise to build stronger therapeutic alliances, as well as improve recovery outcomes

Keywords : Substance-induced Psychosis, cultural narratives, recovery, culturally sensitive care model, internalised stigma

INTRODUCTION

Substance induced psychosis (SIP) poses a significantly critical and expanding public health challenge in Zimbabwe. Characterised by hallucinations and delusions attributed directly to substance use (American Psychiatric Association, 2022), and purportedly fuelled by socio-economic stressors like unemployment, economic hardships and rapid social change (Zimbabwe National Drug and Substance Abuse plan, 2024), SIP places a considerable burden on individuals and Zimbabwe's mental health systems. This is evidenced by a surge in SIP cases at major treatment centres (Mandura, 2023). This trend mirrors broader regional concerns, with Africa identified as having a high prevalence of substance use disorders (Onaolopo, 2022) World Health Organisation, 2024) and projections indicating a sharp increase in drug use (Janson et al., 2024, MOHCC, 2024).

Biomedical models do provide a vitally crucial framework for diagnosis and treatment of SIP via defining its neurobiological mechanisms, but they frequently overlook and work in isolation from the crucial sociocultural

determinants and ecosystems that shape the psychology of illness- how distress is experienced, understood, interpreted, coped with and managed (Patel, 2007; Lebowitz & Appelbaum, 2019). This disconnect accentuates a significant gap: a limited comprehension of narratives, culturally constructed, that act as powerful psychosocial determinants of health behaviour, identity and recovery trajectories, particularly in cultural settings like Zimbabwe. Treating SIP solely as a biomedical disorder without comprehending the patient's poses risks of poor engagement, non-adherence, and ultimately, treatment failure.

In Zimbabwe, much like in many non-Western contexts, spiritual, traditional and biomedical world views on illness and health co-exist and conflict often (Patel et al., 2018; Kajawu et al., 2016). Inside this pluralistic landscape, individuals and their communities interpret illness through cultural narratives, i.e. shared stories, beliefs and explanations that group use to construct meaning, structure experience, assign cause and guide behaviour (Sue et al., 2019). These narratives form an 'explanatory model' through which individuals understand fundamental questions of illness like aetiology, symptoms and appropriate treatment pathways for their suffering [Kleinman, 1981). For individuals in treatment for SIP, the pre-existing cultural narratives become internalised cognitive schemas that powerfully shape their self-concept, interpret their symptoms and their recovery journey.

Existing research in African contexts confirms prevalence of attribution of mental illness to supernatural causes such as witchcraft or spirit possession (Munaki, 2024; Jidong et al, 2021; Kajawu et al, 2019; Watts and Hodgeson, 2023; Subu et al., 2022..11, 12, 13). However, there exists a dearth of psychological inquiry into the specific repertoire of narratives surrounding SIP in Zimbabwe, and how they function as psychological determinants. This gap is multifaceted. First, literature usually addresses psychosis generically, with focus on the substance-induced subtype's unique aetiology and stigmatising challenges being limited. Second, studies often examine community or caregiver beliefs, instead of prioritising the narratives of the individuals in recovery whose internalised perceptions deeply affect the therapeutic processes (Sichimba et al., 2022). Third, there exists insufficient investigation of how these narratives interact with psychological constructs like masculine identity, personal agency and internalised stigma in the recovery trajectory. Understanding these narratives is not an academic exercise but a clinical imperative. Without this knowledge, healthcare providers risk misinterpreting patient behaviour, encountering resistance to treatment, and failing to build the therapeutic alliance necessary for recovery.

This study is theoretically anchored in Kleiman's Exploratory model of illness which regards the patient's subjective meaning-making as vital to clinical engagement. This framework is integrated with stigma and attribution theory, and additionally viewed through a socio-ecological lens, to analyse how social labels become internalised within broader familial and cultural systems. Combined, these lenses provide a coherently unified psychological framework for analysing cultural narratives' effect within the recovery process.

Therefore, this study, positioned where cultural and social psychology interact with clinical practice, aims to address this gap via exploring the cultural narratives held by individuals recovering form SIP. Guided by a qualitative phenomenological design, the study seeks to answer two core questions: (1) what are the prevalent cultural narratives surrounding substance use and psychosis among SIP outpatients in Zimbabwe, and (2) how do these narratives influence client's perceptions of their recovery process as well as their adherence to therapeutic treatment? By investigating the narratives, this research aims to contribute to cultural competence knowledge in mental health practise via its nuanced and contextually grounded analysis. The findings are meant to inform on the development of socially intelligent psychological interventions as well as anti-stigma campaigns and policies. The study culminates in a proposed Culturally-Sensitive Collaborative Care Model for SIP patients offering a phase-based protocol for psychologists to effectively and ethically navigate this narrative ecosystem in partnership with clients.

METHODOLOGY

A qualitative research design was employed for this study. It enabled in-depth exploration of socially constructed narratives that surround SIP among men in Zimbabwe. This methodology was selected with the intention of privileging and floodlighting the subjective meaning-laden experiences of the participants, thus recognising their stories as windows into shared cultural systems (Creswell & Creswell, 2018)

Research Design and epistemology

A phenomenological approach was used as it focuses on the lived experience of the participants (Smith et al, 2021).This design aligns with Berger and Luckman's social constructionist epistemology which postulate that interactions and language built realities (Dressler, 2019; Burr, 2015). The research study was therefore, not designed to uncover an objective truth about SIP, but to further understand the intersubjective realities and narrative frameworks via which the condition is given meaning within a specific psychosocial and cultural context.

Participant selection and context.

The participants were outpatients receiving psychotherapy for SIP at a major central hospital in Harare, Zimbabwe. Information rich cases were selected via purposive sampling. All participants met the following criteria: (i) aged between 18-45 years; (ii) clinically diagnosed with SIP at least six months prior; (iii) clinically stable; and (iv) undergoing outpatient therapy for a minimum of three months.

Ultimately, the sample exclusively consisted of eight male participants. Although homogeneous, this sampling was a theoretical choice made deliberately to allow for a deep, controlled exploration of influence of culturally specific masculinity norms like self-reliance and stoicism (Gough and Novikova, 2020) – on help seeking and recovery behaviour. Additionally, the bulk of SIP patients seen at the central hospital were male. Sampling stopped once data saturation was reached (Terry et al., 2017). The sample exhibited diversity in age, educational background, primary substance use and recovery history.

Data collection.

Data generation occurred through two methods crafted to elicit both collective and personal narratives i. In-depth, semi-structured interviews: these interviews were conducted in the participants' preferred language (Shona, English or Ndebele) and lasted between 45-60 minutes. A piloted guide exploring participants' experiences with substance use, psychosis, cultural beliefs and therapy was utilised. ii. Focus Group Discussion (FGD): a single such discussion with five of the interview participants was conducted to capture the interactive , as well as co-constructed nature of cultural narratives The data was audio-recorded, transcribed verbatim and translated where that was required, for analysis.

Researcher Reflexivity and Positionality

A critical practice of rigor is sustained reflexivity regarding the researcher's positionality. As a masters student psychology intern practising in the same cultural context as the participants, the researcher occupied dual "insider-outsider" role. The researcher was an insider holding an intuitive understanding of local idioms, social norms and spiritual gifts. The researcher was an "outsider" in the role of clinician-researcher affiliated with a university and a hospital system. Therefore the researcher's professional orientation would have bias toward promoting treatment adherence that could create a predisposition to interpret narratives that conflict with biomedical models as barriers to be overcome.

To reduce the impact of these influences and ensure that findings were grounded in participant account, the following was engaged in:

i. Reflexive journaling to separate clinical assumptions from emergent data Peer debriefing with the researcher's supervisor and colleagues to challenge interpretations, explore alternate explanations and prevent analytical tunnel vision

ii. Member checking preliminary findings as well as thematic interpretations were shared with a subset of participants to check whether this resonated with their experiences and intentions, thus enhancing credibility of the analysis

Data analysis

A reflexive thematic analysis (Braun and Clarke, 2019) was used for data analysis. This method is congruent

with a social constructionist orientation since it treats themes as patterns of shared meaning constructed through the researcher's' engagement with the data. The analysis accompanied an iterative six-phase process: transcript familiarisation, initial code generation of data, theme construction; defining and naming themes and selection of illustrative quotes to ground the findings in participants' accounts; and lastly producing the report. This process enabled the identification of prevalent cultural narratives.

Trustworthiness and Methodological Rigor

To ensure the study's trustworthiness and rigor, special emphasis was placed on reflexivity and triangulation via several strategies employed:

Credibility: arrived at through member checking and peer debriefing. Methodological triangulation using both interviews (individual perspectives) and an FDG (group discourse), allowed cross verification of findings across data sources, thus strengthening their validity.

Transferability: this was supported by thick descriptions of the context, participants and methods to allow judgement of applicability to the settings.

Dependability: maintained via a detailed audit trail of methodological and analytical decisions.

Ethical considerations

Ethical approval for the study was granted by Great Zimbabwe University prior to undertaking the study. All participants willingly provided audio-taped verbal and written consent following the thorough explanation of the study's purpose, procedures, risks and benefits. They were additionally informed of their right to withdraw from the study anytime without penalty. Anonymity and confidentiality were maintained through use of codes as pseudonyms and removing identifying details from transcripts. Electronic data was stored in a secure, password-protected environment. Given the sensitive nature of the topic, support resources as well as referrals to mental health personnel were made readily available to participants.

RESULTS

Thematic analysis revealed six predominant cultural narratives. These narratives directly affected the research participants' emotional and cognitive appraisals, behavioural choices and treatment engagement.

Table 1: Predominant narratives, their function and behavioural influence.

Core Narrative	Primary Psychological function	Key Behavioural influence
1. Supernatural attribution	It provides an explanatory model that is culturally resonant; can protect self-concept via reframing	Help seeking is directed towards traditional/spiritual healers. It can conflict with the biomedical care.
2. Normalisation/functionality.	Socially embeds and validates substance use within daily life, minimises risk perceived; justifies use as medication for stress/emotional regulation.	Reduces perceived risk of use; undermines motivation for abstinence
3. Stigma and Othering	Enforces social norms and boundaries through labelling and exclusion	Promotes secrecy, shame, and social isolation; deters help-seeking

4. Collectivism	Positions the family as the central unit of care (not the individual)	May enable support but could override the patient's autonomy in decision-making
5. Masculine Agency	Uphold cultural ideals of strength, control and self-reliance	Can foster resilience but may frame help seeking as a failure of masculinity.
6. Peer Influence	Establishes substance use as a rite of passage and a tool for bonding	Initiates and also sustains use; can provide an abstinence resistant network.

The supernatural attribution narrative

A dominant narrative situated the cause of psychosis outside the biomedical realm and into two distinct forms with a supernatural basis.

i. Malevolent attribution: Participants frequently framed psychosis as resultant of witchcraft (*huroyi*), generational curse (*mamhepo edzindza*), or spiritual possession (*kusvikirwa*). For example, P7 shared, " *A lot of people say its family curses …. Your brains have been put in a calabash* (mudede)." P3 noted, *"We hear stories, like someone can hate you so much that they go to a witch doctor (n'anga), or to the Apostolic sect (Masowe) and ask them to make you insane."*

This narrative legitimised and directed help seeking initially from traditional healers (*n'angas*) or apostolic sect leaders (*Masowe*) or even Christian pastors, thus delaying biomedical interventions.

ii. Benevolent attribution: a nuanced as well as significant finding was participants attributing psychotic symptoms to a spiritual calling or prophetic gift. This narrative by several participants reframed a stigmatised 'mad identity to one of social and spiritual elevation, bringing forth a critically profound conflict with biomedical diagnosis. P1 explained: *"I used to think some of what was happening to me was normal because I used to hear voices and see a lot of hallucinations. I thought I had the gift of prophesying or something… that's when I used to think that I am prophesying."* P3 echoed this*: "I thought had been given the gift of prophesying."*

The belief or social explanation was that the only reason why an individual taking a substance like cannabis would become psychotic while others did not was because he/she had some ties to the supernatural malevolently or benevolently. This belief influenced treatment pathways by directly delaying treatment or even abandoning medication while spiritually congruent healing was pursued.

Substance Use Narrative: Normalisation, Medicine, Taboo

i. Normalisation and acceptance: participants described community given narratives that normalised substance use, especially cannabis, thus embedding it into daily living. P8 stated*, "In Mabuthweni, they see it as something normal. There, drugs are similar to tea"*. Participants additionally justified use by pointing towards global figures and legalisations abroad: *"Do you know that in the United States of America, you can buy cannabis in a shop… Elon Musk himself smokes cannabis."* (FDGCM).

ii. Substance as Medicine: Substances were narratively construed as tools to aid or heighten functionality, as well as cope with psychological and physical ailments. They were seen as remedies for stress relief and (FCGP8: "If I smoke my joint… I can spend the day relaxed"),; enhancing confidence (P7*: cannabis gives me confidence"*); gaining physical strength (P5: *"we grew up being told that marijuana was smoked by those going to war"* P2: *"they increase strength");* for insomnia (FCGP8: *If you have not been able to sleep, sleep will come if you take a hit)*; for spiritual protection (FCGP8: *Weed (chamba) chases away evil spirits;* FCGP4 *if you burn marijuana… it cleanses the air around you, so much so that evil spirits won't be able to get anywhere near you.).*

iii. Taboo and criminalisation: Conversely, findings revealed strong societal narratives that framed substance use as immoral, criminal and markers of social failure. Participants spoke of themselves and similar others being labelled as '*varombe'* (good for nothings), or thieves, and female users were termed '*mahure*' (prostitutes). P3 stated*: "Substance abuse is associated with being thief, being a 'rombe', and always being seen as suited for trouble."* FCGNM agreed: *"We men re referred to as varombe' and women are referred to as whores."*

Although these conflicting narratives created internal and social conflict, they also constructed powerful social scripts and individual schemas that framed use as medicinal or mundane. This often undermined motivation for recovery, fostered shame or secrecy or directly and directly challenged public health messages.

Stigma Narrative and Social Othering: Pervasive weight and social Process.

Study findings showed the stigma narrative emerging as a social label, with stereotyping and social exclusion. Participants frequently reported being labels such as '*varombe*' (good for nothings) or thieves. Being side-lined by family or community (P6: *I get to a place where there are 3 or 4 people, and I sit among them. I just see them getting up one after the other and leaving*."). It also came as an internalised psychological narrative characterised by anticipated rejection leading to self-isolation. P1 described it succinctly: "*I got to a point where I was isolating myself, unable to talk to others…You could get treated well but you won't feel as though you are being treated well."* An additional characteristic was denial of diagnosis and treatment refusal as P7 confessed: *So I was now surprised and asked myself that could I really be taking psychotic medication yet I am not mentally insane. So I abandoned them (the pills)."*

Collectivism Narrative: Familial duty vs. Individual Autonomy

Recovery was consistently and strongly situated within a collectivist framework. Families were revealed to often play a pivotal, sometimes coercive, role as the primary care and decision-making unit. Decision-making was often a family or even clan endeavour. P6 shared*: 'My family played a pivotal role… my parents, all my sisters, all my cousins. Everyone stood with me.*" Sometimes collectivism overrode individual autonomy as observed by P7: *"Everyone was just showing up and having something to say*." This reportedly led to coerced treatment pathways. P4 recalled: *"Its like they all just sat down and said I was crazy. The doctors just took their story and didn't ask me."* Treatment adherence was usually motivated by filial piety instead of personal volition. As P4 affirmed: *"I kept coming (for therapy) out of respect for my mother and my aunts."*

Masculine Agency Narrative: Norms and Personal agency

The all-male sample highlighted narratives rooted in masculine ideals such as self-reliance, individual responsibility and personal control. Some participants framed recovery as individual conquests of willpower. FGDCM asserted *"Using that stuff… its just control… I know the right amount."* FDGP8 reiterated: *"Healing is just based on an individual's mind, in that you alone have to treat yourself"*

Peer Influence Narrative: Social bonding

This narrative constructed substance use as a rite of passage and tool for social bonding. By deeply embedding substance use in peer interactions, it normalised initiation and maintenance via social reinforcement. P8 narrated: *"Friends first gave me …we would just give each other as friends."* P5 described the social pull: *"We started doing it for fun, and they said, 'just try it."*. Evidently, findings showed peer networks often serving as continuous reinforcement systems, making disengagement form peers psychologically and socially costly.

Consequences: Narratives actively shaping coping and adherence

These cultural narratives directly informed coping mechanisms treatment engagement and adherence.

- The supernatural narrative led to reliance on prayer and traditional healing as a coping strategy, thus delaying biomedical care

- The stigma narrative promoted coping through secrecy and social withdrawal.

- The masculine agency narrative fostered coping via behavioural and environmental such as geographical relocation as well as severance of ties with peers (P5*: "I moved from Southlea to Marlborough."*; P1: *"I changed my friends."*

- Normalisation and prophetic gift narratives encouraged acceptance of participants as is and consequently eroded the perceived legitimacy of biomedical treatment, therefore nurturing non-adherence.

- The peer influence narrative additionally reinforced substance use as not only normative but socially rewarding which appeared to complicate efforts to abstain.

Together, these six narratives constituted a relational ecology of meaning that individuals navigated during recovery. They functioned not just as cultural stories or beliefs, but, as social determinants and psychological frameworks that construct and shape identity, govern behaviour and systematically channel help-seeking, obstruct or facilitate the therapeutic process and define the recovery parameters. The following discussion goes on to interprets this ecosystem through psychological lens – explanatory models, internalised stigma, cognitive dissonance and social constructionism – and explores implications for a culturally and socially intelligent ecological paradigm of mental health care while proposing a culturally sensitive model for intervention.

DISCUSSION

This discussion deciphers the six cultural narratives surrounding SIP as the rudimentary psychological architecture through which Zimbabwean men construct their recovery. Analysis of findings contend that the narratives illuminated, serve as internalised cognitive schemas and psychosocial scripts that direct help seeking, identity and therapeutic engagement. The central claim is that narrative competence as a psychological skill is vital for effective intervention. The discussion explores this through lens of explanatory conflict, internalised stigma, psychosocial mechanisms and client-derived insights for clinical practise.

The Centrality of explanatory models, cognitive dissonance and Identity protection.

The dominance of the supernatural explanatory models strongly resonate with Kleiman's (1981) Explanatory Model of illness which demonstrates that patients and their families operate within pluralistic systems of health belief. The finding that psychotic symptoms are often interpreted as 'prophetic gifts' is particularly significant as it contrasts with much of existing regional literature, which chiefly accentuates witchcraft and curses (Munaki, 2024; Egbe et al., 2014). However, this narrative is more than an alternative cause. It is a psychologically protective and attractive cognitive reframe that transfigures a pathological 'mad' identity (*kupenga*) into one spiritual elevation (*svikiro*). As P1 stated, *"I used to think ... I had the gift of prophesying."* It additionally protects self-identity. This reframe constructs considerable cognitive dissonance (Festinger, 1957), with biomedical diagnosis consequently leading to treatment abandonment as the findings demonstrated. Pivotally, viewed from a strength-based perspective, this narrative can be seen as a form of meaning-making and probable post-traumatic growth, where affected individuals strive to build value and coherence from distressing experiences (Tedeshi & Calhoun, 2004). The challenge for psychologists therefore, is to navigate this dissonance through acknowledging the identity-protection function of the spiritual narrative while weaving in the biomedical reality to construct a united recovery identity.

From a Social Label to Maladaptive Self-Schema The Internalisation of Stigma.

From a social constructionist perspective (Berger & Luckman, 1966), the concepts of 'addiction', 'psychosis' and 'recovery', are not permanent biomedical truths but dynamic ones interpreted through culturally specific lens. The substance use normalisation in some communities where drugs are much like drinking your daily 'tea', establishes substance use as mundane acceptable behaviour instead of a medical pathology. Conversely the findings also illustrate stigmatising narratives such as labelling substance users as '*varombe*' (good for nothings), erected a difficult to shed social identity. Furthermore, participants' reported experiences of stigma from healthcare workers. This public stigma becomes internalised thus fabricating a maladaptive schema characterised by low self-efficacy and shame as reflected by Corrigan's (2004) model. This demonstrates how shared narratives and language actively fashion the realities that individuals inhabit.

Navigating the dual-edged sword of collectivism and agency

The Zimbabwean society's collectivist nature played a paradoxical role. In alignment with studies on other collectivist cultures, family involvement is vital to care (Tse & Ng, 2014), providing crucial support that drives therapeutic engagement. Yet again collectivism also sometimes resulted in coercively forcing individuals into supernatural treatments conflicting with biomedical care. Thus, adherence was often times motivated by filial piety.

When it came to personal agency, either the masculine norms of self-reliance and control, fostered a sense of empowerment and responsibility for one's own recovery, or barriers to seeking help for fear of perceived as weak. Therefore participants clearly navigated a psychological double bind (O'Sullivan, 2024), between masculine agency (e.g, "Healing is just based on an individual's mind") and familial collectivism. The former situated help-seeking as failure of masculinity thus promoting isolation and reluctance to engage in therapy, a known barrier in men's mental health (Gough & Novikova, 2020; Banda & Mlambo, 2023); while the later commonly overrode personal autonomy. This overall tension makes strategic reframing necessary in therapy where strength is redefined to encompass seeking help with the aim of protecting one's family as a responsible leader would do.

Consequently, the vital need for engagement between clinicians and family systems without side lining the patient is highlighted. Furthermore, participants' explicit requests for transparent, compassionate and collaborative care directly align with Roger's (1959) humanistic principles that promote effective therapeutic alliance such as shared goals, unconditional positive regard and empathy. These insights generated by participants highlight respecting autonomy and fostering collaboration, which are ethical imperatives that can significantly foster client engagement.

The Psychosocial Engine of Narratives

A psychosocial analysis spells out the regulatory power of the highlighted narratives. Social Identity Theory (Tajfel & Turner, 1979), interprets the 'prophetic gift' as a tactical identity shift to a valued in-group. Secondly the Attribution theory (Weiner, 1985), explains that supernatural narratives put forward external, independent and uncontrollable causes, thus diverting blame. Crucially, Bandura's (1977) Social Learning theory provides a critical framework for understanding how peer influence and celebrity culture normalise substance use. Peer networks clearly serve as continuous reinforcement systems, which made would make disengagement from them psychologically and socially costly. Additionally, observational learning with vicarious reinforcement is demonstrated through references made to figures like Elon Musk smoking cannabis. Thus, peer model networks and media portrayals model substance use as advantageous and harmless. Subsequently, this learned normalisation, including that of seeing drugs as '*similar to tea*' (P8), manufactures a strong descriptive norm that directly blunts risk perception and reduces motivation to change. The highlighted role of social identity poses the need for building social networks that are recovery-supportive.

Clinical and systemic Implications: Towards a culturally Sensitive model.

The findings show profound implications for clinical practice in Zimbabwe and similar contexts. An approach that is purely biomedical is likely to be met with resistance, non-adherence, early dropout and consequently frequent relapse. Synthesising the insights gained from the study, a Culturally Sensitive Collaborative Care model is proposed as a clinical protocol (see Figure 1).

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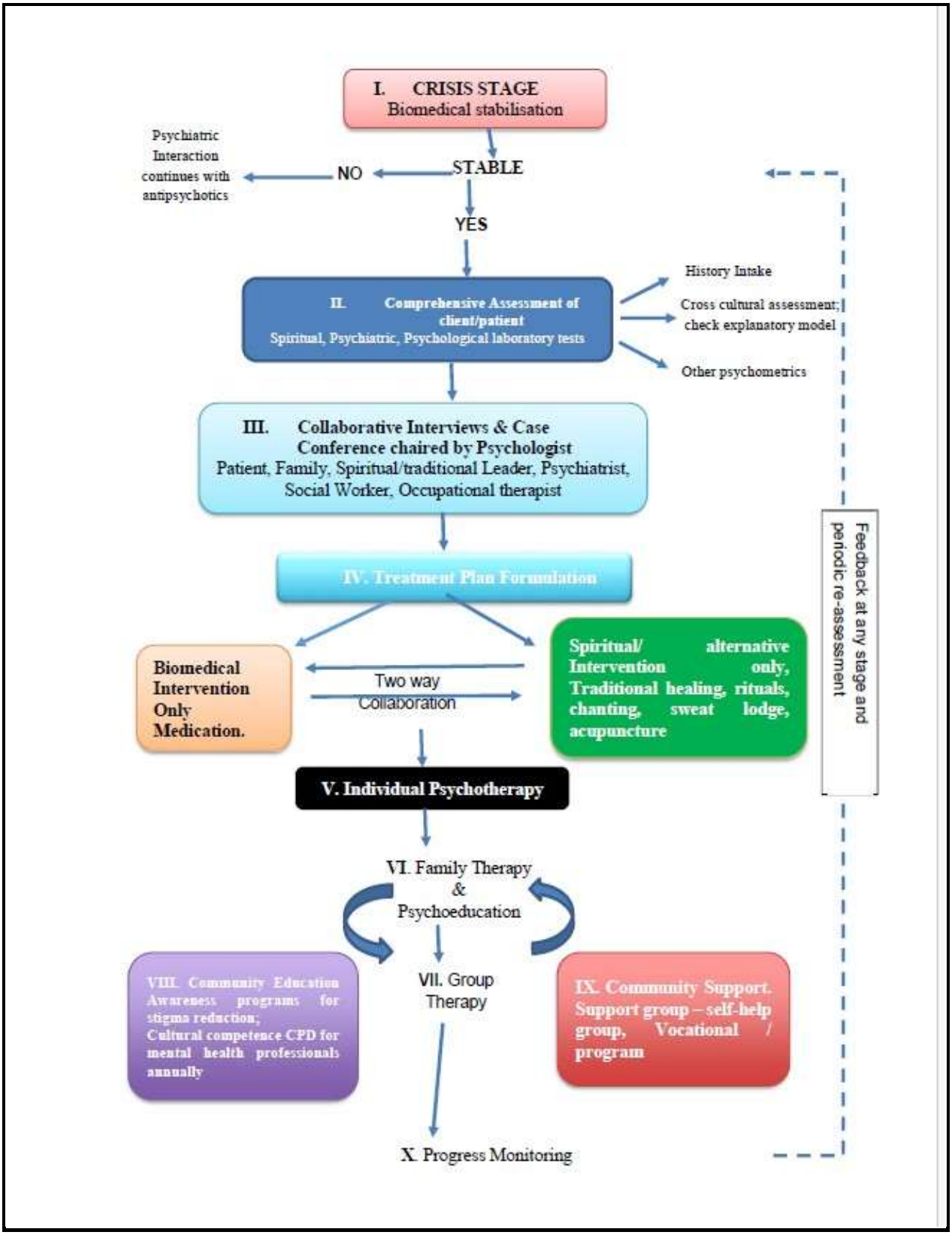
Fig.1 A Cuturally-Sensitive Collaborative Care Model



This model operationalises narrative and cultural competence while also responding to client-voiced needs. This involves:

1. Narrative-centric Assessment (II). By routinely, actively and non-judgementally exploring patients' beliefs about the cause of their illness, their explanatory models and social learning history can be systematically documented. Kleiman's questions can stand as guidance to uncover crucial information that will inform on treatment planning and enable rapport building.

2. Psychologist Facilitated Collaborative conference (III). This creates a structured negotiation among the clients/patients, family, spiritual and biomedical practitioners. Ultimately, a co-created care plan that directly addresses explanatory conflicts and leverages collectivist support can they emerge, which can increase efficacy of therapy.

3. Iterative feedback loops: this can make sure that the intervention stays dynamic and responsive to the client/patient's evolving context and adherence.

4. Leveraging positive cultural forces (V): via therapy, the positive aspects of personal agency (self-efficacy), and collectivism (family support) to booster and fortify recovery, while also working to reduce their negative impacts (coercion, isolation).

5. Addressing stigma at its roots (VIII & IX): anti-stigma campaigns and psychoeducation programs sensitive to clients' cultural contexts must be developed. This must encompass healthcare stuff training to avoid stigmatising practises and language, as directly requested by the study participants. Additionally stigma can be mitigated in the psychoeducation of families within therapy sessions (VI), which can spill over to the community. Patients/clients can be recruited to be mental health advocates as well.

This model translates the psychological challenges into actionable strategies. Table 2 below summarises this and grounds evidence based practise in the specific cultural and psychological realities identified.

Table 2: Synthesis of Psychological Challenges and Corresponding Clinical Strategies.

Narrative theme	Core psychological challenge	Recommended strategy
Prophetic gift	Cognitive dissonance; identity conflict	Acknowledge the protective function; use integrative reframing to bridge explanatory models
Internalised stigma	Low self-efficacy; shame based schema	Utilise cognitive restructuring; enact contact based anti-stigma interventions
Masculine agency	Help-seeking framed as masculine failure/weakness	Reframe as strength and responsible control; employ motivational interviewing (Miller & Rollnick, 2012).
Familial Collectivism	Overridden autonomy; adherence is coerced.	Engage family through psychoeducation; facilitate sessions that centre the client's voice in collective decisions.
Peer normalisation	Substance use reinforced by social learning	Explore and counter learned assumptions; promote new recovery-oriented social networks.

Limitations and future research

This study specifically focused on the narratives shaping SIP. A valuable direction for future research would be comparative studies that examine cultural narratives across different groups, such as primary psychotic disorders like schizophrenia or substance use disorders without psychosis. For instance, the 'prophetic gift' narrative may

be more specific to psychotic phenomena, whereas the 'moral failing/weakness' narrative may might apply in non-psychotic substance use. Similarly, the time limited, acute nature of SIP might interact with recovery narratives differently than chronic primary psychosis. Comparative work such as this might help refine out comprehension of the unique psychosocial and narrative challenges faced by the SIP population, therefore allowing for more precise and targeted interventions. Longitudinal designs could trace narrative evolution through recovery most importantly, implementation science research is necessary to pilot and evaluate culturally sensitive intervention models like the one proposed, thus moving from theoretical insight to measurable clinical impact.

CONCLUSION.

Recovery from SIP in Zimbabwe is a journey navigated through powerful landscape of cultural meaning. The identified narratives about cause of illness, nature of substance use and responsibilities of individuals and their families are central to the illness experience. They construct an internalised psychological architecture that shapes every aspect of the recovery process. For psychology, effectiveness hinges on narrative competence- the skilled, humble engagement with these meaning-making systems, so that one is able to construct, comprehend and interpret the stories. By integrating this competence with insights derived from clients and evidence based psychological theory into structured, collaborative models, practitioners are better able to move from a one-size –fits all biomedical model. They then build effective alliances that in turn foster recovery trajectories that are culturally resonant and clinically sound.

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