UNIVERSITY OF GHANA

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PERCEPTIONS OF PERSONHOOD, SPIRITUALITY, AND MENTAL ILLNESS AMONG EWE AND AKAN ETHNIC GROUPS IN GHANA

BY

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DECLARATION

I hereby declare that this thesis is an outcome of my research work and that no part of it has been presented for any academic award in this university or any other university.

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DEDICATION

To God

I have come this far by your grace.

To my family

My parents, Mr. & Mrs. Bortey, for continuously supporting my dreams and believing in me.

My lovely wife, Cathleen Fafa Asafo, and my son Ellis Asafo. Thank you for always being a source of inspiration and comfort.

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We make one great team. Thank you for all the support.

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LIST OF ABBREVIATIONS

ADHD – Attention Deficit/Hyperactivity Disorder

A.P.A. – American Psychiatric Association

LMIC – Low-and Middle-Income Countries

MHL – Mental Health Literacy

NIDA – National Institute on Drug Abuse

NIMH - National Institute of Mental Health

SUDSs - substance use disorders

UNCRPD - United Nations Convention on the Rights of Persons with Disabilities

W.H.O. -World Health Organization

Abstract

Understanding how cultural conceptions of personhood and spirituality shape attitudes toward mental illness is essential for developing inclusive mental health care in Ghana. This study examined how the Akan and Ewe conceptualize personhood and spirituality, and how these perspectives influence explanations, stigma, treatment practices, and health-seeking behaviours in relation to mental illness.

Qualitative data were gathered using purposive sampling from 67 participants through in-depth interviews (n = 11) and focus group discussions (n = 56), including chiefs, elders, adult men and women, and youth. Participants ranged in age from 18 to 80 years (M = 47.9, SD = 15.9). Data was analysed using reflexive thematic analysis with three themes emerging: (1) conceptualizing personhood, (2) subjectivizing mental illness, and (3) implications for personhood in context.

The findings indicate that personhood is a relational and spiritual construct grounded in communal roles, moral conduct, and spiritual vitality. Mental illness, often attributed to supernatural causes, was perceived to erode personhood by disrupting social identity and spiritual balance. The study highlights the need for culturally sensitive interventions and education that recognize local conceptions of personhood and spirituality while promoting dignity and inclusion for individuals living with mental illness.

Keywords: personhood, spirituality, mental illness, Akan, Ewe, Ghana

Chapter One

Introduction

Background to the Study

Conceptions of personhood underpin various phenomena such as human rights, organisational behaviour, and mental health, although the philosophical foundations are not explicitly mentioned (Pietrzykowski, 2017). While this concept has not received as much attention as, for instance, the concept of personality in mainstream psychology, it has been the subject of controversy and discourse in other fields, such as philosophy, sociology, and law (Sattar, 2021). For instance, Cooley (2007 as cited in Witz & Bae, 2011) regards an individual as a person based on metaphysical characteristics, whereas Kitwood (1997) conceptualises personhood as a status one acquires as a social being in relation to others. Despite the complex nature of personhood, it is generally acknowledged that conceptions of personhood are culturally specific and influence behaviours and practices differently (Gavi et al., 2022; Kpanake, 2018; Krause, 1995). In fact, Martin and Bickhard (2013) categorically stated that considerations of who a person is implicitly form the foundation of the theories and practices of mainstream psychology. Personhood in mental health focuses on the cultural conceptions of what it means to be a person, influencing how individuals with mental illness are treated, their recovery and reintegration into society (Asafo et al., 2025; Jansen, 2025). Therefore, it becomes imperative for societies to develop a mental healthcare system that aligns with their ecological context, cosmology, and socio-cultural realities to adequately meet the existential needs of the people.

A careful study of the literature on personhood reveals a notable difference between Euro-American and African conceptions of personhood. As pointed out by Lim (2016), the West conceptualizes personhood based on the philosophical arguments advanced by Emmanuel Kant.

The Kantian perspective asserts that a human being attains personhood by possessing rationality and the ability to think and make independent decisions, which are considered metaphysical attributes. This philosophy considers the individual as atomistic and independent of the wider community to which they belong (Hill, 2014). Reflecting on this conceptualisation of personhood, Rogers (1961) posited that the purpose of Eurocentric humanistic psychology is to pursue individual development that takes into account individual free will and human potential. Humanistic psychology, therefore, encourages self-awareness and self-exploration rather than seeking to study behaviour in others to understand ourselves. Simply, the focus of Western psychology has been individual-oriented even when a group of people has been the object of study. Naturally, this same philosophical position informs the practice of clinical psychology and mental health care (Kazarian, 2020).

Indeed, as the study and practice of psychology focus on human beings and, therefore, individuals, it stands to reason that the trajectory of the discipline will be influenced by cultural understandings of personhood. Consequently, some psychologists argue that since conceptions of personhood underpin both everyday human practices and academic disciplines, these implicit philosophical positions must also inform psychological theories, models, assessments, pathology, and psychotherapy (Hammack, 2008; Kirmayer, 2007). Western psychology has effectively orientated the development of the discipline in accordance with the general Western concept of personhood. This is the type of psychology that was imported into Africa and has since shaped the development and practice of psychology in Ghana. However, African philosophers argue that many African cultures conceptualise personhood in relational terms, where an individual is recognised as a person based on communal definitions of what constitutes personhood (Gyekye, 2000; Kpanake, 2018; Mbiti, 2008; Menkiti, 1984). Thus, whereas a person in the West is seen

as a self that exists as a whole greater than the sum of the composite community or society to which they belong (Rogers, 1961), in Africa, individuals are perceived as part of the whole that confers upon them their personhood (Mbiti, 2008). Since conceptions of personhood shape cultural understandings of human experience, they also frame how societies interpret and respond to psychological distress. Mental illness, therefore, must be situated within its historical social construction, where shifting cultural, philosophical, and institutional paradigms have influenced its meanings, classifications, and treatments (Foucault, 1965; Horwitz, 2002; Porter, 2002).

Social Construction of Mental Illness: Historical View

Mental illness has historically been a point of controversy (Shields et al., 2016). Arguments about mental illness are strongly based on philosophical and practical issues (Hanna et al., 2018). Conflicts arise mostly from the definition of mental illness and the classification of mental disorders or conditions (Khoury et al., 2012). Historically, there have been differences concerning whether some diseases are considered mental illnesses and how they should be managed (Kleinman et al., 1978).

The definition of mental illness within biomedical disciplines, such as psychiatry and clinical psychology, has traditionally been rooted in the concept of the mind, historically regarded as separate from the body (Kleinman et al., 1978). However, advancements in neuroscience have increasingly blurred the distinction between the mind, the brain, and the body (Solms & Turnbull, 2002). The notion that mental disorders are solely "of and about the mind. The view that dysfunction originates solely within the brain has been challenged, not only on neuroscientific grounds but also from broader perspectives. Scholars argue that sociopolitical

factors such as hunger, poverty, and religion play a crucial role in shaping mental health and well-being (Kirkbride et al., 2024; Livingston et al., 2022; Shields et al., 2016). Restricting mental illness to the realm of the mind is viewed as a form of cultural hegemony, serving to downplay the significance of social determinants in understanding the prevalence of mental disorders (Hanna et al., 2018; Khoury et al., 2012; Kleinman, 1988).

It is also possible that what biomedicine classifies as "mental illness" includes states and behaviours for which no straightforward somatic treatment, such as medication or surgery, is available (Khoury et al., 2012). As a result, conditions that are not well understood may be categorized as mental disorders but later reclassified when scientific advancements reveal their underlying biological causes (Shields et al., 2016). The reclassification of epilepsy was not based on biology alone; it was also shaped by social perceptions, stigma reduction, and professional shifts within medicine, showing that diagnostic categories in mental health emerge from both scientific and sociocultural factors (Temkin, 1971). This aligns with the broader recognition that mental health and well-being are shaped by an interplay of biological, psychological, social, and environmental factors (Sefa-Dedeh, 2014a).

Over time, the role of power inequities in shaping mental illness has gained increasing attention (Moodley & West, 2005). In light of this, several critical mental health researchers argue that 'mental illness' is a social construct (Purgato et al., 2019). Historical research by these scholars highlights how the label 'mental illness' has been used as a tool for social and political control, a moral classification, and a means of legitimizing societal structures (de-Graft Aikins, 2015). Cultures, by defining the boundaries of acceptable behavior, construct deviance—labeling certain actions as violations that result in perceived deviations. Consequently, mental illness is deeply intertwined with cultural norms (Mboweni et al., 2023).

In this way, biomedical professionals, including psychiatrists and clinical psychologists, do not merely uphold but also actively shape social norms related to mental illness (Kralj & Kardum, 2024; Purgato et al., 2019). Throughout history, certain conditions—such as drapetomania (the so-called psychological disorder that supposedly caused enslaved individuals to flee captivity), homosexuality, and masturbation—were framed as mental illnesses to enforce social control (Drescher, 2015; Powell & Scarffe, 2019; Purgato et al., 2019). These classifications served as mechanisms of power, used to regulate marginalized groups. For instance, labeling an enslaved person's desire for freedom and dignity as a mental disorder (drapetomania) requiring treatment was a strategic effort to suppress resistance and prevent uprisings (Myers, 2014). While social constructs vary across different eras and cultures, some patterns remain consistent. Historical analyses, including biblical and ancient texts, reveal that conditions such as depression and mood disorders have long been perceived as signs of ill health, much as they are in contemporary societies (Shields et al., 2016).

Social Construction of Mental Illness: Ghanaian Worldviews

The socio-cultural context of Ghana, like any other, has practical implications for how mental illness is perceived by society. Regarding ideas about etiology, symptomatology, diagnosis, treatment, and care (de-Graft Aikins, 2015), explanatory models of mental illness directly reflect lay people's understandings of the condition. Religion, as it does in much of Africa, plays a vital role in elucidating social phenomena within traditional Ghanaian society (Mbiti, 1975). Consequently, a supernatural perspective is employed to interpret a wide array of societal challenges, including mental illness (Subu et al., 2022). Scholars propose that the traditional Ghanaian worldview encompasses an individual's well-being, balancing the physical, social, and spiritual realms (Ohene & Addom, 2014; Osafo, 2016). Thus, any imbalance arising

from one or more of these domains may result in illness and deviance. Consequently, mental illness reflects societal cultural standards.

The treatment of any health condition, especially mental health disorders, is shaped by socio-cultural beliefs about their causes and available remedies (Badu et al., 2018). For instance, when individuals attribute a loved one's mental illness to a physical or chemical imbalance, they tend to view biomedical interventions as the most appropriate treatment (Twumasi, 2005). Conversely, if they believe the cause is social, they prioritize mending broken relationships as a form of healing (Ohene & Adom, 2014). A common example is the belief that neglecting parental care obligations can bring about a curse (illness), and restoring these responsibilities is thought to bring blessings (healing) (Nukunya, 2003). Similarly, those who violate sacred norms or taboos are believed to provoke the wrath of the gods, potentially leading to personal or communal misfortunes (Okyerefo, 2014). In such cases, ritual purification is often seen as the primary means of restoration. Supernatural afflictions may also be attributed to witchcraft or magical spells, which are believed to require protection or reversal through sacred rites (Nukunya, 2003; Ohene & Adom, 2014; Okyerefo, 2014). The holistic understanding of illness and well-being in traditional Ghanaian thought, similar to perspectives in many African societies (Ajima & Ubana, 2018; Asakitikpi, 2018), stands in stark contrast to the Western concept of mind-body dualism (Ofori-Atta et al., 2018).

External influences such as colonization, globalization, education, religion, and technology have played a significant role in shaping Ghana's social structure and the perspectives of its people (Assimeng, 1997; Nukunya, 2016). The interaction of these diverse influences within Ghana's sociocultural landscape has resulted in multiple explanatory models for mental illness and various approaches to healing (Kpobi & Swartz, 2018; Ofori-Atta et al., 2014). This

is reflected in Ghana's diverse and pluralistic healthcare system, which includes orthodox medicine, traditional herbal treatments, religious and faith-based healing, and an increasing reliance on allopathic medicine (Ofori-Atta et al., 2018). In conclusion, mental health scholars and professionals have traditionally regarded Ghanaians' mental health-seeking behaviours as pragmatic rather than categorical. Factors such as the availability of treatment resources, the perceived aetiology of the illness, and the outcomes associated with particular treatment modalities all impact this pragmatism (Ohene & Adom, 2014; Sefa-Dedeh, 2014b; Twumasi, 2005).

Spirituality, Religion and Faith Healing as Pathways to Mental Healthcare

Religion and faith have long maintained a complex and sometimes ambivalent relationship with mental health (Antoniou & Kalogeropoulos, 2024). Certain religious rituals and expressions have historically been associated with mental illness, while religious belief systems have also shaped understandings of its causes and treatments (Moreira-Almeida et al., 2006). At the same time, numerous empirical studies highlight positive correlations between faith and improved health outcomes (Aggarwal et al., 2023; Behere et al., 2013; Coles & Mannion, 2017). This positive connection has been observed across diverse contexts, including clinical settings and large-scale cross-sectional studies in both Western and non-Western countries (Constantine et al., 2004). Koenig (2009) further observes that contemporary psychiatric research has examined the role of religion and spirituality in relation to conditions such as hysteria, neurosis, and psychotic delusions.

It is therefore important to distinguish between spirituality, religion, and faith, as these constructs, though interconnected, influence mental health in different ways. Religion, with its

organized practices and communal expressions, can provide comfort, meaning, and social support, but it has also been linked to certain mental disorders. Outcomes are often shaped by dimensions such as affiliation, public participation, private practices, and coping strategies (Coles & Mannion, 2017; Gielen et al., 2004; Moreira-Almeida et al., 2006). Spirituality and faith, by contrast, are frequently expressed through personal meaning-making, transcendence, and resilience, and these dimensions are consistently associated with positive psychological well-being (Purgato et al., 2019; Sorsdahl et al., 2010).

Nonetheless, the influence of religion is not generally beneficial. Several studies caution that religious practices and belief systems can also have detrimental effects on overall health and well-being (Coles & Mannion, 2017). Feelings of judgment, as well as extreme religious fanaticism or fervour, have been linked to adverse psychological outcomes (Okyerefo, 2014; Sefa-Dedeh, 2014b). For example, individuals who interpret health challenges as divine punishment may develop hopelessness and emotional exhaustion, which further exacerbate mental health difficulties (Khoury et al., 2012; Sefa-Dedeh, 2014b). Similarly, the pressure to conform to demanding religious expectations or rituals—particularly when perceived as unrealistic—may generate shame, anxiety, and internal conflict (Sefa-Dedeh, 2014b).

Contrary to the modern widespread belief that attributing supernatural causes to mental illness is associated with animistic and underdeveloped cultures, evidence exists of some members of the clergy in the UK who assert that there are spiritual origins to mental illness (Leavey, 2010). In Ghana, belief in the spiritual origins of mental illnesses is common. This belief is supported by the concept of the spiritual nature of human beings, that is, human beings are not only biologically constituted but are also divinely composed before becoming physically embodied (Osafo, 2016). As Kpanake (2018) eloquently expresses, there is an aspect of

personhood linked to spiritual agencies, including God, ancestors, and spirits, which influence the individual. In the case of mental illness, Kpanake (2018) posits that mental illness can be understood as the sick person losing their connection between mind, body, and spirit, rather than merely as a defect in physiological or biochemical structures. From this perspective, mental illness can be interpreted as a disconnection from the self. The role of Indigenous healing, therefore, serves as a means of restoring the 'person' within a context that profoundly embraces a holistic understanding of life, in which disturbances in a person's cosmology can result in ill health for individuals and their communities. Thus, restoration is viewed as the sole remedy (Kpanake, 2018).

Ascribing spirituality to both personhood and mental illness means a lot in the process of diagnosing, treatment and care of people living with mental illness (Milner et al., 2019; Verghese, 2008). Consequently, traditional healing systems are undergirded by notions of personhood and this drives two key issues, a) seeking health/help from faith healers and b) poor handling of supplicants (users of traditional healing) in terms of caregiving and handling (Kpobi & Swartz, 2019; Krah et al., 2018; Nyame et al., 2021). For instance, biomedically, if a person living with mental illness becomes aggressive and poses a danger to others, sedatives are administered to restrain them. However, within the traditional and faith healing context, the person living with mental illness may be perceived to be demon-possessed, and their violent behaviour believed to be caused by the indwelling evil spirit (Kpobi & Swartz, 2018; Subu et al., 2022). Therefore, to restrain them, the person living with mental illness is put in shackles/chains. In the narrative above, it is presumed that if the patient is demon-possessed, then chaining is not done 'on the person, but the other person in the sick person – herein the demon' (Kpobi & Swartz, 2018). That may mean that the patient is an incomplete person and so abuses meted out

to them may not be considered so; they may rather be perceived as restorative. This notion and related practices stand directly opposite to assumptions of the biomedical model and are considered an abuse of the human rights of the patient, regardless of the implicit reasons for chaining/shackling (Ogunwale et al., 2023).

Mental Health Practice and Faith Healing in Ghana

Ghana has long struggled with a weak, underfunded, and fragmented mental health system (Asamoah et al., 2014; Twumasi, 2005). Mental health services remain severely underfunded, accounting for only about 1.4% of total health expenditure, with the majority of resources concentrated in urban areas (Boateng et al., 2014). As of 2014, the country had 123 mental health outpatient facilities, three psychiatric hospitals, seven community-based psychiatric inpatient units, four community residential facilities, and a single-day treatment centre: an inadequate number given Ghana's population of 32.83 million (Kpobi et al., 2014). Additionally, most individuals experiencing mental health conditions receive care in psychiatric hospitals and outpatient facilities. However, with an estimated 2.3 million people living with various mental health disorders, only about 2% are expected to receive treatment (W.H.O., 2022).

Gradually, significant strides have been made in raising awareness, reducing stigma, and improving mental health services in Ghana (Meyer & Ndetei, 2016). Various initiatives have focused on expanding community-based mental health care, strengthening capacity by training more mental health professionals, and integrating mental health services into primary healthcare systems (W.H.O., 2023). In terms of workforce development, Ghana's mental health sector includes 39 psychiatrists, 49 other medical doctors (not specialized in psychiatry), 2,463

registered mental health nurses (RMNs), 244 psychologists, 362 social workers, 52 occupational therapists, 561 community mental health officers (CMHOs), and 35 clinical psychiatric officers (CPOs). Additionally, there is one art therapist and 742 other health or mental health workers, including auxiliary staff, non-doctor/non-physician primary healthcare workers, health assistants, medical assistants, and professional and paraprofessional psychosocial counsellors (WHO-AIMS, 2020).

Most Ghanaians employ systems of mental health care other than the biomedical paradigm. For example, Traditional and Alternative Medicine (TAM) is a vital component of Ghana's mental healthcare system, as it is in many other African countries (Edwards 2014; Opare-Henaku & Utsey, 2017). As a predominantly Christian nation, with 71.2% of the population identifying with the faith (Ghana Statistical Service, n.d.), Ghana has in recent years experienced notable shifts in its religious landscape, particularly through the growth of charismatic and neo-prophetic churches that emphasize healing, miracles, and prophecy (Okyerefo, 2014). For many years, many charismatic preachers have practiced faith healing. Evidence from Ghana suggests that the concept of spirituality influences perceptions of mental health, understandings of illness causation, and treatment approaches (Dzokoto et al., 2023; Kpobi & Swartz, 2019). However, the same spiritual worldview that encourages individuals to seek healing in faith-based settings has also exposed vulnerable persons to human rights violations. Edwards (2014) discusses how the human rights of some people living with mental illness in Ghana's prayer camps are violated by practices such as forced fasting, chaining, and sometimes beating aimed at bringing about healing. Regardless of these violations, these indigenous healing sites (faith-based camps) continue to receive significant patronage (Berhe et al., 2024). This could partly be as a result of the inadequate mental health resources in

infrastructure and human resources, equally predominantly operating on the Western/biomedical model of mental illness or the conceptions by mental health sufferers or their relations of mental illness as having spiritual/existential aetiologies (Badu et al., 2018).

An often-overlooked dimension in discussions of mental illness is the question of personhood: whether individuals with mental disorders are acknowledged and treated as full persons with inherent human rights. Engaging with this conception is critical, as it sheds light on how communities perceive and interact with people living with mental illness in their midst. Bringing personhood into focus shifts attention from abstract systems of explanation and treatment to the lived realities of those directly affected, thereby deepening the link between mental illness, human rights, and social belonging.

Understanding how multiple frameworks, religious, spiritual, social, and biomedical, converge is essential for appreciating the lived experiences of persons with mental illness in Ghana. While institutions, faith communities, and biomedical systems provide important contexts, it is ultimately the individual who must navigate these spaces, making choices, exercising agency, and at times experiencing profound vulnerability. For instance, a person seeking healing in a prayer camp is not merely a recipient of spiritual treatment but also someone whose dignity, autonomy, and rights may be contested. Similarly, within biomedical settings, the individual is not simply a "patient" but a person whose identity, beliefs, and relationships shape their health-seeking journey. By centering the person in this way, the study moves beyond structural explanations to engage more deeply with human agency, subjective experience, and rights: crucial elements for a holistic understanding of mental health in Ghana.

Statement of the Problem

While personhood has been widely examined in philosophy and psychology, its implications for mental health in African contexts remain underexplored. Existing studies on mental illness in Ghana highlight cultural, social, and spiritual explanatory models (Opare-Henaku & Utsey, 2017; Ae-Ngibise et al., 2010), yet they rarely engage with the deeper ontological question of what it means to be a person within specific cultural frameworks. Among the Akan and Ewe, personhood is relational and interdependent, defined through connections with family, community, ancestors, and the spiritual realm (Ameka, 2018; Gyekye, 2000; Kpanake, 2018; Mbiti, 2008). This relational ontology generates important complexities: mental illness may be seen not only as a biological dysfunction but also as a spiritual disruption or relational imbalance.

It remains unclear, however, whether individuals living with mental illness are fully recognized as "persons" within these frameworks. This ambiguity has practical consequences, shaping societal attitudes, care practices, and help-seeking behaviors, while also contributing to stigma, neglect, and human rights violations (Asafo et al., 2025). Ghana's Mental Health Act (Act 846) explicitly upholds the rights of people with mental illness, yet faith-based and traditional healing practices—including chaining, beating, and enforced fasting—persist, exposing gaps in policy enforcement and public perceptions (Lambert et al., 2020).

The biomedical model, grounded in Western notions of individualistic personhood, interprets mental illness as a physiological anomaly to be managed medically (Deacon, 2013). In contrast, Ghana's traditional/spiritual model conceptualizes the individual as both biological and supernatural, framing mental illness as a disturbance requiring spiritual intervention (Kpobi & Swartz, 2019). Although the biopsychosocial model is increasingly promoted, the social and

cultural dimensions remain insufficiently explored, especially in indigenous contexts (Hatala, 2012). This raises ethical concerns since mental capacity and autonomy often determine personhood recognition in biomedical frameworks, while communal belonging and spiritual harmony define it in traditional ones.

The choice to focus on the Akan and Ewe is particularly significant because these two groups are among the largest and most influential in Ghana, with rich and distinct philosophical traditions regarding personhood, spirituality, and healing. Their perspectives not only reflect broader Ghanaian cultural orientations but also reveal important intra-cultural variations that shape how mental illness is understood and treated (Ameka, 2018; Gyekye 2014).

Given these complexities, this study seeks to examine how personhood is conceptualized among the Akan and Ewe and how these perspectives influence explanations, diagnoses, and treatments of mental illness, as well as health-seeking behaviours. In doing so, it contributes to filling a critical gap in the literature by explicitly linking conceptions of personhood with spirituality and mental health, while also providing insights for developing inclusive interventions that bridge biomedical and traditional approaches and safeguard the dignity and rights of persons with mental illness.

Aims and Objectives of the Study

This study examined the Akan and Ewe conceptualizations of personhood and spirituality, as well as their implications for explanations, stigma, treatment practices, and health-seeking behaviours in mental illness. The specific objectives are therefore to:

1. Explore conceptions of personhood in the Akan and Ewe cultures in Ghana

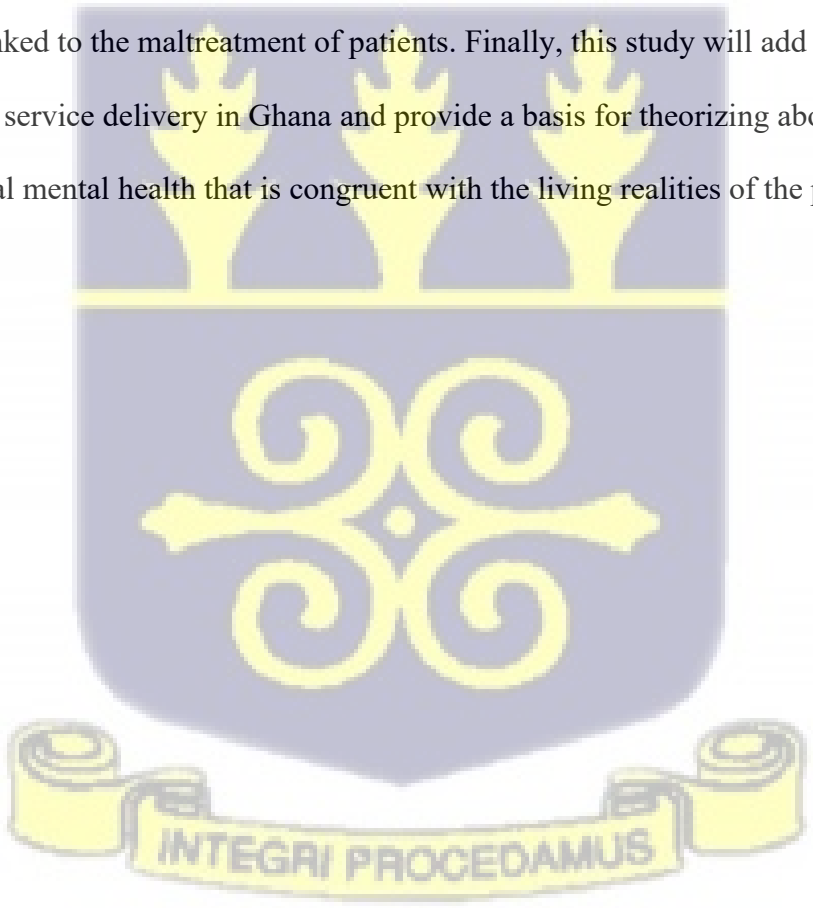
2. Understand whether people living with mental illness are regarded as "persons" in the Ewe and Akan contexts, respectively.
3. Explore notions of personhood and spirituality as they relate to help-seeking and care practices of the mentally ill.
4. Explicate human rights abuses of the mentally ill from Akan/Ewe notions of personhood and mental illness.

Relevance of the Study

Mental health issues are a major threat to the health, well-being, and productivity of people aged 10 to 24, who account for a quarter of the world's population, with 50% of mental disorders developing before the age of 15 and 75% by the age of 25 globally (Colizzi et al., 2020; W.H.O, 2021). In this age group, mental illness represents 45% of the entire burden of disease and is the second most leading cause of mortality through suicide (McGorry et al., 2022). COVID-19 has also significantly exacerbated the global burden of mental health (OECD, 2021), with the global prevalence of conditions such as depression and anxiety notably increasing by 25%, since the onset of COVID-19, with young adults and women known to be the worst affected (World Health Organization [WHO], 2022). With the scanty funding by the government towards providing mental health delivery services, the mental health burden in Ghana is becoming precarious.

This problem is compounded by a large section of the population who patronize alternative or spiritual mental health centers due to several reasons, including the scarcity of mental health facilities, the high cost of accessing professional treatment and the belief in the

spiritual causes of mental illness that the professional mental health service providers refute. Inasmuch as it has been shown that alternative and spiritual healers contribute to mental health care, some of the unscientific processes employed become a worry to various stakeholders. Several studies have been conducted into the operations of these alternative healing centers to improve their services and forge collaboration with the mainstream mental health providers (Osafo et al., 2015). However, the focus has mostly been on the practices within the centers and how to forge collaborations. This study thus becomes a forerunner in incorporating Akan and Ewe conceptions of personhood into understanding conceptions about mental health and treatment processes. The findings from this study will also help to uncover how loss of personhood is linked to the maltreatment of patients. Finally, this study will add to the literature on mental health service delivery in Ghana and provide a basis for theorizing about how to provide beneficial mental health that is congruent with the living realities of the people.



Chapter Two

Literature Review

Introduction

This chapter explores the theoretical foundations of the study and reviews relevant literature to contextualize mental illness and its impact on diagnosis and treatment. Guided by the explanatory model of mental illness, it examines personhood, the social construction of mental illness, and its creation within Ghana's sociocultural context. The chapter also discusses spirituality, religion, and faith healing as key avenues for mental health treatment.

Theoretical Underpinnings for Study

This study aligns with the paradigm of the social construction of mental illness. It is specifically situated within the context of explanatory models of illness. An explanatory model (EM) is defined by Kleinman et al. (1978) as "notions about an episode of ailment and its treatment that are employed by all those engaged in the clinical process". These models are ways of viewing illness, revealing labels and cultural idioms for expressing the experience of illness. Patients' and society's explanatory models, in simple terms, provide physicians with knowledge of the patient's beliefs about the perceived causes of illness, the personal and social meaning patients and their societies attach to the disorder, expectations about what will happen, and which interventions will be most beneficial (Khoury et al., 2012). When a patient's model is compared to the doctor's, the clinician might detect important discrepancies that may pose problems with clinical management.

Kleinman et al. (1978) proposed an ecological model in which "external" (social, political, economic, historical, epidemiological, and technological) variables are linked to

"internal" (psychophysiological, behavioural, and communicative) processes. He adds that the societal dimensions of health, disease, and health care are expressed as a cultural system. Kleinman demonstrates a communal perspective regarding mental illness and how this may relate to a person's status of being considered 'worthy'. Understanding personhood, mental illness, and spirituality through Kleinman's explanatory model framework necessitates a knowledge of the meanings people attach to the causes of mental illness, their beliefs about mental illness, and, eventually, their ideas about how to treat it. Health and illness must be understood in relation to one another utilizing explanatory model principles (Khoury et al. 2012). A breakdown in any of the system's components will affect treatment and help-seeking behaviours (Khoury et al., 2012).

Review of Related Studies

Personhood and Personality

Personality is a central focus in psychology, commonly defined as enduring patterns of thought, emotion, and behavior that distinguish individuals (Allport, 1937; McCrae & Costa, 1997). Dominating current research is the Five-Factor Model (FFM), which categorizes personality into five dimensions: openness, conscientiousness, extraversion, agreeableness, and neuroticism (John, Naumann, & Soto, 2008). Although this framework has been validated across various cultures, cross-cultural scholars caution against assuming it applies universally (Cheung et al., 2011). Beyond trait-based approaches, humanistic theorists like Rogers (1961) and Maslow (1968) viewed personality as evolving through self-actualization, while psychodynamic thinkers such as Freud (1930) emphasized unconscious drives. Despite its scope, psychological research on personality tends to be individualistic, treating people as autonomous entities whose

traits can be objectively assessed. This view contrasts with philosophical and cultural traditions that highlight the relational and ethical aspects of human life.

Closely related to personality is the concept of self-concept, which centers on how individuals perceive and evaluate themselves. Rosenberg (1979) defined self-concept as the totality of one's thoughts and feelings about oneself, including both descriptive and judgmental elements. Markus and Kitayama (1991) expanded on this by demonstrating cultural variations: Western societies often promote an independent, self-contained identity, whereas non-Western cultures emphasize interdependence and relationality. These differences underscore the role of cultural context in shaping self-understanding and identity.

In contrast to personality and self-concept, personhood is a philosophical notion that cannot be reduced to traits or self-perceptions. It involves criteria for being considered a "person," typically associated with rationality, moral responsibility, and autonomy in Western thought (Kant, 1785/1996; Locke, 1690/1975). African philosophical perspectives, however, view personhood as a dynamic and relational achievement rather than an inherent status. Menkiti (1984) argued that personhood is cultivated through community involvement, ethical conduct, and fulfilling social roles. Gyekye (1992) offered a more balanced perspective, suggesting that while all humans possess the potential for personhood, its full expression depends on communal validation and moral behavior. This relational view aligns with anthropological insights that emphasize the social and cultural embeddedness of individuals (Mbiti, 1969). In traditions such as those of the Ewe and Akan, the person is seen not as an isolated entity but as someone shaped by connections to family, ancestors, and the wider community.

The literature thus reveals key distinctions: personality refers to consistent psychological traits; self-concept involves personal self-assessments and identity narratives; and personhood

centers on moral and cultural recognition, often understood as a developmental and context-sensitive process. Although psychology has developed strong models for analyzing personality, it has faced criticism for cultural bias and for overlooking the communal and relational aspects of identity (Nsamenang, 2007). In contrast, African philosophical discussions on personhood offer profound insights into the moral and social dimensions of selfhood, yet remain underrepresented in mainstream psychological discourse. Integrating these perspectives could enrich our understanding of identity, well-being, and moral agency in ways that are culturally informed and holistic.

Conceptualization of Personhood (Global and African Perspectives)

The concept of personhood has been a subject of extensive philosophical inquiry, with perspectives varying across cultures and disciplines. Traditionally, personhood has been defined through metaphysical attributes such as agency, consciousness, identity, rationality, and second-order reflexivity (Kitwood, 1992). Some scholars view personhood as a continuum rather than a fixed category, while others approach it as a moral status relevant to human dignity and ethical considerations (Higgs & Gilleard, 2016).

From Eurocentric thought, personhood is often framed in terms of intrinsic human capacities. Beckwith (2004) argues that personhood is not contingent on functional abilities such as reasoning but rather on the inherent nature of being human. A person does not come into existence through performing human functions but is instead an entity with the intrinsic capacity to produce such functions, regardless of whether they are realized. Kitwood (1997), on the other hand, critiques this individualistic approach, emphasizing that personhood is relational, bestowed by others, and shaped by social interactions. He argues that modern psychiatry, influenced by

medical science, objectifies patients, reducing personhood to a technical process in which individuals are merely treated rather than recognized as interdependent beings.

Higgs and Gilleard (2015) challenge Kitwood's moral definition of personhood, arguing that it lacks empirical evidence and overlooks traditional metaphysical attributes like agency and consciousness. They propose setting aside the concept of personhood in dementia care, asserting that care should be provided based on human dignity rather than theoretical definitions. However, Kitwood's approach aligns with broader critiques of Western psychological models that prioritize individuality at the expense of interdependent relationships.

Pavlo et al. (2019) extend this critique to psychiatry, arguing that the DSM-5's medical model pathologizes human experiences through rigid diagnostic categories. Instead, they advocate for a person-centered, recovery-oriented framework that prioritizes patient agency and collaborative care. This aligns with Kitwood's call to shift from categorization toward holistic, person-centred care. However, Zalzala et al. (2019) highlight challenges in operationalizing such frameworks, including defining how meaning is co-created and linking person-centred approaches to treatment outcomes.

Sofronas et al. (2018) analysed conceptualization or personhood in nursing, arguing that it should remain central to healthcare practices. They caution against reducing personhood to biological criteria and emphasize its dynamic nature, shaped by cultural and ecological contexts. Their findings suggest that personhood must be understood relationally, where dignity, autonomy, and community connections are essential to well-being.

In contrast to Western individualism, African conceptualizations of personhood emphasize communalism and interdependence. Scholars such as Menkiti (1984) and Mbiti

(1970) argue that personhood is not an inherent status but an achievement realized through active participation in the community. The famous maxim "I am because we are; and since we are, therefore I am" encapsulates this perspective, positioning the community as the foundation of personal identity (Kaphagawani, 1998). Kpanake (2018) describes African personhood as a dynamic process involving three interacting agencies: the spiritual (gods, ancestors, spirits), the social (family, clan, community), and the self (responsible for inner experience). He highlights Ubuntu, a philosophy emphasizing mutual dependence, reciprocity, and group solidarity, as a defining feature of African personhood. This interconnected view challenges the Western notion of selfhood as an autonomous, self-contained entity.

The Akan concept of personhood further illustrates this dynamic perspective. In Akan culture, a person is not fully recognized until they contribute to communal well-being. Those who demonstrate social responsibility and moral integrity are called *oye onipa paa* ("a real person"), while those who neglect communal duties may be labeled *onye nnipa* ("not a person") (Gyekye, 2000; Wiredu, 2009). This view contrasts with Western frameworks that prioritize rationality and cognitive function in defining personhood.

The divergence between Western and African conceptualizations of personhood has implications for psychological theory and practice. The dominance of Western, Educated, Industrialized, Rich, and Democratic (WEIRD) perspectives has shaped mainstream psychological models, often overlooking non-Western understandings of selfhood (Adjei, 2019). Studies by Comaroff and Comaroff (2001) caution against generalizing a single African concept of personhood, emphasizing the need for culturally specific interpretations.

Understanding personhood in different cultural contexts is crucial for mental health care, as it influences self-concept, explanations of illness, help-seeking behaviours, and stigma

(Becker et al., 2019; McTighe, 2015). The contrast between Western individualism and African communalism highlights the importance of integrating cultural values into psychological and psychiatric practices. Kitwood's critique of individualistic psychiatry resonates with African perspectives, suggesting that interdependence and social belonging are fundamental to human well-being. It is clear that conceptualizations of personhood are deeply rooted in cultural frameworks, shaping ethical, psychological, and clinical approaches to human identity and care. Whether through Western metaphysical attributes or African communal principles, personhood remains a complex, evolving concept that continues to inform debates in philosophy, mental health, and human development.

The Ewe and Akan Conceptualization of Personhood in Ghana

Ghana is home to diverse ethnic groups, each with unique cultural philosophies, traditions, and worldviews. Among them, the Ewe and Akan communities have distinct yet intersecting perspectives on personhood, deeply rooted in social, moral, and spiritual dimensions (Ameka, 2018). These conceptualizations of personhood influence community structures, social roles, and ethical expectations, emphasizing the importance of relationships and moral responsibility in defining an individual. The Ewe people, primarily located in Ghana's Volta Region and parts of Togo, belong to the larger Gbe linguistic subgroup of the Niger-Congo family (Ladzekpo, 1995). The Ewe ethnic group has a rich cultural tradition that ensures the communal enculturation of individuals from infancy to adulthood through various rites and ceremonies (Ladzekpo, 1995). Occupational groups also play a crucial role in Ewe society, sustaining economic activities such as farming, fishing, hunting, and the making of Kente cloth (Wemegah et al., 2021).

Personhood in Ewe culture is multifaceted, encompassing biological, social, moral, and spiritual dimensions (Ameka, 2018). Gavi et al. (2022) describe Ewe personhood as comprising normative, performative, and spiritual elements. The normative aspect is predominant, as personhood is granted based on an individual's contributions to the community and their moral standing. This view emphasizes performance and agency—simply being born human is insufficient to be considered a full person. Thought patterns and moral judgments are also essential in defining personhood, linking cognitive functions to ethical behaviour.

The Akan are the largest ethnic group in Ghana, primarily represented by the Asante, Fante, Akyem, Akuapem, Assin, and Kwawu subgroups (Greenviews, 2022; Osei-Tutu & Dzokoto, 2020). Their matrilineal kinship system, known as the 'abusua,' plays a fundamental role in social organization, inheritance, and identity formation. Religion is deeply integrated into social and political structures, reflecting a holistic approach to community life (Antwi, 2017). Akan conceptualizations of personhood distinguish between being biologically human and achieving full personhood through social and moral development. Wiredu (1992) explains that the Akan word "Onipa" sometimes refers to a biological human and sometimes to an individual who has attained a significant moral and social status. This distinction implies that personhood is an achievement rather than an automatic status. Former Zambian President Kaunda's praise of British Prime Minister Margaret Thatcher as "truly a person" illustrates this perspective—one earns personhood through exceptional contributions and ethical standing. Similarly, Gyekye (1992) emphasizes the communal aspect of Akan personhood, asserting that individual identity is deeply embedded within the larger social network. In his work "Person and Community in African Thought," he argues that personhood extends beyond biological existence to include

social and moral elements, reinforcing the idea that an individual's identity is shaped by their interactions with family, community, and ancestors.

Both Ewe and Akan perspectives on personhood underscore the communal and moral dimensions of identity. While the Ewe framework emphasizes normative and performative aspects, where personhood is granted based on contributions to society, the Akan concept stresses the necessity of attaining personhood through moral and social achievements. In both cultures, the metaphysical dimension plays a role, but it is not the sole determinant of personhood. Thought patterns and ethical conduct are integral to being recognized as a full person, reinforcing the broader African philosophical emphasis on communal responsibility and social integration (Gavi et al., 2022). The conceptualization of personhood in Ewe and Akan societies reflects deeply rooted values that prioritize moral integrity, communal contributions, and personal development over mere biological existence. These perspectives continue to influence contemporary social structures, ethical norms, and cultural identities in Ghana today.

History of Mental Illness

Perceptions and attitudes towards mental illness have evolved throughout history (Jutras, 2017). Behaviour, whether normal or abnormal, was understood within its specific cultural and historical context. Theories about the origins of mental illness have evolved, with explanations ranging from supernatural and somatogenic to psychogenic factors (Farreras, 2020). When physical causes were unknown or treatment failed, mental illness was often attributed to spiritual or demonic possession, sorcery, the evil eye, or the wrath of a deity (Quintanilla, 2010). For instance, ancient Chinese medicine (circa 2700 BC) linked mental and physical disorders to an imbalance of the yin and yang forces (Tseng, 1973). The supernatural explanation dominated for centuries, guiding both the understanding and treatment of mental illness, which included

spiritual interventions, exorcisms, and more extreme practices like trephination — sometimes resulting in death (Foerschner, 2010). Before the 1950s, religion heavily influenced societal laws and mental health care, with other factors like politics or social status playing a lesser role. However, gender did affect treatment: women displaying atypical behaviour were often accused of witchcraft and subjected to severe punishments (Jutras, 2017; Tasca et al., 2012).

Greek and Egyptian physicians shifted from supernatural explanations of mental illness to somatogenic and psychogenic theories (Farreras, 2020). Somatogenic theories linked mental illness to physical dysfunctions like heredity or brain injury, while psychogenic theories focused on traumatic experiences and distorted perceptions (Worthy et al., 2020). Hippocrates (460-370 BC) attributed mental illness to imbalances in the four bodily humors (blood, yellow bile, black bile, and phlegm) and rejected the idea that mental illness was shameful or punishable. Despite these advances, treatments remained harsh and ineffective (Farreras, 2020). Methods adopted such as trephination, bloodletting, use of herbal medicine and purging often failed (Cottrell et al., 2021), leading to physical restraint, solitary confinement or institutionalization in asylums (Jutras, 2017)

Modern psychopathology theories emerged in the late 19th and early 20th centuries, shaped by two key theories: Freud's psychodynamic theory, which linked mental illness to unresolved unconscious conflicts, and Watson's behaviourism, which attributed psychopathology to learned behaviours (American Psychiatric Association [A.P.A], 2022). This period also saw a shift towards classifying mental illness, leading to the creation of the first *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in 1952, with continuous revisions through 2013 (Poteet, n.d.). By the 1950s, pharmacological treatments became widely

accepted due to their effectiveness and perceived ethicality, contributing to the deinstitutionalization of patients from mental health facilities (Cottrell et al., 2021).

Western concepts of mental illness have fluctuated between periods of scientific stagnation and discrimination, and moments of significant theoretical progress and innovation (Rossler, 2016; Jutras, 2017). After the Middle Ages, as supernatural explanations faded, a shift toward rational thought and empirical reasoning paved the way for more humanistic approaches to treatment. This evolution led to modern classification systems and evidence-based treatment models. However, despite these advances, challenges remain in adopting the most suitable mental health care models for society — a pressing issue likely to shape the future of mental health care.

Diminished personhood in mental illness

Personhood encompasses both self-perception and how others perceive an individual (Young, 2019). A person's sense of personhood can be shaped by their interactions with others, and when it is disregarded or threatened, they may experience distress and depersonalization (Winnicott, 2023). Cutler et al. (2021) argue that personhood is a fundamental right that should not be diminished due to mental illness or disability. Although person-centered care has gained traction in healthcare (Sofronas et al., 2018), the concept remains underexplored in mental health care.

Hall et al. (2019) examined the feasibility of people-centered mental health services in Timor-Leste, highlighting sociocultural barriers to implementation. The study found that individuals with mental illness or disabilities were often seen as lacking personhood, socially excluded, and labeled as aggressive or irrational. Mental illness was even likened to losing a family member due to the perceived loss of normalcy. However, the research does not consider

the potential benefits of a family-centered approach and questions whether people-centered care can be effectively implemented in Low- and Middle-Income Countries (LMICs) without aligning with local cultural norms.

Similarly, Hagen et al. (2020) explored the experiences of female patients with suicidality in psychiatric hospitals, revealing themes of liminality and a weakened sense of personhood. Patients described liminality as a state of confusion and vulnerability, where their pain and insecurity were heightened. Many worried about their future, questioning whether they would recover, find meaning, or maintain their identity. The study highlights the importance of care that acknowledges and strengthens personhood, emphasizing the need for further exploration of relational aspects — especially patients' struggles to feel heard and recognized.

Cutler et al. (2020) examined how consumer perceptions of safety in acute psychiatric facilities were shaped by personhood. Participants associated safety with feeling valued, respected, and having their choices honored — all essential aspects of personhood. Admission to an acute unit often triggered feelings of shame and humiliation, posing a threat to their sense of self. Feeling equal meant having their dignity and worth recognized, which relied heavily on person-centered interactions from staff, primarily nurses. The study highlights the need for further exploration of metaphors used to describe diminished personhood and patient experiences.

Several studies on dementia emphasize the loss or diminishing of personhood (Fazio et al., 2018; Hennelly et al., 2018; Higgs & Gilleard, 2016; Smebye, 2013). However, research over the past 20 years has shifted dementia care away from deficit-centered models, advocating for person-centered care that preserves dignity (Hampson & Morris, 2016). Johnston and Narayanasamy (2016) argue that dementia care should extend beyond pharmacological

treatments to include psychosocial interventions, though these interventions often prioritize caregivers and symptom management rather than directly enhancing the personhood of individuals with dementia.

Kitwood's approach, which emphasizes sustaining individuality, has positively influenced dementia care, though it isn't without limitations. Smebye and Kirkevold (2013) suggest that personhood in dementia is concealed rather than lost, maintained through close emotional relationships but diminished by impersonal or task-focused care. Yet, their study overlooked socio-cultural factors and excluded direct interviews with persons with dementia, leaving gaps in understanding.

Higgs and Gilleard (2016) critique the practicality of using personhood as a basis for dementia care, arguing for interventions that build on people's existing abilities while mitigating the impact of their limitations. While personhood remains a vital concept, balancing its philosophical complexities with practical strategies for enhancing well-being is essential for improving dementia care.

Personhood, Law and Agency

From a legal perspective, a person is regarded as anyone capable of possessing rights, duties, and responsibilities (Dyschkant, 2015). Possessing legal personhood ensures the protection of one's rights and recognizes an individual's legal agency to take actions such as voting, making health decisions, or getting married (McSherry, 2012). Such status is granted by law and determines who qualifies to be treated as a person and under what circumstances. The rules concerning personhood vary across different times and places (Pietrzykowski, 2017). The prevalent rhetoric about legal personhood has often emphasized cognitive functioning and

rationality as evidence of autonomy and unique features between individuals deserving of legal personhood and those who do not (Flynn & Arstein-Kerslake, 2014). Dyschkant (2015) asserts that a 'legal person' has often been attributed to being a human being. However, some can exercise their rights and duties, whilst others do not. In essence, one can possess the attributes of legal personhood and not be a human being and vice versa. He further calls for separating the capacity-oriented aspect of personhood from definitions of a human that is species based as the legal definition of personhood highlights one's capabilities over their genetic makeup. This leaves out fetus life, infants and the permanently unconscious or persons on life support. Some groups (women, children, slaves, etc.) have historically been denied legal personhood, limiting their status to that of property or objects. Most individuals with disabilities (particularly those with intellectual and psycho-social impairments) are disadvantaged in terms of being acknowledged for their legal ability and human rights due to the emphasis on cognition and rationality. These views have changed over time as it is widely accepted that factors such as gender, race, social status and other categories do not form legal reasons for conferring personhood on individuals, as they do not influence cognitive functioning (Flynn & Arstein-Kerslake, 2014).

The adoption of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and General Comment 1 on Article 12 (GC1) has shifted the perspective on disability from a biomedical model to a human rights-based approach (United Nations Committee on the Rights of Persons with Disabilities, 2014). This shift has sparked debates regarding the legal capacity of individuals with mental health conditions. The biomedical approach to mental health historically permitted a system of proxy decision-making for those deemed 'incapable,' often leading to human rights violations against individuals with mental

illnesses (Minkowitz, 2006). In contrast, the CRPD emphasizes respecting and communicating an individual's own choices rather than relying on the decisions of a proxy. This approach affirms the equal personhood of individuals living with mental illness (Mahomed et al., 2018).

Burns (2013) argues that achieving formal equality for individuals with mental illness must be complemented by efforts to attain fundamental equality. He advocates for a human rights approach that affirms their full personhood, emphasizing dignity, autonomy, and decision-making rights. Burns identifies multiple layers of inequality, including disparities in service access, demographic factors, diagnostic biases, structural inequalities, inadequate mental health funding, and insufficient protection from abuse. He calls for a re-examination of language, models of mental illness, and societal perceptions to address these systemic inequalities.

Despite efforts made to change this narrative, persons living with mental illness are consistently subjected to treatment that constantly violates their human rights, particularly legal arbitrary incapacitations and guardianships (Eiroa-Orosa & Tormo-Clemente, 2022). This results in a lack of agency, which refers to the ability with (or without) mental illness to make decisions or uphold one's basic rights amid injustice (Lysaker & Leonhardt, 2012).

Personhood, Stigma & Discrimination in Mental illness

Discrimination and personhood are deeply interconnected concepts that reflect the complex interplay between power, cultural norms, and identity (Agmon et al., 2016). Historically, some groups have been denied full personhood through systemic discrimination, as seen in slavery, colonialism, and apartheid (Johnson, 2015). While progress has been made in areas like women's rights, cultural ideologies in many African societies still reinforce male

privilege, portraying women as lacking autonomy and confining them to familial roles (Kareithi, 2014). Such dynamics diminish individual personhood and perpetuate structural inequalities.

Manzini (2018) critiques Menkiti's (1984) normative conception of personhood for its exclusionary tendencies, as it ties personhood to communal roles and rational capacity, potentially marginalizing individuals based on gender, queerness and, disability. Manzini argues for an evolving discourse that embraces diversity and affirms the inherent worth of every individual. Similarly, Brettell (2011) highlights how immigrants' experiences of discrimination extend beyond race to include language, class, and immigration status, illustrating how personhood can be denied through subtle social exclusion.

Equally, persons with mental illness face heightened stigma, discrimination, and human rights violations, particularly in Low- and Middle-Income Countries (LMICs). The stigma surrounding mental illness often makes life more challenging than the condition itself (Girma et al., 2022). The American Psychiatric Association (2022) notes that more than half of individuals with mental illness avoid seeking help due to fears of discrimination or job loss. Misconceptions about mental illness sustain this stigma, which creates significant barriers to holistic care (Hanafiah & Van Bortel, 2015). Stigma is not only social but institutional, deterring investments in mental healthcare (Tawiah et al., 2015).

Research consistently shows that stigma exacerbates mental illness, complicates reintegration efforts, and affects caregivers, families, and healthcare professionals (Javed et al., 2021; Krupchanka et al., 2018). Babicki et al. (2018) found high levels of public stigma in Poland, with participants expressing reluctance to work with or employ individuals with mental illness, thereby limiting their economic opportunities. In Ghana, Gyamfi et al. (2018) found that

self-stigma, anticipated stigma, and perceived discrimination shaped individuals' views of themselves, reinforcing negative self-perceptions and limiting their prospects.

Tyerman et al. (2021) explored how stigma impedes person-centred mental health care. Their systematic review revealed that stigma undermines the quality of care and nurse-client relationships, highlighting the need for further research to understand how healthcare systems may inadvertently perpetuate stigma by prioritizing physical health over mental health.

The concept of personhood becomes particularly relevant in understanding stigma's impact on individuals with mental illness. Burns (2009) explains that persons with mental disabilities experience discrimination on multiple levels, eroding their personhood and social value. Subu et al. (2021) argue that stigma diminishes self-esteem, interpersonal connections, and quality of life, reinforcing the marginalization of persons with mental illness. However, mental illness itself is a socially constructed concept that evolves (Teague & Robinson, 2019).

Adequate knowledge and public education may help dismantle misconceptions and lessen stigma (Papadopoulos et al., 2013). Understanding the cultural contexts of mental illness is crucial, especially in Africa, where help-seeking behaviours are shaped by beliefs about illness causation, service accessibility, and systemic healthcare limitations (Arthur et al., 2015; Monteiro, 2015). Addressing these factors through culturally sensitive interventions could promote early detection, treatment adherence, and community-based care, fostering environments where individuals with mental illness are recognized as full persons with intrinsic worth and equal rights.

This also highlights the need to reconceptualize personhood in ways that counteract stigma and discrimination. By amplifying diverse voices and acknowledging the social

determinants of mental health, future research and policy can contribute to a more inclusive understanding of mental illness—one that affirms human dignity, promotes mental well-being, and reduces barriers to care.

Mental Illness & Occupational Therapy

People with serious mental illnesses have shorter life expectancies and a higher risk of cardiovascular and metabolic conditions (Ilyas et al., 2017). They often spend more time alone and engage less in structured activities than the general population. Disrupted activity patterns can hinder recovery, making meaningful community participation essential. Occupational therapy in mental health services aims to enhance functional performance in daily tasks (Daly et al., 2022). It aids with symptom relief, restoration of social function, illness prevention, improved re-employment rates, and general health. Increasing literature highlights the effectiveness of occupational therapy in promoting engagement and improving outcomes for people living with mental illness (Höhl et al., 2017).

Doroud et al. (2015) conducted a scoping review exploring the link between occupational engagement and mental health recovery. Evidence suggests that recovery is an ongoing process involving community participation, gradual re-engagement, and integration into everyday occupational life. Engaging in meaningful work fosters connectedness, hope, identity, meaning, and empowerment, and helps individuals build routines and manage their illness.

Williams et al. (2016) emphasize that even with their desire to remain employed and the introduction of vocational training and employment support, it is still difficult to support people with major mental illnesses in their jobs. This review, which aimed to assess factors that affect job tenure of workers with severe mental illness, regardless of the type of employment support they were offered, was divided into three themes: (1) the worker's experience with the current

job; (2) natural workplace supports; and (3) strategies for integrating work, recovery, and wellness. These factors can guide the support of persons with mental illness in employment with future research focusing on job tenure not only in terms of duration but also the quality of jobs held, value for career development, and the role of services in offering support.

Ikiugu et al. (2017) examined the effectiveness of theory-based occupational therapy interventions in improving occupational performance and well-being in people with mental health diagnoses. The findings reveal that the intervention had a moderate influence on improving occupational performance and a minor impact on well-being. Theory-based occupational therapy interventions should thus be an essential component of mental health rehabilitation services since they have the potential to improve occupational performance and well-being among people with mental illnesses.

D'Amico et al. (2018) conducted a systematic review on the effectiveness of occupational therapy interventions for individuals with serious mental illness. The review covered activities of daily living, social interaction, leisure, and relaxation. Strong evidence supported psychoeducation, occupational therapy, and cognitive therapy, while skill-based interventions had moderate support, and technology-based interventions had limited evidence. The findings highlight the importance of evidence-based practice, advocate for occupational therapists' role in mental health care, and emphasize the need for further research.

The literature encourages increased studies into the role of occupational therapy, with measures that track engagement, changes in activity patterns, and health-related outcomes. Randomized clinical trials of excellent quality are essential to proving efficacy. Different models of functional trials within the natural setting of psychiatric rehabilitation are also required as

occupational therapy interventions are complex and embedded within a variety of multidisciplinary techniques.

Collectivist Versus Individualistic Cultures

Culture shapes individual and group attitudes, values, and behaviors, guiding reasoning, interactions, and judgment within shared linguistic, historical, or geographical contexts (Bhullar et al., 2012). Hofstede (1993) defines culture as "the collective programming of the mind" (p. 89) and identifies four dimensions influencing culture: individualism/collectivism, power/distance, masculinity/femininity, and uncertainty/avoidance. Despite critiques, individualism and collectivism remain key predictors of cultural variation (Brougham & Haar, 2013), influencing psychological factors like self-perception, motivation, cognition, emotional regulation, and social support (Heu et al., 2019). This framework is valuable for understanding how cultural-psychological factors affect mental illness.

Altweck et al. (2015) posit that earlier studies indicate greater levels of mental health literacy (MHL), which refers to knowledge and supportive ideas regarding mental illness, among European and North American cultures as compared to Asian and African cultures. However, there is still a dearth of quantitative studies looking at the factors that contribute to this cultural difference. Their study found that collectivism is linked to lay perceptions about getting treatment in India and to causal beliefs about mental illness in the European American group. These findings highlight the need to comprehend cultural variations in attitudes about mental illness, particularly help-seeking attitudes.

Bhullar et al. (2012) explored the associations of cultural orientation with emotional intelligence, mental health, and satisfaction with life in Australia and India, which are an individualistic and collectivistic cultures respectively. The results found collectivistic orientation

to be significantly associated with greater emotional intelligence and better mental health outcomes. This indicated that those identified as collectivists and originated from a collectivistic culture were more likely to report lower levels of stress, anxiety, and depression. I-C orientations, however, were not predictors of satisfaction with life.

Individualism and collectivism can both influence loneliness, which is linked to various mental and physical health concerns, including depression, suicidal ideation, aggression, obesity, and increased blood pressure (Cacioppo et al., 2015). In individualistic cultures, loneliness may arise from social isolation, whereas in collectivist cultures, disconnection from group norms or relationships can contribute to feelings of loneliness. Heu et al. (2019) found that both cultural orientations carry psychological risk factors for loneliness due to differing expectations of social integration. Their cross-sectional surveys across five countries revealed that while individualism was linked to lower social embedding, collectivism was associated with reduced loneliness without significantly amplifying social pressures.

Cultural perspectives on mental illness stigma have also been analyzed through the lens of individualism and collectivism. A study by Papadopoulos et al. (2013) involving four UK-based cultural groups (White-English, American, Greek/Greek Cypriot, and Chinese) found that cultures with higher levels of mental illness stigma were more likely to align with collectivist values. Conversely, cultures with more positive attitudes toward mental illness tended to reflect individualistic ideals. The researchers concluded that future studies seeking a comprehensive understanding of mental illness stigma should take collectivism and individualism into account.

Knyazev et al. (2017) investigated how cultural attitudes influence the relationship between depression and vulnerability factors by analyzing depressive symptoms, personality traits, stress levels, emotion regulation strategies, and individualist/collectivist orientations in a

nonclinical Russian sample. Using structural equation modeling, their findings revealed that a collectivist orientation intensified the impact of stress and neuroticism on depression. This contrasts with previous research in East Asian cultures, where collectivism has been shown to have protective effects against depression.

Help-Seeking Behaviors in Mental Health in Africa

Despite the high prevalence of mental illness, mental health care remains a low priority in Africa with under-resourced, inadequate, and inequitably distributed services (Monteiro, 2015). The services available are markedly underutilized as persons with mental illness do not seek help (Bird et al., 2011), due to various complex barriers. These barriers can be internal, such as fear of diagnosis or stigma, or external, including cultural beliefs, lack of trust in the healthcare system, and limited confidence in health professionals (Peppin et al. 2009). The psychosocial and cultural contexts somewhat shape people's beliefs and perceptions about the cause of mental illness and by extension their choice of healthcare (Arthur et al., 2015). Perceptions of illness severity also affect the decision to seek care (Nsereko et al., 2011). These factors collectively hinder timely access to appropriate mental health treatment, worsening outcomes for those in need (Daniel et al., 2018).

In Africa, perceptions of mental illness are often shaped by non-scientific beliefs, contributing to delays in treatment-seeking. Mental illness is frequently attributed to misfortune, moral failings, religious transgressions, or witchcraft (Id et al., 2020). Limited public understanding and biased attitudes toward mental illness hinder the provision of quality, holistic care and affect both treatment-seeking and adherence (Yuan et al., 2017). Help is typically sought as a last resort, after other options have failed and symptoms have worsened, negatively impacting treatment outcomes. A few studies offer insights into help-seeking behaviours,

intentions, and barriers across the continent, emphasizing the complex interplay of cultural and structural factors in accessing care.

Id et al. (2020) explored attitudes and help-seeking behaviors in rural Jimma, Ethiopia, finding poor attitudes toward mental health and a preference for traditional and religious healing. Similarly, Labys et al. (2016) examined help-seeking patterns in a rural South African community, revealing that most individuals relied on informal caregivers, with over half never interacting with formal health services. Only 1 in 8 had visited a psychiatric hospital, and help-seeking often involved traditional healers, rituals, and cyclical returns to non-medical practices. In Ugandan communities, Nsereko et al. (2011) found that traditional healers were the first point of contact, with Western care considered a last resort. Help-seeking behaviors were influenced by beliefs about mental illness, service accessibility, costs, and stigma.

In Ghana, limited research explores the relationship between beliefs about mental illness and help-seeking, though spiritual explanations are common (Read, 2012). Badu et al. (2018) conducted an integrative review identifying barriers to mental health care, including attitudes, service awareness, cost, accessibility, medication effectiveness, and geographic proximity. Systemic challenges, such as low funding, irregular medication supply, inadequate psychiatric facilities, and poor management of mental health cadres, further restrict access. Facilitators included task-shifting, decentralization, and existing support services. The authors noted that research tends to focus on systemic shortcomings and stigma, neglecting the quality and effectiveness of care, especially for underserved groups like children, adolescents, persons with disabilities, and the elderly.

Spirituality and Mental Health: Influence, Practices, and Barriers to Care

Spirituality is a vital aspect of culture, with beliefs and practices varying across societies and influencing mental health and illness (Sweet & Paul, 2022). While spirituality has gained attention in mental health literature, its role in care remains underexplored (Ho et al., 2016). Mental illness is often viewed through a spiritual lens, seen as a result of sin, demonic possession, or spiritual influences (Lehmann et al., 2022; Lloyd & Panagopoulos, 2022). These beliefs shape how mental illness is experienced and influence help-seeking behavior (Sweet & Paul, 2022). Despite its significance, unresolved issues persist, including spirituality's dual role as a risk or protective factor (Peteet, 2019), apprehensions about its use (Carlisle, 2015), diverse interpretations (Gopalkrishnan, 2018), and its unique impact on individual mental health (Baumsteiger & Chenneville, 2015).

Distinguishing between genuine spiritual beliefs that enhance well-being and pathological reflections is challenging, as mental health concerns often overlap with spiritual issues (Cook, 2020; Pearce et al., 2019; Sullivan, 2009). Many mental health professionals struggle to provide spiritually competent care, leading to patients' spiritual needs being overlooked, dismissed, or pathologized (Cone & Giske, 2022; Milner et al., 2019). This gap may stem from a limited understanding of spirituality's diverse roles in modern life and mental health contexts, highlighting the need for continued research and greater sensitivity in clinical practice. In recent years, spirituality's protective and healing role has gained recognition, prompting the development of interventions that integrate spirituality for more holistic care (Kao et al., 2020).

Several studies have focused on spirituality and mental health or illness. A positive relationship between spirituality and physical and mental health has been established. Through meaning-making, coping, and resilience, spirituality can help people adjust to pressures. It can

also help people anchor their identities in important ideas and values (Captari et al., 2018). Studies show that spirituality can improve and promote mental health, positive religious coping, community and support, and positive beliefs (Weber & Pargament, 2014).

Jones et al. (2019) explored the experiences of 16 individuals living with severe mental illness, identifying three themes: concepts of spirituality, benefits of intentional spiritual practices, and spiritual benefits of recreational activities. Participants reported finding peace, coping strategies, and hope through practices like meditation, yoga, prayer, and worship. Similarly, Captari et al. (2018) found that religious/spirituality-tailored psychotherapy led to greater psychological and spiritual improvements compared to no-treatment controls and standard therapies, highlighting the positive impact of integrating clients' spiritual beliefs into treatment. Research exploring the perceived effectiveness of traditional and faith healing for mental disorders suggests that, despite methodological limitations, stakeholders view these practices as valuable, especially when combined with biomedical care (van der Watt et al., 2018). People who trust in traditional or faith healing often continue seeking these treatments, presenting opportunities for collaboration to address resource shortages in low- to middle-income countries.

Spirituality has also been identified as a facilitator of mental health recovery, alongside personal agency and social support (van Weeghel et al., 2019). It's associated with reduced rates of depression (Braam & Koenig, 2019), anxiety (Bovero et al., 2019), and suicide (Captari et al., 2018), though findings for severe conditions like bipolar disorder and schizophrenia are more varied (Oman & Lukoff, 2018). Mufamadi and Sodi (2010) explored traditional religious healers' perceptions of mental illness in South Africa's Limpopo Province. Healers identified heredity, witchcraft, sorcery, and taboo violations as key causes, viewing mental illness as both a

supernatural phenomenon and a calling to healing. Their diagnostic and treatment practices followed logical, culturally congruent systems. Given the pervasiveness of religion, especially in LMICs, many individuals turn to religious spaces when seeking explanations and solutions to life stressors, including mental illness (Khoury et al., 2012).

In Ghana, psychological distress is prevalent, but treatment gaps persist due to limited infrastructure, inadequate facilities, and a shortage of mental health professionals (Dixon, 2012). The biomedical approach often clashes with local beliefs, leading many to seek care from traditional and faith-based healers who are perceived to share a deeper understanding of mental illness (Ae-Ngibise et al., 2010; Benyah, 2023; Lambert et al., 2020). Kpobi & Swartz (2019) found that evidence for the use and preference for non-biomedical mental health care is largely anecdotal. Research has largely focused on bridging collaboration between these healers and mental health professionals (Kpobi et al., 2024; Nyame et al., 2021; Ofori-Atta et al., 2018; Osafo, 2016). Arias et al. (2016) found that prayer camp staff were open to partnerships, especially if it helped address infrastructure deficiencies and provided technical support for medication management. While challenges remain, the literature emphasizes the value of spirituality in mental health treatment and the need for integrated services for individuals who already find spiritual practices helpful. Understanding what spirituality means to individuals and how it influences their lives is a crucial first step in creating more holistic care.

Despite their significance, studies on prayer camps highlight two major concerns. First, certain practices within these camps raise human rights violations, potentially exacerbating mental health conditions. Second, the exclusive focus on spiritual explanations for mental illness may overshadow or disregard other valid causes of mental health conditions (Khoury et al.,

2012). In this context, religion can sometimes contribute to poorer mental health outcomes in parts of Ghana.

Research on faith-based healing practices has documented widespread mistreatment of individuals with mental illness. A longitudinal anthropological study by Read et al. (2009) examining severe mental illness in rural Ghana sampled 40 households with a family member experiencing mental illness. The findings revealed that chaining, physical abuse, and starvation ('fasting') were commonly practiced both in homes and treatment centers.

Kpobi and Swartz (2019) conducted a scoping review on Ghana's Indigenous and faith-healing practices in mental health care, highlighting the coexistence of Indigenous, faith-based, and biomedical approaches. While biomedical practices are well-documented, evidence for non-biomedical care is mostly anecdotal, with limited small-scale research on alternative healers' beliefs. The researchers emphasized the need for further data to enhance mental health services. In Ghana and other highly spiritual African contexts, indigenous healers view mental illness as an imbalance across physical, mental, spiritual, and social dimensions, treating patients with herbal remedies and spiritual practices, contrasting with the pathology-centered biomedical approach. Badu et al. (2018) explored facilitators and barriers to mental health care access in Ghana, noting systemic flaws and stigma as major obstacles. They found that mental health services in Ghana prioritize systemic challenges over the effectiveness and quality of care, overlooking vulnerable populations such as children, adolescents, those with disabilities, and the elderly. Barriers to mental health care include government neglect, lack of awareness, and social stigma, deterring individuals from seeking professional help. While their study highlighted critical issues, it failed to explore the cultural beliefs surrounding mental illness, which are key factors influencing mental health care access in Ghana. Addressing these cultural perceptions is

essential for improving access and creating more effective interventions that integrate both spiritual and biomedical approaches.

Collaborative Mental Health Care Delivery

Mental health care collaboration is increasingly being promoted in many low- and middle-income countries (LMICs). However, significant challenges persist, particularly in fostering cross-professional partnerships between biomedical and ethnomedical practitioners. The primary source of tension lies in differing beliefs about the causes of illness. For instance, Shields et al. (2016) examined a collaborative initiative between faith-based and allopathic mental health practitioners in India. Interviews with 16 practitioners revealed substantial barriers to cooperation, emphasizing the need for trust, rapport, and open communication. Faith-based healers often perceive allopathic professionals as a threat to their practices and livelihoods. However, the study did not explore the deeper cultural and philosophical differences that define these two approaches to mental healthcare.

Other studies have also explored the possibility of a merger or collaboration between the conventional and non-conventional models of psychiatric treatments. Campbell-Hall et al. (2010) explored perceptions of mental health service users and providers in South Africa to assess the potential for collaboration between Western and traditional healthcare systems in community mental health services. Using qualitative methods, including interviews and focus groups, the study found that most service users adhered to traditional illness models and alternated between treatment systems, negatively impacting adherence and outcomes. Traditional healers felt unappreciated by Western practitioners but were open to training and collaboration. However, Western-trained professionals showed little interest in such partnerships. The study highlights the

willingness of traditional healers to collaborate but does not examine the underlying philosophical differences between the two systems.

Similar tensions between traditional healers and biomedical practitioners have been documented in Ghana. Ag-ngibise et al. (2010) found that the relationship between these two systems of mental health care is marked by a lack of mutual respect, with biomedical practitioners often viewing traditional healers with suspicion, making collaboration unlikely. In a study of 12 neo-prophetic ministers in Ghana, Osafo et al. (2015) reported that these faith healers predominantly framed mental illness as a spiritual issue rather than a biomedical condition. They employed two main treatment approaches: hope induction and prophetic deliverance. Similar findings were observed among Pentecostal clergy. Asamoah et al. (2014) reported that 20 male Pentecostal leaders leaned toward a diabolical explanatory model of mental illness rather than a biomedical one. Research suggests that faith healers and traditional practitioners in Ghana commonly adhere to spiritual explanations of mental illness. This perspective is shared by traditional priests, Imams, and herbalists (Kpobi et al., 2014). However, whether the similarities in their explanatory models encourage collaboration remains an open question, as their religious beliefs and practices differ significantly.

Overall, the global burden of mental illness is disproportionately high in low- and middle-income countries (LMICs) like Ghana. One key challenge is the inadequate funding allocated to allopathic mental health care by the central government. Critics argue that the biomedical model of mental health care often fails to adequately address the needs of individuals in non-Western cultures, as it does not integrate local worldviews into treatment approaches (Kpanake, 2018; Shields et al., 2016). Before the colonial introduction of allopathic treatments, indigenous Ghanaian communities had established their own diagnostic and treatment methods

based on communal beliefs about the causes of mental illness. However, with the advent of biomedical approaches, these traditional methods were marginalized and, in some cases, demonized.

Given the limited availability of formal mental health services, many individuals turn to traditional and faith-based healing practitioners. However, concerns persist regarding the human rights violations associated with some of these practices, including chaining, scarring, and forced fasting (Kpobi & Swartz, 2019). Notably, many non-allopathic practitioners do not perceive these actions as abusive, as they believe mental illness strips individuals of their personhood, making the treatment directed not at the person but at the spiritual entities responsible for the condition. Despite this, limited research has explored conceptions of personhood and their impact on mental health care in a cultural context where supernatural beliefs remain deeply influential.

Rationale for the Study

Conceptions of personhood underpin all models of mental healthcare delivery. While the underpinning philosophies of the biomedical model are delineated, despite many disputations, the indigenous method remains anecdotal. Much of the healing system is based on the personal opinions of practitioners based on their beliefs and cultural orientation. Moreover, not much community research has been done in Ghana to investigate the direct relationship between local conceptions of personhood and models of mental healthcare. This study was, therefore undertaken for several reasons. Firstly, instead of relying solely on assertions of philosophers in Ghana on who a person is, this study was undertaken to have a first-hand understanding of how the people conceptualise personhood in relation to mental illness. This study therefore adds to the limited literature around personhood and mental health particularly from the Ghanaian

perspective. Secondly, the study provides insight to understand stigma and discrimination and factors to consider in mitigating its impact on people with mental illness.

Research Questions

1. Who is a person among the Akans/Ewes?
2. What is the knowledge of mental health/illness among the Akans/Ewes?
3. How does mental health/illness affect personhood among the Akans/Ewes?
4. Can personhood explain stigma and discrimination among people living with mental illness among the Akans/Ewes?

Chapter Three

Methodology

Introduction

This chapter details the research methods employed in this study. The chapter presents the philosophical underpinnings of the study, design, study area, sample and sampling procedures, population, data collection methods, ethical issues, and the data analysis procedure.

Research paradigm

A research paradigm represents the researcher's worldview (Wahyuni, 2012) which entails the researcher's thoughts and belief system rooted in ontological, epistemological, axiological, and methodological assumptions that influence the thinking and behavior of the researcher. Therefore, the worldview of this researcher significantly influenced the entire research process and informed choices. Shannon-Baker (2015) categorizes research paradigms into three distinct groups; positivism, interpretivism, and pragmatism, which are all underpinned by philosophical beliefs of reality, values, and knowledge. This study aimed to explore who a 'person' is, how mental health and illness affect personhood, knowledge of mental health and illness among Ewes and Akans, and how personhood explains stigma and discrimination among people living with mental illness. In determining the exact paradigm of inquiry to undergird this study, the researcher had a clear philosophical stance on how truth or reality is perceived, by what methodology and methods knowledge is acquired, and by which ways values are explained as this was critical to inform the specific paradigm for the research (Creswell, 2012).

This study rested on the interpretivism/social constructivism paradigm, a perspective that asserts that to better understand and gain knowledge from a social phenomenon, a researcher must inquire it from the perspectives of the people experiencing it (Barbour 2014; Charmaz

2014). Hence, interpretivists endeavor to understand the experiences, actions, perceptions, and meanings of individuals and the social context within which they occur; in addition to how the individual's position within the larger social structure informs these experiences, accounts, perceptions and meanings (Bryman 2008; Charmaz 2014).

The Interpretivism / Social Constructivism Paradigm

Interpretivism emerged from the phenomenology of Edmund Husserl and other philosophical works on hermeneutics (interpretive) (Antwi & Hamza, 2015). The interpretivism approach aligns with a particular belief that reality is socially constructed or made meaningful through people's understandings and interpretations of a specific phenomenon (Berger & Luckman, 1996). From this arises the notion of a relativist ontology, implying that reality is not unitary but several (Lincoln et al., 2013). That is, individuals may view a particular thing in varied ways and arrive at diverse interpretations based on their experiential, cognition, and other perceptions they hold. They build understanding based on details, specifics, and shared meaning (Morgan & Smircich, 1980). In contrast to the positivist paradigm, which deals with objectivism, naive realism worldview, and quantification of the variable being researched, interpretive-constructivists postulate that the meaning given to a number is a social construction and not just an absolute that exists objectively assigned by people. Therefore, numbers cannot speak for themselves. Instead, they assume the meaning people assign them (Rubin & Rubin, 2005). Interpretive research prioritizes interpretations of actions and the meanings participants assign to a phenomenon over measurement and quantification (William, 2000).

The core tenet of the interpretivist paradigm is to understand the subjective worldview of reality and human experience (Guba & Lincoln, 1989). This approach permits the researcher to gain an insider perspective on a topic of study from the perspective of the very persons who live

that experience; something anthropology would call the 'emic perspective' (Olive, 2014). The aim is to better understand and interpret their thoughts, viewpoints and meanings placed on events within a particular context which is shaped by their social, historical and experiential factors. The emphasis is to understand the participants and how they interpret and make meaning of their worldview and not to impose a different reality on their experience. The researcher thus becomes a collaborator in generating the knowledge and not an 'expert' on the knowledge. This is because by nature, humans are sense-makers and therefore within the intersubjective social and lifeworld they are embedded, they assign meanings to objects, situations and everyday events. Hence, reality is socially constructed in the interpretive paradigm (Bogdan & Biklen, 1998). Interpretivism takes up relativism ontology, subjectivism epistemology, balanced axiology, and an ethnographic naturalist methodology (Lincoln, et al., 2013).

Ontologically, interpretivists' assert that truth can be formed in several ways based on people, their backgrounds, and interpretations rather than a single truth known by all. Interpretivist holds a relativistic worldview that reality is contextual, a composite of multiple views socially constructed by individuals and society's shared or lived experiences and how they perceive reality (Guba & Lincoln, 1994). By assuming, in this study, and accepting that the Akans and Ewes have their peculiar conceptions and realities of who a person is and what constitutes personhood, spirituality, and mental illness, the researcher accepted that multiple factors could impact their social characteristics. Their responses concerning their construction of personhood, spirituality, and mental illness, were shaped by their social interaction, discourses, experiential and historical factors.

The epistemological disposition of interpretivism assumes subjectivity, which is founded on real-world phenomena, and it is determined interactionally (Jason & Glenwick, 2016). Per

Creswell (2013), the interaction between the participant and inquirer must occur in a natural setting, and this is vital in knowledge creation. As a result, the inquirer cannot disengage from the research process, and the research findings are guided by the interpretation of scientific observation and interactions. As this researcher engaged the research participants, it became evident that the ontological position of the Akans and Ewes reflected in the subjectivity of their responses to the research questions. This is because the meanings ascribed to the research questions were negotiated by their history, culture, language, symbols and social interaction that have been stretched and fashioned to help them answer the research questions in a way that makes sense to them. This research goal axiologically was to understand traditional healing systems as undergirded with notions of personhood and spirituality in relation to the conceptualization of the etiology, diagnosis and treatment of mental illness and aims to produce inductive knowledge that will inform individuals and literature. Miller & Rose (1990) states that in deciphering meanings, the use of language plays a crucial role. These are also influenced by individual and collective values, suggesting the strong role of value-laden judgments for an interpretivist's axiological considerations. The axiological position of interpretivists is that values and facts are not clearly separable. Adopting a relativist position was more advantageous because it was congruent with the viewpoint of the researcher and discursive practices on society, research and clinical practice.

Critics argued that interpretivism paradigm is limited in terms of generalizing the research findings, replication in other context, credibility and reliability of findings due to its subjective nature contending that positivists ensure objectivity, reliability, validity, generalizability and accuracy through a quantitative methodology of scientific rigor (Antwi & Hamza, 2015). Nevertheless, interpretivist debate that, the sole aim of qualitative inquiry is not

the generalization of research findings but rather it seeks to explore participants' experience and their meanings, to obtain rich information on a phenomenon. These meanings are constructed best socially by both the participant experiencing the phenomenon and the researcher collecting the data in a mutually engaging setting (Creswell & Creswell, 2017). Interpretivists emphasize that qualitative research ensures methodological rigor but not in the same manner as positivist which uses validity and reliability to ensure rigor. Qualitative researchers, instead, employ dependability, credibility, confirmability, and transferability, to ensure rigor in research (Guba & Lincoln, 1989). The premise for the selection of interpretivist-social constructionist research paradigm for this study was because this study aimed, through mutual interactions and engagement, to uncover and understand how the Akans and Ewes within their social context each circumscribe the phenomenon of personhood, spirituality and mental illness and also to ensure the effective co-construction of the multiple realities involved.

Social Constructivism

Social constructivism is a theoretical stance that acknowledges the joint creation of knowledge between the researcher (observer) and the participants (observed) with a goal toward an interpretive understanding of participants' meanings (Charmaz 2005). The participants of interest in social constructionism are those whom anthropologists call culture, and sociologists call society an example such as the Akans and Ewes. This researcher believed that both the Akans and the Ewes do not have a single reality and their understanding of the world to ascribe meaning to events is the outcome of negotiation among groups of people and their historical process of interaction (Green & Thorogood, 2014). This illustrates that meaning is a construction made by people and not a property of events and objects themselves. Likewise, it is the result of

their prevalent cultural framework of social traditions, discursive, ethnolinguistic, value systems and symbolic practices (Cojocaru & Bragaru, 2012).

Research Design

Hennick et al. (2020) define research design as a framework that logically integrates research components to effectively address study objectives. The choice of design influences the entire research process, including sampling, data collection, analysis, and reporting (Bryman, 2016). Research design stems from research philosophies: positivism aligns with quantitative methods, interpretivism with qualitative inquiry, and pragmatism with a mixed-methods approach (Shannon-Baker, 2015; Creswell, 2014).

This study adopted a qualitative research design, aligned with interpretivism, to explore the meanings individuals or groups attribute to socio-cultural phenomena (Creswell & Creswell, 2017). Qualitative methods capture narratives, behaviors, and nuanced issues that quantitative tools may overlook, such as emotions, perspectives, and underlying values (Bryman, 2016). This approach was suitable as it allowed participants to reflect on and discuss their subjective experiences in their natural settings, providing rich descriptions and deeper insights relevant to the research objectives. Through open-ended inquiry, qualitative methods allow for flexibility in data collection and analysis, making it possible to adapt to emerging themes and unexpected findings (Busetto et al., 2020). By prioritizing context and meaning, this approach enables researchers to understand not just what participants think but also why they think that way, thereby offering a more holistic and interpretive analysis of the research phenomenon (Lim, 2024).

Furthermore, qualitative research methods are particularly advantageous when studying sensitive or deeply personal topics, as they provide a platform for participants to share their

thoughts and feelings more naturally and conversationally. The interactive nature of qualitative research fosters rapport between researchers and participants, enhancing the authenticity and depth of the data collected (Busetto et al., 2020). This study employed methods such as in-depth interviews, focus groups, and participant observations to capture detailed descriptions of participants lived experiences within their natural settings.

By employing a qualitative research design, this study ensured that the voices, perspectives, and cultural contexts of participants were meaningfully represented, aligning with the research objectives. The emphasis on subjective meaning-making and narrative exploration enriched the findings, contributing to a deeper and more contextually grounded understanding of the socio-cultural phenomenon under investigation.

Research Setting

The study was conducted in Tutu (Eastern Region) and Keta (Volta Region) of Ghana, predominantly inhabited by the Akuapem and Anlo-Ewe ethnic groups, respectively. These areas were chosen for their rich cultural traditions, distinct chieftaincy structures (Akuapemodwira, 2022; Art of the Motherland, n.d.), proximity to Accra, and the researcher's fluency in Twi and Ewe. These areas blend urban and traditional influences. Keta, the ancestral home of the Anlo-Ewes, hosts the *Hogbetsotso Za* festival, celebrating their escape from Notsie, Togo (Kukubor, 1994; Merolla, 2007). Located in southeastern Ghana, between the Atlantic Ocean and Keta Lagoon (GSS, 2014), it was once a trading hub for slaves, gold, and spices (Britannica, 2013). The community (98.7% Ewe) is highly homogenous (GSS, 2010) and relies on farming, fishing, and trade (GSS, 2014). Occupational associations promote skill development and communal welfare (Ladzekpo, 1995).

Tutu is a village in Ghana's Eastern Region, home to the Akuapem people, an Akan subgroup who speak Akuapem Twi (51.6%) and celebrate the Ohum festival (GSS, 2014). Oral history claims they were the first settlers on the Akuapem Ridge, existing before the formation of Okuapemman (Gyamerah & Tsibu, 2021). The community follows a patrilineal inheritance system, emphasizing the importance of male children. Their economy is based on subsistence and small-scale farming, though some migrants, like teachers and nurses, have settled for work or housing (GSS, 2014). Strong community ties and shared ancestry contribute to their flexible approach to marriage (Gyamerah & Tsibu, 2021).

Population

The population for this study was males and females aged 18 years and above from the Ewe and Akan ethnic groups who are natives of the research locations. Non-resident natives of these areas who are knowledgeable, noted to visit home frequently, and are reachable were also included. In addition, immigrants who had spent more than 10 years in the locations and were knowledgeable in the culture and traditions of the areas were considered part of the population. The rationale for selecting the Akan and Ewe is that they are two of the largest and most influential ethnic groups in Ghana (Gyekye, 2000; Nukunya, 2003). Both groups have rich and distinct philosophical traditions regarding personhood, spirituality, and healing (Gyekye, 1997; Mbiti, 2008; Menkiti, 1984). Their conceptual frameworks not only reflect broader Ghanaian cultural orientations but also reveal intra-cultural variations that shape how mental illness is understood, experienced, and treated (Assimeng, 1999; Osei, 2003). Focusing on these groups therefore provides deeper insights into how indigenous worldviews inform mental health beliefs and practices, while also highlighting the implications for culturally sensitive mental health care in Ghana (Kpobi & Swartz, 2019).

Sample and Sampling Technique.

The study sample included Ewe and Akan adults (18+ years) selected using a purposive sampling technique for their cultural knowledge and willingness to share insights. Four distinct participant groups were sampled for this study (Youth, 18 – 35 years; Men only, 36 – 59 years; Women only, 36 – 59 years; and Elders, 60 years and above), reflecting the demographic classification of the national population statistics. The subgroups were created to reflect sociocultural distinctions in age and gender that shape perceptions of personhood and health in Ghana. Men and women aged 36–59 were separated to allow open discussion of gendered roles, while youth (18–35 years) and elders (60 years and above) were sometimes grouped to reflect the cultural value of intergenerational dialogue. Including youth groups also allowed the study to explore the extent to which younger members of communities are exposed to and influenced by their cultural traditions. This approach ensured cultural appropriateness, minimized power imbalances, and enriched the perspectives gathered (Assimeng, 1999; Kpobi & Swartz, 2019).

The initial study sample was 90 participants, 60 for the Focus Group Discussions (FGDs) and 30 for the Individual Interviews (IDIs). However, data collection concluded with 67 participants due to information saturation: 56 participants across eight FGDs and 11 for IDIs, with no overlap between groups. The sample size followed Malterud et al.'s (2016) "information power" principle which indicates that 'the more information the sample holds relevant for the actual study, the lower number of participants is needed' (p. 1753). As participants were culturally grounded, high information power was achieved. Consistent with research on data saturation (Hennink et al., 2017; Hennink & Kaiser, 2021), no new insights emerged after 9–17 interviews or 4–8 focus groups in homogenous populations.

Inclusion criteria

1. Participants must be 18 years of age or above.
2. Participants must be a native of Tutu or Keta, be able to communicate in English, Akan, or Ewe, and must be living in these communities.
3. Participants must be willing to give consent to be a part of the study.

Exclusion criteria

1. Participants who were below 18 years of age
2. Participants who are not natives of Tutu or Keta, are unable to communicate in English, Akan or Ewe, and do not live in these communities.
3. Participants who are not willing to give consent to be a part of the study

Research Instrument

An open-ended interview guide was developed based on global and local philosophical literature on personhood (see Appendix 1). It included nine main questions with follow-ups to encourage comprehensive responses. The guide explored participants' perceptions of health, mental health, and mental illness, and delved into their understanding of personhood — including beliefs about who can experience mental illness and whether it can be cured. Initially written in English, the guide was independently translated into Twi and Ewe and back into English to ensure accuracy. The open-ended, semi-structured design allowed participants to share their perspectives freely, enabling deeper exploration of their personal theories and social practices regarding personhood (Flick, 2006). This flexible approach facilitated rich, culturally grounded insights from both the Akan and Ewe participants.

Table 1 presents

Sample Questions from the Sections in the Open-Ended Question Guide

Personhood, Spirituality, and Mental Illness
i. What is your understanding of health/being healthy?
ii. What is your understanding of mental health?
iii. What is mental Illness?
iv. Who is a person as understood in your community/among the Ewes? (Probe further)
v. Is every human being a person? (Probe why)
vi. Can mental illness be prevented?
vii. How does society perceive the mentally ill? (probe)
viii. What sense are you making of all these questions we have been asking you?
ix. Do you have any other comments?

Piloting

The research was piloted in Taviefe (Volta Region) and Akwapim Tutu (Eastern Region), with the interview guide tested in both Ewe and Twi. Conducting the pilot study in these two culturally distinct settings allowed the research team to assess the clarity, appropriateness, and cultural sensitivity of the questions across different linguistic and ethnic contexts. The pilot phase provided valuable insights into how participants interpreted certain terms and concepts, especially those related to mental health, spirituality, and personhood. In addition to refining the wording and sequencing of questions, the pilot helped identify areas where translation required adjustment to capture local nuances in Ewe and Twi. It also drew attention to culturally embedded metaphors and idioms that participants used when discussing illness, healing, and well-being, which were subsequently integrated into the final guide.

Equally important, the pilot study highlighted the role of non-verbal cues—such as pauses, gestures, and tone of voice—in communicating meaning. This was particularly relevant when participants discussed sensitive issues like stigma, family involvement, or religious practices. Recognizing these cues informed both the design of the interview guide and the training of field researchers, ensuring that they remained attentive to subtle expressions of discomfort, hesitation, or emphasis. The lessons learned from the pilot enhanced the validity of the interview tool, improved researcher sensitivity to context, and ensured that the guide was both linguistically accurate and culturally grounded. This process strengthened the quality of data collection in the main study and increased participants' comfort and willingness to share their experiences.

Procedure

When conducting this study, the researcher was partially immersed at Keta and Tutu (study sites), spending 3 months (accumulation of 30 days each) at these villages. He traveled in and out of Keta and Tutu. The research employed a focal person at each research site. The focal persons were natives of the communities studied. They assisted the researcher and team in community entry, organized the interview location and focus group discussions, and helped recruit participants. In every community, the researcher observed the traditional protocols by visiting the chief's palace upon entry. This was facilitated by the focal person. The researcher formally introduced himself to the chief and elders, presenting an information sheet about the study along with an introductory letter from the University of Ghana. In keeping with local customs of respect and acceptance, he also offered bottles of schnapps [1] and money as a traditional gesture of goodwill. Once permission had been granted, the researcher immersed himself in the place by observing the way of life of the population without active participation. The focal person provided leads to people based on the categories of persons the researcher had

earlier identified to help understand the research topic. A meeting was then arranged with the participants to prepare them for consent and participation. A suitable time of the participants' choosing was agreed upon for the interviews to be conducted. The focal person identified and invited people who met the inclusion criteria and were interested in the study to a central point.

The study employed both individual in-depth interviews and focus group discussions for data collection. Individual interviews offered participants a private setting to share detailed and sensitive insights on personhood, spirituality, and mental illness, while focus groups facilitated the exploration of shared meanings, divergences, and cultural narratives. Using both methods allowed for triangulation, providing a richer and more validated understanding of the phenomena under study (Lambert & Loiselle, 2008). Focus group discussions and individual interviews were conducted in the chief's palace, a school classroom, a church building, and the homes of some elders and the focal person. For every participant in both the individual and focus group interviews, the researcher introduced himself and provided an introductory letter to anyone who required identification. He also provided a written consent form to all participants and read out the consent for some participants who required. Participants were then required to sign the consent form for the interviews. Participants were given an incentive of Twenty (20) Ghana cedis for their time as a token of appreciation.

Participants were given prior notice in all instances by the focal person and the researcher about the research. All participants who were interested were given the time and location of the interview. The researcher assured all participants of their rights and explained the data collection rules. For example, he explained to participants that all views were welcome; if any participant needed to contribute or ask a question, they could simply give a signal by raising their hand and then mentioning their number (pseudo-name) before making their response. Data were collected

through in-depth, face-to-face interviews with participants in their communities. Each interview session lasted between 45 minutes and 1.5 hours, depending on the availability and comfort of participants, as well as the depth of discussion. With the participants' consent, all interviews were audio-recorded to ensure accuracy and completeness. Field notes were also taken to capture contextual details and non-verbal cues that were significant for interpretation.

Ethical considerations

Ethical approval for this study was obtained from the Ethical and Protocol Review Committee of the University of Ghana, College of Humanities (Approval ID: ECH 320/ 21-22). The Committee reviewed the study's objectives, methodology, consent process, and data management procedures to ensure compliance with international and institutional ethical standards for research involving human participants. Approval was granted on June 1st, 2022, permitting data collection in the selected study sites.

Data collection took place during the COVID-19 pandemic, requiring extra safety measures to protect participants. The researcher provided masks and sanitizers, wore a mask at all times, and logged personal travel history. Interviews were conducted with microphones to maintain distance, and seating arrangements and home locations were mapped for potential contact tracing. Participants received COVID-19 information sheets, and their questions were addressed based on available knowledge at the time. They were treated with respect, assured of confidentiality, and informed of their right to withdraw or skip uncomfortable questions. All audio files and transcripts were stored securely on a password-protected computer, with backup copies kept on an encrypted external hard drive. Only the researcher and supervisory team had access to the data. To protect confidentiality, pseudonyms were assigned to participants, and identifying details were removed from transcripts before analysis.

Data Processing and Analysis

In qualitative research, data analysis is guided by the research objectives and the nature of the data collected. It involves gathering, organizing, and interpreting data to uncover its meaning (Braun & Clarke, 2006). This study used Reflexive Thematic Analysis (RTA) by Braun and Clarke (2019) to explore how the Akans in Tutu and the Ewes in Keta understand and construct personhood, and how this influences self-definition and behavior. RTA fits well within the interpretive research paradigm, allowing for a rich, detailed analysis (Clarke & Braun, 2018). The analysis of the data was done using both an inductive and deductive approach.

The aim here was to identify, analyze and report patterns of themes that emerge from the mass of qualitative data, while permitting conceptually informed interpretation of meaning in rich detail (Braun & Clarke, 2006). Braun and Clark (2019) outline six phases involved in RTA. The processes involved in these phases are not linear; the previous phase may be revisited to ensure correspondence with the data as the analysis progresses. The six phases of RTA:

1. ***Data Familiarization:*** This phase focused on organizing the data into text. The researcher carefully listened to the audio recordings multiple times to immerse themselves in the data and grasp its depth. Interviews were transcribed verbatim, then read and re-read while cross-checking with the audio to ensure accuracy. This process enhanced familiarity with the data, helping to identify connections across participants' narratives, in line with Bogdan and Bilken's (2007) suggestion that transcripts should be read at least twice for a richer understanding.
2. ***Initial Code Generation:*** In this stage of RTA analysis, initial codes were manually generated through a line-by-line review of transcripts. The researcher examined participants' descriptions, language patterns, and conceptual interpretations of

personhood, coding relevant sections. Four qualitative research experts independently developed and refined codes through discussion. Each transcript was coded afresh to allow new codes to emerge, with color-coding used for organization and clarity. Examples of the codes include expected social roles, body integrity, witchcraft/sorcery, spiritual causes, biomedical causes, social stressors, moral transgressions, curses, etc.

3. ***Generating initial themes:*** In this stage of data analysis, the initial themes are generated. During this process, the codes that were generated in phase two were sorted out and those that shared similarities or overlapped were clustered together and labelled with different highlighter colours with a succinct statement to form the initial themes yet expressive enough to remind me of the sources these themes emerged.
4. ***Reviewing Themes***: at this stage, the researcher ensured the usefulness and the exact representations of the themes against the data. To this end, he returned to the transcript data, read and compared the theme against it to ascertain whether the themes were supported by the data. Any unsupported themes were either divided up, re-clustered, recreated or even discarded. This procedure was to ensure that the themes were relevant and are accurate representations of the data leading to major and minor themes.
5. ***Defining and naming the themes:*** in this phase, the themes that were identified as relevant and represent the data accurately were named and defined to describe the core idea of what each theme meant as in the opinion of Braun & Clarke (2006).
6. ***Writing report:*** this is the last section in the analysis process, which involved writing up and presenting a succinct narrative of the participants' stories as informed by the themes.

Methodological rigor

Speziale et al. (2011) emphasized that methodological rigor is essential for ensuring research procedures align with the intended approach. Morse et al. (2002) argue that without rigor, qualitative research lacks credibility and fails to contribute new knowledge. While validity and reliability are key in quantitative research, trustworthiness is the standard for qualitative inquiry (Korstjens & Moser, 2018). To achieve trustworthiness, this study adhered to Guba and Lincoln's (1989) four criteria: credibility, transferability, dependability, and confirmability.

Credibility

Credibility ensures that research findings are believable and accurately reflect reality (Korstjens & Moser, 2018). To establish credibility, the researcher engaged participants in FGDs and IDIs lasting 40–70 minutes, and conducted member checking by discussing interview responses and preliminary themes with participants for validation. Triangulation further strengthened credibility: methodological triangulation combined FGDs, IDIs, field notes, and observations; investigator triangulation involved qualitative research experts in data analysis and interpretation; and environmental triangulation examined personhood, spirituality, and mental illness across two distinct contexts, Tutu and Keta.

Transferability

Transferability refers to the extent to which research findings can be applied to other contexts or settings (Forero et al., 2018). This was achieved through thick description of the study's methodology, including detailed accounts of the setting, participant background, research design, sampling techniques, eligibility criteria, and data collection and analysis procedures. These rich contextual details allow other researchers to assess the relevance of the findings and determine whether and how to replicate the study in different settings (Stahl & King, 2020).

Dependability

Dependability ensures that research findings are consistent and reliable over time (Korstjens & Moser, 2018). To establish this, the study underwent peer review and external auditing, where experts scrutinized the theoretical framework, methodology, and findings to verify their accuracy and coherence before finalizing the research.

Confirmability

Confirmability ensures that research findings truly reflect participants' responses, not the researcher's biases (Maher et al., 2018). This was achieved by detailing participants' demographics alongside their narratives, helping readers link findings to specific participant contexts. The researcher personally transcribed all audio recordings promptly after interviews, replaying them multiple times to capture non-verbal cues and verify accuracy, ensuring the data remained authentic and trustworthy.

Researcher Reflexivity

Reflexivity acknowledges the researcher's active role and influence in the research process (Corlett & Mavin, 2018). It involves self-awareness, critical reflection, and transparency about personal assumptions, biases, and experiences that may shape the study (Patnaik, 2013). Even though the researcher is an Ewe with excellent knowledge of the language and cultural artifacts, and with proficiency in Twi language, he spent a considerable amount of time observing the living complexities of these two ethnic groups, and this did not affect data collection as there is a tendency for observer bias to occur (Hoeben, 2018). Since the researcher was partially immersed in both communities, maintaining neutrality during data collection and analysis was essential. Awareness of their mental health professional background helped the researcher stay objective during interviews by setting aside personal views and listening attentively. Reflexive thematic

analysis was chosen for data interpretation, and measures like hiring a research assistant for transcription, coding data with multiple researchers, peer review, and member checking (Birt et al., 2016) ensured the findings authentically reflected participants' perspectives, maintaining credibility, transferability, and dependability (Alvarez-Hernandez, 2021).

Chapter Four

Results

The chapter presents the results of the analysis. The main themes and sub-themes observed in the analysis are presented below. Participant demographics are presented in Tables 2 and 3.

Table 2 presents…

Demographic Details of Participants (Individual Interviews)

Participant No.	Age	Gender	Marital status
T001	56	Male	Married
T002	60	Female	Single
T003	73	Male	Married
T004	65	Male	Divorced
T005	68	Male	Married
T006	71	Male	Married
AKK001	65	Male	Single
RBFK001	73	Male	Married
RBFK002	69	Male	Married
K003	74	Male	Single
TGFK004	69	Male	Married

Table 3 presents…

Demographic Details of Participants (Focus Group Discussions)

Group	No. of participants	Average Age	Code
Keta Elders	8	71.5	Keta Elders FGD
Keta Men	8	49.5	Keta Men FGD
Keta Women	8	46.2	Keta Women FGD
Keta Youth	8	25.0	Keta Youth FGD
Tutu Elders	6	69.3	Tutu Elders FGD
Tutu Youth	6	27.5	Tutu Youth FGD
Tutu Men	6	47.4	Tutu Men FGD
Tutu Women	6	46.3	Tutu Women FGD

Table 4 presents…

Aggregated Description of Study Participants

Variable	Category	N	%
Total Participants	—	**67**	100
Gender (individual interviews only)	Male	10	90.9
	Female	1	9.1
Age Group (individual interviews only)	20–29	0	0.0
	30–39	0	0.0
	40–49	0	0.0
	50–59	1	9.1
	60–69	6	54.5
	70+	4	36.4

Variable	Category	N	%
Marital Status (individual interviews only)	Married	7	63.6
	Single	3	27.3
	Divorced	1	9.1
Group Membership (FGDs)	Keta Elders	8	—
	Keta Men	8	—
	Keta Women	8	—
	Keta Youth	8	—
	Tutu Elders	6	—
	Tutu Youth	6	—
	Tutu Men	6	—
	Tutu Women	6	—
	Subtotal (FGDs)	**56**	—

Demographic Characteristics of Participants

Individual In-Depth Interviews

A total of 11 participants were involved in the individual interviews, with ages ranging from 56 to 74 years (M = 68.5, SD = 5.5). The sample was predominantly male (n = 9; 81.8%) with only two females (18.2%). In terms of marital status, seven participants (63.6%) were married, three (27.3%) were single, and one (9.1%) was divorced. The majority of participants were older adults and elders, reflecting their recognized authority and experiential knowledge regarding cultural understandings of personhood and spirituality.

Focus Group Discussions

A total of 56 participants took part in eight focus group discussions across the Akan and Ewe communities. Group sizes ranged from 6 to 8 members, with the average age of participants varying by group. Elders' groups were the oldest, with mean ages of 71.5 years (Keta Elders) and 69.3 years (Tutu Elders). The men's and women's groups in both communities had middle-age averages ranging between 46.2 and 49.5 years, while the youth groups were the youngest, with mean ages of 25.0 years (Keta Youth) and 27.5 years (Tutu Youth). This distribution ensured representation across generational, gendered, and social roles, allowing for diverse perspectives on personhood, spirituality, and mental illness.

Major Themes

Three (3) main themes and eleven sub-themes emerged after the analysis. These themes and sub-themes are: Conceptualization of personhood (*Prescriptive performativities (ethno-cultural), Corporeal dimension, Numinous dimension)*, Subjectivizing mental illness (*construing mental health/mental illness, etiological reflections, unipolar representations, treatment regime, prevention of mental illness)* and Implications for personhood in context (*Human rights abuses, spotlighting occupational therapy, collaborative engagements and culture competence for practitioners)*.

Table 5 presents…

Summary of main themes and subthemes from the Participant Interviews

Major themes	Sub-themes
Conceptualizing personhood,	1. Prescriptive "performativities" (ethno-cultural) 2. Corporeal Dimension 3. Numinous dimension
Subjectivizing mental illness	1. Construing mental health/illness 2. Etiological reflections 3. Unipolar Representations 4. Treatment regime 5. Prevention of mental illness
Implications for Personhood in Context	1. Human rights abuses 2. Spotlighting occupational therapy 3. Collaborative engagements and culture competence for practitioners

Theme one (1): Conceptualizing personhood

This theme examines participants' perspectives on what it means to be a person. It explores philosophical, cultural, legal, and ethical considerations about the attributes, rights, responsibilities, and inherent worth of individuals within their context. Within the Ewe and Akan contexts, personhood is conceptualized based on '*prescriptive performativities', corporeal dimension, numinous dimension,* or a combination.

Prescriptive "performativities".

This sub-theme highlights the accepted norms of conduct in the community against which people are evaluated. Participants describe personhood as tied to individuals' alignment with these socially accepted norms, where conformity grants them the status of persons within their community. These norms primarily revolve around performing specific actions and fulfilling status roles, with an emphasis on behaving in ways that align with societal expectations. This is exemplified in the words below:

> When they say that this man is a person, it means that he is doing things in the right manner (nute*ɟ*ewɔla). If you do something and others say you have not done it well and you accept your fault, they say this individual is understanding so he is a person... (Keta Men FGD)

According to the participant, standards of behavior are embedded in community norms, where 'doing things in the right manner' means meeting societal expectations. This suggests that personhood is conferred, not automatic, and based on society's objective evaluation. When individuals conform to accepted norms, they are recognized as persons. Another reinforced this perspective by distinguishing between humans and animals: "...The way we behave as human beings is different from that of animals. An example is what we eat and wear and the way we act. This has distinguished us from animals..." (Keta Men FGD). This comparison seems to imply that in some instances, people are likened to animals when they fail to act in a manner that is acceptable to society. In a sense, behaviour that departs from societal expectations may push society to treat some individuals as non-persons. Deductively, they may even be treated or accorded the courtesies of animals. It becomes clear that society plays a role by setting the rules, rewarding individuals who conform, and punishing individuals who deviate from the norms. This is equally demonstrated by a participant from Tutu who added that;

> When you do everything correctly. For example, in working with this woman (referring to the focal person in the community the researchers contacted), when you came here-. Every day you come here, this woman is punctual and does everything you require of her. You can see that she is clearly a person. (73-year-old man, IDI, Tutu)

As expressed above, the woman he refers to is believed to conform to standards by being punctual and diligent, which falls within actions the society may consider to determine personhood. Being recognized as a person in the community often depends on how well someone fulfills their responsibilities and meets societal expectations. Essentially, a person gains this recognition by regularly adhering to the community's norms. This also implies that personhood exists in a continuum and must consistently progress. Another participant adds to this with an example and said;

> For some people, for example, when there is money involved, they may take the money and still not do the work as you want or as you expect. The person could be walking around alright, but though they are not mad, some of their actions are not what is expected. It is the actions/deeds of an individual that make them persons. (Tutu, 73-year-old male, IDI)

From the above example, a person's behavior, particularly in fulfilling responsibilities, shapes how they are perceived. Even if they appear fine, failing to honor commitments—such as not delivering after payment—can raise doubts about their reliability. In the community, personhood is closely linked to one's actions and accountability.

The responses highlight that personhood is often shaped by actions that align with what society views as acceptable or appropriate. When someone's actions match their community's

expectations, they are seen as a 'person.' Conversely, if their actions differ from these expectations, they may not be regarded in the same way.

Being recognized as a 'person' was often associated with possessing certain virtues. Virtues such as respect, honesty, kindness, generosity, and patience were considered important for one to be viewed in this way. This is asserted by a 72-year-old participant who shared that: "One is said to be a person based on good character, ability to speak well and having compassion for others (Tutu, 72-year-old female, IDI). Her assertion implies that being regarded as a person is often linked to having good character, polite interaction with others, and showing compassion. These qualities seem to play an important role in how individuals are perceived within their community. Similarly, being respectful is seen as a sign of being a person, as illustrated here:

> As human beings, when a brother is doing something and you tell him that what he is doing is not good, but he continues doing it, you will say that the person doesn't respect. But anyone that you will talk to, and he listens, we say that individual is respectful and so is a person (Keta Men FGD).

This implies that being considered respectful and thus recognized as a person is often tied to how one responds to feedback or guidance. If someone listens and changes their behaviour when advised, they are viewed as respectful and are more likely to be regarded as persons within the community. Additionally, showing care and concern is believed to reveal one's personhood as stated here:

> When they say this individual is a person but the other is not a person, it is based on some sterling qualities such as showing care and concern to others. That reveals one's personhood and makes others say that he/she is a person (Keta Men FGD).

The above seems to suggest that being recognized as a person is linked to displaying qualities like care and concern for others. These actions seem to reveal a deeper sense of character that leads people to regard someone positively within the community. This is further highlighted here: We have those who are persons (care about others) and those who are not. A person is someone who has a particular way of doing things, talking and is respectful. Such a person has patience for fellow humans (Tutu, 63-year-old man, IDI). The distinction above suggests that personhood is tied to one's conduct—expressing care, respect, and patience in actions and interactions. Speech and behavior shape how one is perceived within the community. From respondents' perspectives, good character is reflected in moral integrity, compassion, respect, honesty, and ethical behavior. Thus, personhood is earned and affirmed through the consistent practice of these virtues.

Apart from virtues, significant achievements and accomplishments in life were also necessary to attain the status of a 'person'. To illustrate this, some participants referred to significant historical figures and how their accomplishments are examples that reflect personhood, even after the person has passed away. For example, one man from Keta mentioned that, ...We consider individuals who have achieved something as persons. In addition, we consider our forefathers who have achieved great things, such as Togbui Tsali and Gemedzra, among others, who have achieved a lot, and they are considered as persons (Keta Men FGD).

According to the Keta Men, recognition as a person is often tied to significant achievements, with those who make notable contributions being highly esteemed. Figures like Togbui Tsali, the renowned hunter who aided the Ewes in escaping King Agorkoli from Notsie to present-day Ghana, and Togbui Gemedzra are revered for their accomplishments and seen as embodiments of personhood. The comment further suggests that personhood seemingly extends beyond an

individual's lifetime or death, directly tied to their actions and /or achievements while alive. They equally reiterate that: ...They are persons, but those (the likes of Togbui Tsali) are the people we readily point out as persons. And we give special respect to those people than the rest (Keta Men FGD). This distinguishes between ordinary persons and those with special status, like Togbui Tsali. While everyone is recognized as a person, some individuals stand out due to exceptional qualities, earning heightened respect. These figures serve as benchmarks for personhood within the cultural context. The statement suggests a hierarchy of personhood based on traits, achievements, or spiritual significance while still affirming the personhood of others. One woman agrees that those who have achieved great things in life and contributed to society are persons (Tutu Women FGD), emphasising the importance of social contributions in defining personhood. It suggests that a person's value or recognition as a "person" is elevated through significant achievements and societal impact. It also underscores the communal dimension of personhood, where an individual's value is measured by their impact on the wider community. Achievements and accomplishments were also associated with the possession of wealth. For example, participants noted that by my understanding, a person is someone who has acquired a lot of wealth or property (Tutu Youth FGD). Similarly, others observed, Yes, I believe that if you have a lot of money, then you have achieved a lot, and that makes you a person (Tutu Men FGD), while another participant stated, A wealthy man is a person (Keta Youth FGD).

These statements suggest that wealth and property acquisition play a key role in the recognition of personhood, with financial success influencing an individual's status within the community. However, perspectives differed on the extent of this influence. While wealth was acknowledged as valuable, many emphasized that its use and societal impact mattered more in defining personhood than mere possession. For instance, one participant argued, You are wealthy

but not a person because you do not use your wealth to do anything meaningful (Tutu Men FGD). This indicates that wealth alone is insufficient to define personhood; rather, a person's status is linked to how their wealth is applied for meaningful purposes. The emphasis is on contributing to others or society, suggesting that material success without a positive impact may not lead to recognition as a full person. Another participant stated, He is a person because he used his wealth to help people in need. He used the money for charity work (Tutu Women FGD). This perspective implies that personhood is tied to using wealth for the well-being of others, where acts of generosity and social responsibility play a central role in shaping one's status. Likewise, it was mentioned that,

> ...but personhood is about the inward character that makes people recommend that this man is a person. Some people have money, but they do not care about others, so people do not care about their wealth either. Personhood is about your attitude. He may give money to people, but they will just consider him as showing off his wealth (Keta Men FGD).

The above statement suggests that personhood is more associated with one's inner character and attitude than simply wealth. It implies that even if someone has money, if they lack genuine care for others, their wealth holds little value in the eyes of the community. The emphasis is on the intention behind actions, indicating that giving money without sincerity may be perceived as flaunting rather than true generosity.

The discussions on wealth led to broader conversations about other factors influencing personhood, such as rites of passage (like marriage and naming) and status roles (including royalty, family heritage, prominent titles, or gender roles). While these aspects were

acknowledged as significant, some participants emphasized that they do not automatically define someone as a person. For example, it was mentioned that:

> Outdooring and the rest do not make one a person but the lifestyle and character that the person possesses, the faithfulness (nutefewowo)[1], care and mercy that the person has is what will classify him as a person, not the outdooring and marriages (Keta Men FGD).

From the above, it is observed that rites of passage, such as outdooring and marriage, do not necessarily define personhood. Instead, it points to the importance of a person's lifestyle, character, and traits like faithfulness, care, and compassion in determining their status as a person within the community. Emphasis is placed on personal virtues rather than social ceremonies. This is equally evident here:

> Outdooring does not make one a person. It is naming that goes on during an outdooring. When they give birth to a child; he/she is a person, but the naming is just a ritual and part of the culture that is performed for the child (Keta Men FGD)

The above statement highlights that the process of outdooring itself does not determine personhood. Instead, it is the act of naming during the outdooring that is seen as a cultural ritual. According to this participant, the birth of a child already signifies personhood, while naming is considered an additional cultural practice rather than a defining factor of personhood. In agreement, a participant reiterated that it's a custom that will be followed, it does not make one a person (Keta Men FGD). The participant conveyed that the custom of naming or marriage is a practice that is observed, but it does not define or establish one as a person. This suggests that

[1] Literally "a doer of things"

customs are followed for cultural reasons, but they do not determine an individual's status as a person. Similar arguments were made for status roles, as illustrated below:

> Sometimes it appears that the one from a noble family is a person, but it is your attitude and conduct that will authenticate that (wɔ nu te*f*e). So, in general, we are all human beings but other things make society talk about someone as a person. (Keta Men FGD)

The earlier assertion seems to indicate that while coming from a noble family may give the impression of being a person, it is ultimately a person's attitude (*wɔ nu te*f*e*) and behaviour that validate their personhood. It suggests that, in general, everyone is recognized as human, but certain qualities and actions can influence how society perceives and talks about someone as a person. Another added that:

> You can bear a prominent name, but no one will mention you with that name. You can identify yourself as righteous and strong, and you should be called a person, but that will not happen because your attitude does not depict that. You can consider yourself brave, patient, or a warlord, but before people, you are a coward. You will not be called a person. It is your actions that will speak for you (Keta Elders FGD).

This means that having a prominent name or self-identifying with positive qualities does not automatically ensure recognition as a person. Instead, he emphasizes that true acknowledgment comes from one's actions and behavior. Even if someone views themselves as righteous, strong, or brave, they will only be recognized as such by others if their actions reflect those attributes. Ultimately, how one behaves will determine one's perceived personhood. Another Elder added that:

> I have also observed that if someone comes from a royal family but is without any good character, it does not automatically mean that he/she is a person. An individual can come from an unrecognized family and be considered a person than the other based on the attitude (Keta Elders FGD).

This statement suggests that having a royal background does not necessarily ensure recognition as a person if one's character is lacking. It points out that an individual's attitude and behavior are more important in determining their personhood than their family background. Consequently, someone from a less prominent family might be regarded as a person if their character is exemplary, while someone from a royal family might not be recognized as such if their conduct falls short. As such, it does not matter which family one belongs to as described below:

> ...What I know is that the attitude of someone and the way he speaks determines his personhood. It does not matter which family he comes from. Someone can come from a royal family and be no person, likewise, someone can come from a non-royal family and be no person and vice versa. So, it is not about the family (Keta Elder FGD).

The above suggests that personhood is defined by an individual's attitude and manner of speaking rather than their family background. It emphasizes that both those from royal and non-royal families can be regarded as persons or not, depending on their behavior and character. Essentially, it also conveys that family lineage is not the determining factor for personhood; instead, personal attributes and conduct are more significant.

Another status role through which personhood is understood is based on gender roles or differences. This means that the way individuals are recognized as "persons" can be influenced

by the roles and expectations assigned to them based on their gender. This is observed in the extract:

> Among the Akans, if they give birth, they ask who he has given birth to; if a boy, they say she has given birth to a person. To them, a person is a man. Among the Anlo, if you give birth to a woman, someone will come for her one day, but if it is a man, he remains in the family and will bring a woman who will come and stay in the family. So, a man is a person (Tutu Men FGD).

The above statement reflects the view that personhood may be associated more with being male. Among the Akans, the birth of a boy is seen as the birth of a person, while in the Anlo context, a man is considered to have a lasting presence in the family, whereas a woman is seen as someone who will eventually leave. This highlights a gender-based distinction in how personhood is perceived within these communities. An instance was given to further elaborate on this:

> The reason is, if something happens now, women will be there, but they will be shouting that persons should come. The person they are referring to is a man who is to come and intervene and bring peace. So, if they say a person, they are referring to a man (Tutu Men FGD).

This shows that in certain situations, the term person is culturally understood to specifically refer to men, particularly when intervening in a crisis or bringing peace. It suggests that men are seen as responsible for taking action and resolving issues, reinforcing a gendered notion of personhood. This is further illustrated by participants who noted that women are not logs of wood, but they regard men as persons more than women (Tutu Men FGD). Another participant explained that when someone has a newborn baby and says I had a person, it means the child is

male. It is painful for the woman when such an expression is used. It is not meant to be an insult (Tutu, 85-year-old man, IDI).

Like the others, the above statements imply that while women are valued and active community members, men are often regarded with higher status or recognition as *persons*. This suggests that men are afforded greater importance in certain contexts compared to women. These debates further revealed disparities between personhood and status roles, with the prominent theme being that personhood is socially determined and conferred by society. Based on these statements, personhood is not self-determined but rather requires recognition from others. For instance, participants agreed that:

> Yes, what you said is true. No one can declare himself a person. But the 'person' we refer to here is not just a human being but the one whose conduct (nutefewowo) and attitude are clear for everyone to see. That is what will prove that you are a person, so no one person can declare himself a person (Keta Men FGD).

This statement indicates that personhood is not self-declared but determined by one's visible conduct and attitude. It suggests that recognition as a person is based on how an individual's behaviour is perceived by others rather than on self-assertion. To be acknowledged as a person, one's actions and demeanour must be evident and validated publicly. As one participant explained, nobody can stand on their own and claim he is a person. Someone in the society must say it based on the conduct of the person (Tutu, 78-year-old woman, IDI). This further underscores that personhood is not something individuals can assert for themselves; instead, it must be recognized and affirmed by others in the community based on conduct. A 74-year-old participant from Keta similarly supported this view, stating that...

> That depends on those that you are in the house with; you cannot be in your own house and call yourself a person. The house you belong to and the children you are raising help you determine their personhood (Keta, 74-year-old man, IDI).

The Keta participant's statement suggests that personhood is influenced by one's relationships and roles within a household and, by extension, the community. It implies that being recognized as a person is connected to how one interacts with and is perceived by those around them. Thus, recognition of personhood may come from the family and community rather than from self-assertion. This perspective aligned with the broader discussion among participants about who can determine personhood.

Some participants asserted that personhood is conferred by figures of authority such as chiefs, elders, community leaders, and parents, as well as those with moral integrity, knowledge, and experience. Others argued that anyone in the community can recognize and confer personhood. This variation highlights the complexity of personhood, balancing authoritative and inclusive perspectives. Participants mention who they believe can confer personhood, as seen below:

> The citizens or groups an individual belongs to can say that this man is a person, and the chiefs also can say of someone as being a person. Yes, as a chief can do that. Likewise, citizens can also say whether the chief is a person or not a person. How you talk to your subject and how good you are to your people (Keta Men FGD)

The above shows that both citizens and chiefs can confer personhood, emphasizing its relational nature. A chief is recognized as a person through the treatment of subjects, just as citizens are

evaluated by their community, making personhood a mutual social construct. Another participant asserted that it was the elderly:

> Those who can say that this individual is no person are the elderly with experience. When a child is doing something, it is the elderly ones who will say that this individual is a person, and he is doing well based on what they do. No one individual can say by him/herself that I am a person; someone must endorse and recommend me as a person. Your actions will speak about you and testify of your personhood. It is others who will say you are a person (Keta Men FGD)

The recognition of personhood is largely determined by experienced elders who assess an individual's actions and conduct. Personhood is not self-assigned but validated by others, particularly those with wisdom and authority. Judgment is based on behaviour, with one's status as a person affirmed through actions that align with societal expectations. A similar view is seen below:

> Those who are good, righteous, and morally upright can determine personhood. Parents and teachers. The reason is that there is an assurance that those teaching are presenting some fact and the pastor is a trustworthy person, which is why it is those people (Keta Elders FGD)

The above statement suggests that morally upright figures like parents, teachers, and pastors are seen as credible judges of personhood. Their perceived integrity and reliability make them trusted in assessing and affirming an individual's personhood.

Participants who believed personhood could be conferred by anyone stated the following:

> No, it does not depend on those people (chiefs and other leaders in the community). Anyone can determine who is a person or not. In this era, everyone thinks differently. Maybe the chief might tell you that this individual is a person but the pastor will say something different about the same person; this person is of no value to me, and he is not a person. The chief has said good things about the person but the pastor has said otherwise about the same person (Tutu, 63-year-old man, IDI).

The statement suggests that personhood recognition is subjective and not limited to authority figures. Chiefs, pastors, and others may have differing views, reflecting diverse and evolving perspectives within the community. Another participant equally said that:

> No, when someone is made a pastor, he is likened to a president he looks after the congregation. Therefore, when any issue arises, the pastor is the one who ensures that they are settled. He organizes teaching services. Someone can inform the pastor that a congregant is sick, and he will make time to visit the sick congregant. He looks after the congregation and, therefore, the father of all the congregants. He cannot determine whether someone is a person or not (Tutu, 70-year-old woman, IDI).

The 70-year-old woman suggests that while a pastor serves as a leader and caretaker within the congregation, their role does not extend to determining personhood. This implies that personhood is assessed through other criteria, independent of a pastor's authority or responsibilities. The participant below seems to buttress this point and adds:

> Before a chief is born, there is already an elder. As an elder, a child who is under you might be made a chief. By the position given to the child, you must respect that child. In this case, who determines that the other is a person (Tutu, 63-year-old man, IDI)?

This statement suggests that respect is granted based on position, as seen when a child becomes a chief, even outranking elders. It raises questions about who ultimately determines personhood, indicating that recognition is shaped not only by age or status but by broader social and relational dynamics.

The notion that personhood is conferred suggests it is neither innate nor permanent. Participants indicate that individuals may lose their personhood status if they fail to meet societal expectations, as recognition depends on actions, behavior, and adherence to social norms. Below are some extracts;

> Yes, he can lose it because he has turned away from all the good deeds he did in the community that got him recommended by the citizens, and his attitude and behaviour have changed. So, he is no longer like he was before. That can make him lose his personhood unless he changes again before he regains it. So, personhood can be lost (Keta Men FGD).

This statement suggests that personhood is fluid rather than permanent. Individuals who deviate from the behaviours that earned them recognition may lose their status, highlighting that personhood is contingent on maintaining consistent positive conduct. Regaining personhood would require a return to the previously recognized standards of behaviour. As one participant explained, yes, someone can lose his personhood. For instance, they have ordained someone as a king because of his good deeds, and all of a sudden, he starts living a deviant life, he may lose his personhood" (Keta Elders FGD). This perspective implies that even those initially granted personhood, such as a king recognized for his good deeds, risk losing that status if they fail to uphold social and moral expectations. Another participant provided a similar example: …for instance, someone gets married, but before the marriage, he was not known to be flirting around

with women, but because of the attitude of the woman, he starts to flirt around, this has made him lose his personhood… (Keta Elders FGD).

This statement suggests that personhood can be affected by changes in behaviour, especially when it is perceived to deviate from prior conduct. In this case, the individual, once respected, loses their personhood due to engaging in behaviour like flirting, which is seen as a negative shift influenced by the dynamics of the marriage. It highlights how one's actions can impact one's social standing and recognition as a person.

Individuals who deviate from societal norms or engage in unacceptable behaviours are often subjected to discriminatory or derogatory labels. These judgments reflect how social sanctions can strip a person of status within the community. For instance, one participant noted: "At times we say the person is not well at all, he is not behaving like those using their mind" (Keta Youth FGD), suggesting that irrational behaviour is equated with a lack of sound judgment. Others drew on dehumanizing comparisons: "This person is just behaving like a dog; we use the name of an animal to qualify them" (Keta Youth FGD), or "Sometimes we liken them to pigs… if someone enters the room covered with water and mud, we will say the person is like a pig" (Keta Youth FGD). Such remarks highlight how individuals who act or appear outside social expectations may be demeaned through animal metaphors, stripping them of dignity. Similarly, derogatory terms such as "foolish and useless" (Tutu, 63-year-old male, IDI), "tying a yam (crazy)" (Keta Men FGD), "he is away from the house (eda afo)" (Keta Men FGD), and "bloody fools" (Keta Men FGD) were used to describe those considered irrational, irresponsible, or socially deviant. Collectively, these expressions reveal how negative labeling serves to distance individuals from social acceptance and recognition as full persons.

Yet, not all participants equated social deviance with a total loss of personhood. While acknowledging the prevalence of harsh judgments, some emphasized that personhood endures despite individual flaws. As one participant stated: "Yes, everyone is a person, but we all have our flaws" (Tutu, 63-year-old male, IDI). This perspective suggests that while social recognition of personhood can be diminished through negative labelling, the fundamental essence of being a person remains intact. In this way, personhood is understood not only as socially conferred but also as an inherent quality that persists despite human imperfections. This is supported by another participant who said:

> Yes, sometimes a person will be good and other times not. That is why we have good and bad; I hope you understand it now. We are all persons but we have our flaws. No one says we should take our bad deeds/character away from him or her. When someone dies and tributes are being read, only good things will be said. The evil things the person did will not be mentioned (Tutu, 63-year-old male, IDI).

The 63-year-old's remark suggests that personhood persists despite deviations from societal norms. This distinction between inherent worth and behavior implies a level of acceptance for human imperfection, emphasizing that one's core identity as a person remains intact regardless of misconduct. Similarly, the participant below believes it is upbringing, and as such, individuals are still persons despite deviating from the norm:

> "That individual is a person, but the upbringing is not good; hence, there is a lack of discipline and respect. They are persons because they are a living being, but concerning actions/deeds, they cannot be considered as persons". (Tutu, 72-year-old female, IDI)

The speaker suggests a distinction between one's basic humanity and their actions, indicating that although they may be biologically a person, their conduct might prevent them from being fully recognized as one in a social or moral sense. The inferences from all the extracts suggest that the assessment of personhood is multifaceted, influenced by cultural beliefs, ethical considerations, and the perceived impact of an individual's actions on the community.

Corporeal dimension.

The corporeal dimension of personhood emphasizes biological characteristics as the foundation of human existence. It refers to the physical aspects of being human, including the body and its functions. Participants frequently defined personhood in terms of visible features such as the brain, hands, feet, eyes, and nose. For example, one participant explained, … someone who has eyes, nose, mouth, hands, and feet. If you see these, then you have seen a person (Keta Youth FGD). Another added, It is also a person with eyes, nose, and other parts of the body (Tutu Women FGD), underscoring the belief that physical features are central to identifying someone as a person. Beyond appearance, personhood was also linked to the brain and cognitive function. As one elder stated, It is the brain or the mind that defines your personhood, and if it does not correspond to other people's view, that is why they isolate you (Keta, 74-year-old man, IDI). This reflects the view that the brain is essential to being recognized as a person, and that social acceptance may depend on whether one's mental functions align with community expectations.

In addition to physical and cognitive attributes, participants associated personhood with the presence of life itself. As one participant noted, A person is one who has life and lives on earth (Tutu Youth FGD). Others reinforced this perspective, with statements such as If you have life, then you are a person (Tutu Youth FGD) and That's why they said in the beginning that a

person is one with life (Tutu Youth FGD). Collectively, these views highlight life as the essential criterion for recognition as a person, emphasizing that being alive forms the most basic foundation of personhood.

The theme also emphasizes continuous existence as tied to bodily functions that sustain life. This is clearly reflected in the statement: To be able to breathe and have blood. You might have eyes, nose, body, etc., but without the ability to breathe, you cannot be a person (Tutu Men FGD). Such a perspective highlights fundamental biological processes, especially breathing, as essential to maintaining personhood, since they ensure the continuation of life. This idea is echoed by another participant who stated, A person is the one with breath (Tutu, 70-year-old male, IDI), further underscoring breath as the central marker of life. The connection between breath and personhood is vividly expressed by a 72-year-old female who noted: Yes, because it is the breath that gives man the energy to go about his activities. When a person dies and the breath leaves the body, the body is just dust. So that is what makes you a person (Tutu, 72-year-old female, IDI). Collectively, these accounts demonstrate that breath and by extension life itself, is considered the defining feature of being a person.

From a biological perspective, participants also linked personhood to the process of birth, presenting the act of being born as the moment when one becomes a person. One participant stated, A person is someone who has been born. A person gives birth to a person. I will give birth to a person, and so a person is someone who has been born (Tutu, 60-year-old female, IDI). This framing highlights continuity through reproduction, where personhood is passed on from one generation to the next, reinforcing the biological notion of lineage and inheritance. Another participant expanded this view by connecting personhood to traits derived from one's parents: Two people come together to form a person. So, among the Akans, there are certain traits that

you get from each parent when you are born. That makes you a person (Tutu Men FGD). Here, personhood is seen as rooted in inherited characteristics, pointing to the significance of genetic makeup. Similarly, the view that As soon as a child is born, that child is a person (Tutu Women FGD) affirms birth as the defining threshold for personhood.

Taken together, these perspectives illustrate that, within the corporeal dimension, personhood is closely tied to biological markers such as breath, life, birth, and inheritance. These accounts reflect a deeply embodied understanding of what it means to be a person, where the recognition of personhood begins with physical existence and is sustained by the continuation of life functions.

Thus, personhood is closely tied to biological traits, cognitive function, and birth, with recognition rooted in physical attributes and life events that define one's existence within the community. This cultural understanding is comprehensive, integrating physical, non-physical, and spiritual dimensions. Personhood is seen as a result of creation, reproduction, and the interplay of these elements, with metaphorical language highlighting their complexity and interdependence.

Numinous dimension. (Spiritual Dimension)

Under this sub-theme, participants reveal that an individual could be considered a person based on spiritual or transcendental qualities. This could involve beliefs about connections in the afterlife, a connection to a higher or divine power. The understanding of personhood extends beyond the physical and incorporates spiritual or transcendental qualities. Below are some extracts:

> I understand that a person is created by God, who gives us the power to exercise dominion over other creatures by manifesting the qualities He has instilled in us, such as knowledge, wisdom, understanding, and other attributes. These are the things which we must showcase for people to see and know that we are persons (Keta Men FGD).

The participant's assertion links personhood to embracing the power and responsibility given by God. Beyond biological existence, it emphasizes purposeful engagement with inherent abilities, shaping identity through action. In agreement, another participant stated that a person is the handiwork of God. God used clay to create humans, and the spirit also entered us. So, different things come together to form persons (Keta Men FGD, 2025). This reflects the belief in divine creation, where personhood is shaped by both physical and spiritual traits, aligning with religious doctrines emphasizing human sanctity and uniqueness under a higher power. The participant below provides a more indigenous perspective by adding that:

> According to the philosophy of the Ewes, man originated from somewhere. That place is thought of as being a farm so this place is referred to as 'bome'[2]. They believe that there is somebody in the farm, 'bome' (a spiritual world where humans are created) called the Bometor[3] (God) and this said person is the one who uses clay to mold what is called man. The soul is what I said earlier that the Creator breathed into man. Man is nothing when the soul departs from him (Agbotadua Kumassah, Keta).

Agbotadua Kumassah's view reflects the Ewe people's cosmological and metaphysical beliefs about human origins, particularly the idea of a divine being (God) creating humans from

[2] Bome is the ewe name for far
[3] Bometor is the ewe name for the owner of the farm

clay. This perspective emphasizes deliberate and purposeful creation, reinforcing the sacred nature of personhood within the Ewe cultural and spiritual context.

The points made by the Keta Men and Agbotadua Kumassah above highlight a deep connection of personhood to spiritual beliefs and divine creation. Individuals are seen as possessing qualities endowed by a higher power, with human creation linked to a spiritual realm. This perspective adds depth and sacredness to personhood within the cultural and philosophical framework.

Theme Two (2): Subjectivizing Mental Illness

This main theme examined participants' understanding of mental health and illness and revealed five (5) sub-themes: *construing mental health/mental illness, sources of mental illness, symptoms of mental illness, treatment of mental illness, and mental illness prevention.*

Construing mental health/mental illness.

This theme demonstrates participants' understanding of mental health and illness within the Ewe and Akan communities. Participants' interpretation of mental health and illness was multifaceted, emphasizing the dynamic interaction between societal, biological, and spiritual elements. For example, one participant explained that a mentally healthy person is a person with no mental health challenge, having the energy to go about their daily activities (Tutu Men FGD, 2025). This view aligns with the traditional medical model, which often defines health as the absence of illness. Thus, mental health is presented as a state of well-being devoid of serious psychological issues, while also highlighting the functional aspect of actively engaging in daily living. Similarly, the Tutu youth noted that mental health refers to taking care of yourself so that your actions do not cause problems for the mind. For example, overthinking about something brings no benefit (Tutu Youth FGD, 2025), emphasizing the active management of thoughts and

behaviors to avoid unnecessary stress or mental strain. Another participant further explained that when you are mentally stable, it means that you don't have any worries (Tutu Women FGD, 2025), suggesting that mental stability is defined by an absence of concerns and anxieties, linking emotional well-being to mental health. However, while emotional balance is a critical factor, this perspective may oversimplify the broader and more complex nature of mental health, which involves various cognitive, emotional, and social components.

Participants equally expressed diverse perspectives on their understanding of mental illness. For example, mental illness was described as: I am thinking that it refers to a mad person. That is what I know as mental illness (Tutu Youth FGD), suggesting that mental illness is primarily associated with visible or extreme conditions like madness, reflecting a narrow understanding of mental health challenges. The speaker seems to equate mental illness with severe disorders, possibly overlooking more subtle or less apparent mental health issues. Mental illness was also believed to be:

> My view is that a person can be healthy in the body but not when it comes to the brain. I would say the brain is not functioning correctly. The person is mentally handicapped, as our teachers have taught us. The person can use his strength when it is required, but cannot use his brain when it is required to be used (Tutu Men FGD).

Mental illness is viewed as a disconnect between physical and cognitive abilities, emphasizing its impact on thinking and reasoning rather than physical strength. This perspective aligns with the view that mental health issues originate in the brain, impairing cognitive function while leaving physical abilities unaffected. Mental illness was also associated with observable changes in behaviour: If a person has a mental illness, he/she does things anyhow. The person isn't how he/she used to be before. You will notice changes in whatever the person does (Tutu

Women FGD), suggesting that mental illness is associated with noticeable behavioral changes. The individual is perceived to act differently from their previous self, with their actions becoming inconsistent or erratic. It reflects the view that mental illness manifests through shifts in a person's usual conduct, making the changes in behavior a key indicator of the condition.

In summary, the insights gleaned from these extracts reveal that participants possess an understanding of mental health and mental illness that incorporates cultural, psychological, and behavioral dimensions. Their multifaceted descriptions indicate a blend of different perspectives, highlighting the intricate and nuanced nature of mental health and illness within their sociocultural framework.

Etiological Reflections.

Participants expressed varied perspectives on the origins and causes of mental illness, identifying several factors that may interact and contribute to its complexity. These factors included biological, psychological, spiritual, environmental, and social elements. Biological factors implicated as potential contributors to mental illness are prenatal harm, genetic predispositions, and brain lesions or malformations. For instance,

> I would say the brain is not functioning correctly. The person is mentally handicapped, as our teachers have taught us. The person can use his strength when it is required but cannot use the brain when it is required to be used (Tutu Men FGD).

The above seems to view mental illness as a dysfunction in cognitive abilities, indicating that the individual's brain may not operate effectively. The term "mentally handicapped" implies a perceived limitation in mental functioning. Furthermore, the participant highlights a distinction between physical strength and cognitive capability, suggesting that while the individual may be

physically capable, their mental faculties are compromised. This reflects an understanding that mental health can be assessed through functional criteria, focusing on appropriately utilizing cognitive resources. Similarly, another participant said, My understanding of mental illness is a person who forgets easily within a short time what he has been told, a short memory span (Tutu Men FGD), implying that mental illness is associated with cognitive impairments, particularly regarding memory. The reference to a "short memory span" suggests a concern that difficulties in retaining information may indicate an underlying mental health issue. This understanding reflects a specific view of mental illness, highlighting those cognitive functions, such as memory, that play a significant role in how individuals perceive mental health. It may also suggest that the participant views memory loss as a visible sign of mental health challenges, indicating a potential lack of awareness of the broader spectrum of mental illness. Furthermore, another participant also shared that:

> Mental illness comes at a time when there is a problem in your brain. Maybe your brain is inconsistent. Maybe when you see the plantain over there, you think it is something else. Yeah, something like that. When your mind is not exactly consistent. Even the way you talk does not go the way it is meant to (Tutu, 56-year-old male, IDI).

The statement suggests that this 56-year-old perceives mental illness as a disruption in brain function, characterized by inconsistencies in thought processes and perception. The example of misidentifying a plantain indicates that the participant believes mental illness can lead to distorted perceptions of reality. Furthermore, the mention of inconsistent speech implies that mental illness affects not only cognition but also communication. Overall, this perspective emphasizes a connection between cognitive functioning and mental health, highlighting how disruptions in the brain can manifest in various ways, affecting both thought and behaviour.

Participants provided a range of perspectives on the causes of mental illness, with various physical traumas identified as potential triggers. Traumatic brain injuries, for example, were commonly recognized as contributing factors. One participant explained that when you are in conflict with someone, and they slap you or you fall and hit your head on the ground, it can cause mental disturbances (Keta Women FGD, 2025). Similarly, another participant noted that when maybe you get injured in some manner, maybe when you sort of hit your head, it can give you mental illness (Tutu IDI, 56-year-old male, 2025). These accounts suggest that external events, particularly those involving physical harm, can play a significant role in the development of mental illness. Participants implied that mental disorders may be exacerbated or triggered by accidents or incidents that result in head injuries, highlighting the relationship between physical trauma and mental illness.

Further elaborating on this connection, one participant offered a more physiological explanation: the organs in our brain have fixed positions, so an accident can occur, and the brain can move from one place to another. This will make the brain not function as it is supposed to, and this can make the brain inactive (Keta Youth FGD, 2025). This explanation underscores the structural and functional nature of the brain, suggesting that any disruption to its natural positioning through trauma may lead to impaired cognitive functioning.

In addition to injuries, illness was also mentioned as a cause of mental disturbances. For instance, one participant explained: high fever. When that fever attacks you, you will lose control in your brain. So, that fever disturbs a lot of people, and they can no longer be themselves (Keta Women FGD, 2025). This account highlights the temporary nature of mental illness that may arise from severe physical illness, such as a high fever. The description that you will lose control of your brain implies that the cognitive and psychological effects of fever can disrupt normal

mental functioning, while the assertion that they can no longer be themselves suggests that fever-induced mental disturbances may influence not only behaviour but also one's sense of identity.

Mental illness was also believed to be hereditary, with participants recognizing that mental health issues can be passed from one generation to the next within families. Participants acknowledged the diversity in family traits, suggesting that each family possesses its own set of characteristics or challenges, some of which may include mental illness. This is seen in the extract below:

> What I have heard is that every family has its peculiar characteristics. Some are known to be intelligent, others for strength or beauty, and some have diseases that run in the family. Some also have money, while others have a mental illness running in the family. At times, that is not the case. And so, every family has what they deal with (Tutu Youth FGD).

The above implies an acceptance of the unique nature of family dynamics, emphasizing that certain families may be known for traits such as intelligence or beauty, while others may have hereditary diseases, including mental illness. This highlights the broad understanding of diversity within families, recognizing that they are shaped by distinctive features, including health-related challenges. Supporting this viewpoint, they added that, yes, some exist in families. There are some people, as they grow and mature, who may struggle a little with mental health issues (Tutu Elders FGD), which seems to indicate an awareness of how mental health problems may become more apparent as individuals age and mature, further acknowledging the complex interplay between aging and mental health/illness. It also suggests that familial mental illness can surface at different stages in life. Additionally, another participant believed that mental illness could be directly inherited: But it can be inherited from the parents (Tutu, 73-year-old male, IDI). This

reflects an understanding of the genetic component of mental illness, implying that parents can pass on mental health conditions to their children. This statement reinforces the notion that mental illness may not only stem from external factors but can also arise from biological or hereditary influences within families.

Many participants further suggested that mental illness in children could be linked to prenatal factors, such as developmental complications, brain tumours, or the mother's lifestyle choices during pregnancy, which may serve as potential risk factors. For instance, a participant mentioned that:

> Children can also be mentally ill when there is a deformity in their formation. That is, the things connecting to the brain aren't formed well, or there is a malfunction in the tissues. Those who study it, neurologists, can talk about it better if there is a tumor in the brain, a blockage preventing the easy flow of blood through the veins. The child's mental illness might also come from the mother of the child. It could be a problem with diet, exercise or other issues. This can lead to the child to developing mental illness. (Keta, Agbotadua Kumassah, IDI)

The statement from Agbotadua Kumassah suggests that mental illness in children could result from physical and developmental issues, such as improper brain formation, neurological malfunctions, or blockages in blood flow. It also implies that maternal health factors, including diet and exercise during pregnancy, may influence the child's mental well-being. It was also believed that attempted abortion could result in mental illness among children: Some pregnant women go for medication to abort their babies. After taking the medication, if the abortion is not successful, the medicine can affect the eye, ear, or the brain of the child (Tutu Men FGD). This suggests that failed abortion attempts using medication may result in developmental

complications, potentially affecting organs such as the eyes, ears, or brain. It underscores concerns that a mother's actions during pregnancy can impact a child's physical and neurological health, highlighting the perceived long-term effects of such interventions.

Drug and substance use was also believed to be a cause of mental illness, as illustrated here:

> It is caused by the consumption of hard substances like drugs and alcohol. The repeated consumption of hard drugs and alcohol causes mental illness. The substances vary. We have weed and alcohol. This time around, people lace alcohol with some substances that, when consumed, affect the brain, and the long-term effect is causing mental illness. Yeah, I was talking about weed, cocaine, and 'tramol' (tramadol). I believe 'tramol' is a prescription medicine and you will be given a dosage, which, when you stick to it, you will not have any mental health issues (Tutu Men FGD).

The participant's observation suggests that mental illness can stem from repeated drug and alcohol abuse, especially when substances like marijuana, cocaine, and tramadol are misused or combined harmfully. While tramadol is a prescription drug, its misuse is highlighted as a potential contributor to mental health challenges, emphasizing the impact of substance abuse on brain function over time. A 73-year-old man equally asserted that: Alcohol use, cigarette use, and other things, such as the use of marijuana and cocaine. They can all cause mental illness (Tutu, 73-year-old male, IDI), which also suggests a belief in the connection between substance use (alcohol, cigarettes, marijuana, cocaine) and the potential development of mental illness. This perspective aligns with common knowledge about the risk associated with such behaviours and the impact of substance abuse on mental health. The Keta Elders also noted that:

> Some are as a result how we treat our bodies because there are certain things that we must not do beyond the expectation of how God destined it, smoking, drinking, snuffing, etc. Some snuff, when taken, enters our brain and affects the brain (Keta Elder FGD).

This perspective suggests that behaviours like smoking, drinking, or using snuff can harm the brain and overall mental health. It implies that the body has natural limits, and exceeding them through substance use may lead to negative consequences. The phrase "God destined it" introduces a moral or spiritual dimension, framing these effects as potential consequences of violating divine or natural expectations.

Participants also linked mental illness to spiritual causes, such as diabolical manipulations or curses, often viewed as consequences of offending others, violating societal rules, or as punishment for transgressing cultural norms. For instance, it was believed that:

> Another way mental illness is caused is by a curse. In some cases, some families are known to have mental illness. There are people in the family tree who have suffered from it. It could be a generational thing a person's great-grandfather, grandfather, and father suffered from the same thing the person is suffering from. What I want to say is that mental illness can be inherited from a curse. The curse could be a generational curse or as a person's own doing (Tutu Men FGD).

The statement suggests that mental illness may be attributed to curses, either generational or resulting from an individual's actions. This perspective frames some mental health conditions as inherited spiritual consequences passed down through family lines or as punishments for personal misdeeds. A similar view is observed in the comment:

> The curses that my elder brother talked about are true. For example, some families only have females. The family head might go to consult an oracle or god and give a condition that, should you give us males, there will be yearly rituals for the god. If the family head did not inform any family member about this before his death, the god would start attacking the males in the family. When that happens, you will see that the females will be progressing in their respective fields of endeavor, and the males will not see progress or have mental illness (Tutu Men FGD).

The participant's statement suggests that mental illness and stagnation among males in a family may be seen as spiritual consequences of unfulfilled ancestral promises to deities or oracles. This belief implies that failing to honor such commitments can result in divine retribution, manifesting as mental health challenges or a lack of progress. Other participants further asserted, as they have said, that also exists. We have the physical aspect and the spiritual aspect as well. As they already mentioned, a person can do that to you spiritually (Tutu Youth FGD), recognizing that, alongside the physical aspect of mental illness, there is also a spiritual dimension. This suggests that mental illness may be attributed to spiritual causes, with external forces or individuals influencing a person's mental health through supernatural means. One cited reason is retribution, where those who have been wronged may spiritually inflict mental illness on the wrongdoer as a form of punishment. For instance, if you cheat someone, that person can decide to deal with you spiritually by giving you mental illness (Tutu Youth FGD). This implies that mental illness may be perceived as a form of spiritual punishment, where those feeling wronged retaliate by invoking mental illness through spiritual means. Such beliefs seem to reflect the idea that moral transgressions can lead to spiritual consequences, potentially affecting one's mental health. Another presents a scenario illustrating this:

> As we are here, we are ok here, it is just something small that will happen, and your neighbor will say 'I will show you' and you will think that he is just kidding, he has cursed you. (How will he show you?). He will not come to you; he will move away from you and enter the spiritual world. (That means he has used a charm?) yes (Keta Women FGD).

The above suggests a belief in the power of spiritual curses or charms to cause harm, even in response to minor disputes or perceived offenses. It reflects the notion that individuals may seek spiritual retaliation, highlighting a cultural perspective where interpersonal conflicts extend into the spiritual realm, with spiritual actions seen as effective in shaping outcomes. The scenario equally reflects this:

> Sometimes it comes from our friends. Maybe when we offend them, instead of them saying it so we can apologize, they will not, and in turn, they will destroy you by casting a spell on you, especially your mind. Your brain will be 'torch' (torched) so you can become mentally ill (Keta Youth FGD).

The Keta Youth's scenario underscores the belief that unresolved interpersonal conflicts, especially among friends, can lead to spiritual retaliation. He suggests that disputes may escalate into actions like casting spells intended to cause harm, particularly affecting mental health. Additionally, some participants noted that mental illness might be spiritually inflicted, not necessarily as a punishment for wrongdoing or as a response to an offense. It was attributed to hatred, dislike, or envy as seen here:

> I have heard that in spiritual illness if a person possesses an evil spirit, he/she can pass it on to you, but I have not seen such a thing before. That illness may not exist in your

> family or may not be close to you, but before you realize it, you may be affected. It can be a result of a person's detest or hatred for you that will cause them to do that. So, for the spiritual one, it exists (Tutu Elders FGDs).

This statement reflects a belief that mental illness can be transferred through the influence of evil spirits, independent of familial history. It suggests that spiritual forces may cause mental illness regardless of a person's background. The mention of detest or hatred implies that interpersonal relationships and negative emotions could play a role in spiritually inflicted mental illness. Similarly, another participant mentioned that:

> If you work with someone who is probably ahead of you in terms of the job, some people can give you mental illness. As we walk as friends, if one envies you, they can cause that to happen to you. That is why they say, 'They will not kill you but rather destroy you'. (Tutu, 60-year-old woman, IDI)

The participant's statement suggests that envy among colleagues can lead to the belief that one person may spiritually inflict mental illness on another, especially if they feel threatened by their success. The phrase "they may not kill you but destroy you" implies that mental illness is perceived as a form of prolonged suffering rather than a swift end. This view frames mental illness as a deliberate means of undermining a person's well-being over time. A 65-year-old man equally mentioned that:

> Even when a child is born, someone can spiritually buy mental illness for that child. Someone can also buy the illness for you, even though you have not wronged them in any way, just because they hate you and want to destroy your life (Tutu, 65-year-old male, IDI)

The statement reflects a belief that mental illness can be spiritually inflicted, even from birth or without personal wrongdoing. It suggests that envy, hatred, or malice may drive deliberate attempts to harm others by causing mental illness as a form of destruction. This perspective frames mental health challenges as potential consequences of spiritual attacks fueled by negative emotions.

Mental illness was also believed to be a repercussion of violating the norms of society as seen here: When you cheat on your husband, it can cause mental illness because when the house is spiritually established and you go out with a different man, you can derail from your normalcy (Keta Women FGD). It suggests infidelity, particularly in a spiritually grounded household, may lead to mental illness. It implies that violating the sanctity of marriage through cheating could disrupt one's mental stability, indicating a connection between moral conduct and mental health within a spiritual framework. Similarly, it was asserted that:

> I may say that the causes of mental illness are numerous. Sometimes, when you are a married man and your wife has an affair with another man before she returns to you, you can go mad, and they will say that the man is away from home because of the woman's actions, that Kwadzo had sex with her. Then you will be drinking, lying down on paths, and stripping yourself naked in public, and people will see you as mad. So, if you are not alert, a lot can happen to you. It may bring madness, and this one is spiritual. So, madness is caused in varied ways, and this is one (Keta Men FGD).

The above suggests a belief that marital infidelity, particularly by a wife, can negatively impact the husband's mental health. This perspective, rooted in spiritual beliefs, implies that such actions may lead to emotional and psychological disturbances. The reference to madness indicates a perceived loss of control or behavioral changes, possibly viewed as a spiritual

consequence of the wife's actions. Also, another participant cited that, When you take something that does not belong to you, the owner can take you to a god for that to be done to you. Then, it (mental illness) will happen to you (Tutu, 73-year-old male, IDI). This perspective links taking something without permission to the onset of mental illness, reflecting a cultural belief in the spiritual consequences of unethical behavior. It suggests that such actions may invite retribution, with mental health issues seen as a form of punishment or correction for moral transgressions. Similarly, another participant noted that unfulfilled promises to a god could result in spiritual punishment:

> Some are from the family. For example, when they have a covenant with a god and do not fulfill their promises, that God can place a sickness on the family in anger, and that whole generation will be affected, be it sickness or mental illness. (Keta Youth FGD)

The above further reinforces the belief that mental illness may be spiritually induced because of moral or spiritual violations. Subsequently, participants highlight what type of methods are used to inflict mental illness spiritually such as the use of potions, charms, or invoking spirits. This reflects a broader understanding of how spiritual practices and rituals may be employed to inflict or alleviate mental illness, depending on the intent of those involved: Yes, it happens, we say they have charmed the person. They use charms on the person through the spirit, and it reflects physically. There are different ways they charm people (Keta Youth FGD). This suggests the belief that mental illness can be caused by spiritual manipulations through the use of charms. It suggests that these spiritual actions are believed to manifest in the physical realm, influencing a person's behaviour or mental health. Another participant mentioned that some use potions or cast spells. Even water is used in several ways to charm people. If the spirit is working, the body cannot see it; it will curse the person (Tutu, 60-year-old woman, IDI), which suggests a belief in

the use of various substances, including potions and water, as tools for spiritual manipulation. It implies that these practices can lead to unseen spiritual influences affecting an individual, potentially resulting in negative outcomes or curses and, by extension, mental illness. Similarly, it was mentioned that someone can invoke some spirits on you that will give you a mental illness, or you will be summoned by a spirit to give you mental illness (Keta Women FGD). This reinforces the notion that external spiritual forces can be used to target individuals intentionally, further contributing to the understanding that spiritual actions and rituals are believed to have tangible effects on mental health.

While many believed that mental illness had spiritual underpinnings, others presented contrary views and argued that mental illness could not result from spiritual manipulations:

> Spirits do exist. We cannot say that spirits do not exist. As for me, I don't believe it. If you do not get it because it runs in your family, and if you also don't go out to buy it and use it... Spirits indeed exist, but for me, I don't believe in a spiritual cause. Everyone has what they believe in. For that person, that is his/her belief. But I don't have that belief. For that, I don't think it is any spirit. I know spirits do exist, but I don't believe it. (Tutu, 60-year-old female, IDI)

The above statement presents a nuanced view of spirits and their alleged influence on mental health. While acknowledging the belief in spirits, the participant remains skeptical about their direct role in causing mental illness. This highlights the diversity of perspectives, suggesting that while some attribute mental health challenges to spiritual factors, others consider familial or personal experiences as more plausible explanations. This comment further supports her statement: I do not believe that it is caused by a spirit. Rather, it is how you live your life and how well you live with others (Tutu Youth, FGD). This viewpoint attributes mental illness to

lifestyle choices and social relationships rather than spiritual causes. It emphasizes personal responsibility and social harmony, suggesting that an individual's behavior and interactions play a more significant role in mental well-being. This perspective shifts the focus from spiritual explanations to tangible, everyday factors in understanding mental health.

In line with this, mental illness is also thought to be influenced by negative life experiences, such as death, stressors, or circumstantial events, which can disrupt thought processes and contribute to mental health challenges. Together, these perspectives highlight an understanding of mental illness that combines both personal and environmental influences. For example,

> Mental illness can occur when one overthinks or when something unexpected happens. For instance, if you put something valuable somewhere and you are informed that someone has stolen it, how you will think about it may cause mental illness (Keta Men FGD).

The assertion by the Keta Men suggests that mental illness may stem from overthinking or unexpected stressful situations. Distressing events, such as losing something valuable, can trigger intense worry or emotional turmoil, potentially leading to mental health difficulties. This highlights the link between external stressors and mental well-being, emphasizing that mental illness can arise from everyday life experiences. Similarly, pain was described as another negative life experience that could result in mental illness: Pain is also a contributing factor. When someone does something that hurts or causes you pain. That is what makes you ruminate until your mind becomes hot (Tutu Youth FGD) The statement suggests that emotional pain or hurt caused by someone's actions can lead to persistent rumination (often unproductive thinking about the causes or consequences of one's emotional state (Ehring, 2021), which may escalate

into mental distress. It highlights how unresolved emotional pain can affect a person's mental state, potentially contributing to mental health challenges when the mind becomes overwhelmed by the intensity of these feelings. Another instance that was given was:

> For example, a shock from a misfortune. When something unexpected happens to you, it can also cause mental illness. For example, when you leave your home for work in the morning and come back to find out that your home has been burnt down and this resulted in the loss of a loved one, your wife, or child. It can take you into that situation (Tutu Youth FGD).

The above highlights how traumatic events, such as the sudden loss of loved ones or property, may cause overwhelming emotional distress, potentially leading to mental health issues. It emphasizes the role of life-altering experiences in contributing to psychological challenges, showing the connection between emotional shocks and mental illness. Another agreed that:

> What they have listed is also true. When someone loses a loved one or something valuable, it makes the person start to worry and think too much. Such a person might not respond to your greeting. You can see the person looking at you in the face but has not heard what you are saying. When this continues, it can result in mental illness (Tutu Men FGD).

They highlight how significant losses, whether of a loved one or something valuable, can lead to excessive worry and preoccupation, affecting mental well-being. The example of someone not responding to greetings or appearing disconnected suggests that emotional distress may cause detachment from their surroundings. If prolonged, such stress can contribute to mental health challenges, emphasizing the link between emotional distress and visible behavioral changes.

Evidently, mental illness is a complex and multifaceted phenomenon that has been explored through various lenses, including biological, psychological, and sociocultural perspectives.

Representations (unipolar conceptions of the presentation of Mental Illness).

This sub-theme, drawn from participants' perceptions, presents how mental illness is believed to manifest. Some participants indicated that these challenges are reflected in aggressive behavior, disheveled appearance, incoherent speech and actions, and a loss of personal control or autonomy. It was cited that:

> For example, it can happen that you don't know the person, you have not seen him before. As you people are speaking to us, the person keeps interrupting people's conversation without any provocation, and he is not allowing other people to talk, this indicates that the person is not normal (Keta Men FGD).

The comment highlights the perception that interrupting conversations without provocation and preventing others from speaking may be viewed as a sign of abnormal behaviour, potentially indicating mental health challenges. This observation reflects how certain social disruptions are linked to perceptions of an individual's mental well-being. It was further elaborated that:

> Too much talking is a symptom, and what is being said too has no substance. Never-ending what he has said, and the talking is not directed at anyone. Another symptom is stripping naked among people and not be shy about it (Tutu Men FGD).

The comment above highlights behaviors like excessive, incoherent speech and inappropriate actions, such as undressing in public without any sense of shame, as signs associated with mental illness. These actions are viewed as outward expressions of underlying psychological or emotional disturbances. Additionally, the mention of: …the way of dressing and walking shows

that the person is not normal. The person can wear anything and go naked the whole day roaming the town (Tutu Men FGD) emphasizes the connection between noticeable changes in appearance, such as dressing inappropriately or being naked in public, and mental illness. These visible signs suggest a loss of self-awareness or disregard for social norms, often perceived as symptoms of mental illness within the community. Other indicators include actions like: The person picks up food on the floor (Tutu Men FGD), which suggests a disregard for basic hygiene and social conventions, which can be perceived as a reflection of the individual's altered state of mind or cognitive functioning. Further reinforcing this, it was stated that: When you live with someone who is developing mental illness, and you are observant you can tell. The actions of the person in the house will tell you that there is something wrong with the person (Tutu, Men, FGD), making behavioral changes in daily activities noticeable early on. This focus on visible signs inadvertently highlights a gap where individuals not showing obvious symptoms may go unnoticed.

Treatment Regime.

This sub-theme examines perspectives on mental illness treatment, including its curability, who can provide care, available treatment methods, and participants' openness to these approaches if they were to experience mental illness. It also explores how individuals recognize when someone has recovered. A few participants expressed the belief that mental illness could indeed be cured, as illustrated by the statement: Yes, it can be cured (Tutu Youth FGD) reflecting a sense of optimism in the possibility of recovery, which stands in contrast to the view that mental illness is a permanent or untreatable condition. It suggests that, within the community, there is recognition of the effectiveness of certain treatment approaches, and with

the right interventions, individuals can return to a state of well-being. This perspective was also evident here:

> We can eradicate it. As we sit here right now, we can eradicate it. I say that because, at first, we were not so knowledgeable. But now we can eradicate it. All you have to do is to follow the procedure. You will go to the hospital as required and take medication as prescribed by the doctor. If you think you cannot do that, Pantang Hospital is available. You can take them there. They will take care of the person for you so you can be free. (Tutu Youth FGD)

This assertion highlights an increasing awareness of mental health treatments within the community, indicating a shift from traditional beliefs toward modern medical approaches such as hospital care and prescribed medications. It reflects growing confidence in the healthcare system's ability to provide effective treatment and a sense of optimism about recovery through established medical interventions. Another participant also believed in the possibility of curing mental illness but emphasized faith: Yes, it can be cured. For believers, everyone knows that there is nothing difficult for the Lord to do (Tutu Youth FGD). This underscores the coexistence of faith-based perspectives alongside medical approaches, where divine intervention is seen as an essential component of the healing process for those who hold strong religious beliefs.

Together, these views suggest that treatment for mental illness is viewed as possible and achievable through both medical and spiritual channels, fostering a hopeful and multifaceted attitude toward mental health recovery. This balance between faith in modern healthcare and spiritual belief systems reflects the diversity of approaches within the community, reinforcing optimism about the healing potential.

Some participants believed that mental illness was a persistent, unchangeable condition that could not be cured. For instance, one stated, Madness is continuous and there is nothing you can do about it (Tutu Youth FGD). This perspective reflects a fatalistic view, suggesting that once someone experiences mental illness, recovery is seen as impossible. Such beliefs may be fuelled by a lack of information about effective treatments, societal misconceptions, or the stigma associated with mental health challenges, potentially leading to a sense of hopelessness regarding improvement. Building on this, they shared that:

> No, it can't be cured because people who are cured still have something within; that's why they are still put on drugs when they are ok. It is not like malaria, because if I fall sick and go to the hospital and am cured if the symptoms are not there, no medicine would be given again (Keta Youth FGD).

This comment underscores a belief that even after apparent recovery from mental illness, a residual condition persists, necessitating ongoing medication. It suggests skepticism about the possibility of complete healing, reflecting broader societal attitudes toward mental health. The idea that something remains within the individual reinforces concerns about relapse and the long-term management of mental illness rather than a definitive cure. Another elaborated on this view:

> The reason is that the mind is what controls the body. When the mind develops a problem and is treated, the person will still think, so it will remain. That is what causes the remnants. For a mental illness to be cured in someone, like for example a teacher, and for him/her to go back to work, I haven't heard that before (Tutu Youth FGD).

This perspective highlights the perceived complexity of mental illness and the challenges associated with full recovery. The notion of "remnants" implies that even after treatment, traces

of the illness may linger, influencing long-term well-being. Additionally, skepticism about reintegration into professional life suggests broader societal concerns about the reliability of recovery. These attitudes reveal a contrast between optimism about mental health treatment and a more cautious or doubtful stance on whether complete healing is possible.

A section of participants acknowledges that while mental illness may not be fully curable, its effects on individuals can be minimized. This perspective is illustrated in the remark: There is a saying that, even if they cannot cure it, they can reduce it (Worowso). But if you look at it deeply, a day will come when their actions based on an issue will show (Tutu Elders FGD). The phrase "it can be reduced" (worowso) highlights a recognition that mental health conditions can be managed or alleviated to some degree. However, the caution expressed suggests an understanding of the potential for these challenges to resurface, indicating the complexities associated with mental illness. This implies a heightened awareness of the long-term consequences and the multifaceted nature of these conditions, which may not be entirely resolved. This was emphasized here: Right now, you would think the person has recovered, but it will get to a time that the things this person will do, all you will say is ‘ei this guy.’ It means the illness is still there (Tutu Elders FGD). This statement suggests that mental health recovery is not always straightforward, as individuals may exhibit behaviors over time that hint at lingering or recurring issues. The phrase "ei this guy" reflects a mix of surprise and concern, indicating that unexpected actions can raise doubts about the stability of one’s mental health. This highlights the importance of long-term observation and assessment, emphasizing that recovery should not be judged solely on immediate improvements but rather on sustained well-being over time. Another stated, I haven’t heard such a thing before. Even if it is treated, it will return. A little stupidity will still manifest (Tutu Elders FGD). This perspective reflects skepticism about the

effectiveness of treatment for mental illness, possibly stemming from a lack of exposure to success stories or information regarding effective interventions. The phrase "I haven't heard such a thing before" signals a gap in knowledge about the potential for recovery, emphasizing how limited awareness can shape beliefs about mental health and its treatment.

Together, these insights illustrate a nuanced understanding of mental illness within the community, acknowledging both the potential for management and the challenges that come with it. They highlight the need for ongoing education and support to shift perceptions and improve treatment outcomes for those affected by mental health issues.

Most participants emphasized various factors that affect the ability to treat mental illness, primarily centred around its aetiology, which is identified through various methods. They indicated that a form of 'diagnosis' occurs to ascertain the cause of the illness and whether it can be treated before seeking assistance, as demonstrated in the following excerpts. For example, it was noted that:

> The first step is to sit down and think about the origins of the problem and whether it has happened before. After that, you will know the next step to take, and then you can approach the herbalist for help (Keta Men FGD).

The Keta Men's assertion reflects this method of investigation, where understanding the origins and past occurrences of the issue informs the choice of treatment. It implies that individuals may first engage in careful thought before deciding whether to seek alternative help, such as from an herbalist. They further explain how this investigation is done:

> You can do a personal investigation, but we have another one that is paying a visit to spiritualists to investigate for you through soothsaying or divination. It is in different

> forms, they use mirrors, water, and priests who are in a room, where they will invite your soul and query him about what is happening to you (Keta Men FGD).

This demonstrates that in certain contexts, individuals may rely on both personal inquiry and spiritual methods, such as soothsaying or divination, to uncover the cause of a problem. It suggests that these traditional practices, which involve symbolic tools like mirrors and water, play a role in providing insights that might be otherwise unavailable. It was also stated,

> That is what we are saying that our grandfathers received some deity, and at times it comes from what we eat, but in case a sickness just befalls someone and the cause is unknown, those in the field of traditional worship trace the route of the sickness; it can be cured. But if it is something done by yourself, there is nothing that could be done (Keta Men FGD).

This comment highlights the multifaceted nature of mental illness, acknowledging influences from ancestral deities and dietary factors. It also underscores the role of traditional healers and spiritual leaders in diagnosing and treating illnesses of spiritual origin, suggesting a reliance on spiritual expertise in the community. The idea that an unknown cause can lead to a curable condition, while self-induced issues may be beyond remedy, reflects the complex beliefs surrounding interventions in mental health. Another participant elaborated on spiritual consultations from the Ewe perspective: Ewes do consultation through our god to discover what it is before we decide to go to a hospital or herbalist (Keta, 74-year-old male, IDI). His statement suggests a cultural practice where spiritual guidance is sought before making decisions about health care. The emphasis on consultation implies a belief in the spiritual realm's influence on health decisions and reflects a preferential order in choosing treatment options based on insights

gained through spiritual consultations. The role of family elders in determining the source of mental illness was also emphasized:

> ...if there is an elderly person in the house who knows something about the family, you have to consult him to see if someone has suffered such a disease before. If it happened before, it means that the sickness has returned, but if no one has suffered such before, then it is a spiritual thing (Keta Men FGD).

This statement suggests a cultural reliance on the knowledge of elders in diagnosing health issues. Consulting an elderly family member indicates a belief that previous occurrences of an illness can inform whether the current condition is a recurrence or has a spiritual cause. It reflects the community's view that health issues may have familial or hereditary links and emphasizes the integration of spiritual beliefs in their understanding of mental illness.

Thus, participants indicated that the perceived curability of mental illness is influenced by its aetiology, traditional beliefs, and consultations with spiritual leaders and family elders; suggesting a complexity in cultural beliefs and practices that shapes treatment decisions.

Some participants identified various healers they believed could treat mental illness, including pastors, doctors, herbalists, and spiritualists a noted here: Well, some of the illnesses are physical and spiritual, so the spiritual is by the herbalist and pastors, and the physical are by doctors (Keta Youth FGD). This highlights the dual nature of mental illness, recognizing both physical and spiritual factors. By attributing the treatment of spiritual aspects to herbalists and pastors, the participant reflects an understanding encompassing both traditional and religious healing practices. Another group echoed this belief: Herbalists and other people cure mental illness. There are people like that who God has given those gifts, and they know herbs that cure

those illnesses (Keta Men FGD). This reinforces the community's belief in the efficacy of herbal medicine and the belief that certain individuals possess divine gifts for healing. This suggests that spiritual forces are integral to their understanding of mental health recovery. Further, another participant emphasized the role of pastors: It is cured by pastors or God through pastors. It is caused by a family spirit or any other spirit, so the pastor will pray and see the origins of the sickness (Keta Women FGD), equally indicating that mental health issues are viewed not just as medical concerns but also as spiritual matters requiring intervention from religious figures. The reliance on pastors for understanding and alleviating mental illness further illustrates the community's reliance on divine intervention and the importance of spiritual practices in recovery. In contrast, some pointed to hospitals as a viable option for treatment: It can be cured through, for example, hospitals. You can take the person there, where he/she will be questioned about how the illness started (Keta Elders FGD). This reflects trust in medical institutions and emphasizes the importance of thorough assessments in understanding mental health conditions. Their beliefs in various healers, from medical professionals to spiritual leaders, offer a dynamic interaction between biomedical and traditional healing practices. Recognizing these perspectives is crucial for healthcare providers to engage with patients in culturally sensitive ways, honouring their diverse beliefs and treatment preferences. This understanding also underscores the need for integrated approaches to mental health that accommodate both spiritual and medical dimensions.

Participants mentioned various methods for treating mental illness, as seen in the following statements. Spiritual approaches included, Through fasting and the traditional people use herbs (Keta Women FGD). Fasting, often tied to spiritual or religious practices, and the use of herbs is suggested as some of the methods that are considered effective in these contexts. This suggests a blend of spiritual and traditional methods, reflecting the holistic view of healing

within these cultural contexts. Similarly, the use of herbs was mentioned*:* First there are herbs they use for them. There are some they smash and squeeze into their noses and at times they drink it which stimulate them to sleep to avoid stress they are passing through (Keta Men FGD). This method is also believed to be effective in treating mental illness. Another instance of spiritual treatment was described: I have seen that before where the person was taken to see a spiritualist and was chained. The spiritualist did everything possible, the person was healed and was able to go back to their job (Tutu Elders FGD). The chaining likely represents some form of restraint, and the participant's observation that the individual recovered enough to return to work underscores the community's belief in the effectiveness of spiritual interventions. The role of pastors in providing "direction" was also noted: The pastors will provide 'a direction.' They will let you buy some items. They will show you what to do and how you should do it (Tutu Youth FGD). This emphasizes the role of spiritual leaders in offering guidance and rituals for healing. By following the prescribed actions, individuals may feel they are actively participating in their recovery. In contrast, a medical perspective was introduced: I have heard that they are given medication at the hospital which will take them back to their original state (Tutu Youth FGD). This statement reflects a recognition of the role of medications in treating mental illness and suggests confidence in the potential for biomedical interventions to restore mental health. Similarly, physical health was connected to mental illness: At times what we eat also causes mental illness when there is a mismatch. With the blood, if it is identified at a hospital, medicines are given, and it cures it (Keta Men FGD). This view suggests that diet and physical health are seen as contributors to mental well-being, with the hospital's intervention considered essential for recovery. Together, these perspectives illustrate the community's belief in a range of treatment

options—from spiritual to biomedical—highlighting the importance of culturally sensitive approaches that recognize both traditional and modern healing practices.

Participants shared their views on determining whether mental illness has been cured, offering nuanced perspectives:

> People who develop mental illness and are treated are sometimes able to come back to their normal state as they were before. Others may be cured and will still be unable to go back to their original state, which shows that they have not fully recovered (Tutu Youth FGD).

This perspective acknowledges that mental health recovery is not always a straightforward process, as individuals may experience varying degrees of restoration. While some may regain their premorbid state, others might continue to experience residual effects despite being considered "cured." This understanding challenges the notion of absolute recovery, instead emphasizing a spectrum where improvement is possible but may not always mean a complete return to one's previous mental state. It highlights the nuanced and individualized nature of mental health recovery, reinforcing the importance of continued support and monitoring. Similarly, behavioural changes could signal a recovery: When the person's weird behaviours are cured, we can say the person is back to normal life (Keta Youth FGD). This emphasizes observable behavior as a key indicator of recovery, suggesting that a return to socially acceptable or expected behavior is considered evidence of mental well-being. Another perspective reinforces this focus on pre-morbid characteristics: You know a person's original nature before he/she develops a mental illness. And so, after they are cured, you will know by their nature (Tutu Youth FGD). Here, it suggests that recovery involves the re-emergence of an individual's "original nature," implying that mental illness can obscure core aspects of

personality or behavior. There is an expectation that recovery will bring about a return to these intrinsic qualities.

This perspective highlights the need for a culturally sensitive and holistic approach to mental health recovery. It suggests that recovery is not solely about symptom reduction but also about restoring an individual's core identity, behavior, and personhood. For mental health practitioners, this means integrating biomedical, psychological, and socio-cultural considerations when assessing recovery. Recognizing these varied interpretations can help in designing interventions that align with patients' beliefs and lived experiences, ultimately fostering better engagement and long-term well-being.

Mental illness prevention.

This sub-theme explores participants' views on whether mental illness can be prevented and the measures that could potentially aid in the prevention of mental illness. Some participants expressed skepticism about the full preventability of mental illness as noted here: ... So, this sickness cannot be prevented unless God (Keta Men FGD). This statement reflects a belief in divine intervention as the primary means of prevention, highlighting a sense of human limitation in controlling or avoiding mental illness. It suggests that some participants view mental health as being influenced by forces outside of human understanding or ability, emphasizing reliance on spiritual or divine factors in matters of health. Another participant also explained that: Oh, just as we cannot prevent all physical illness, it has the potential to develop. I am not sure we can prevent all mental illnesses from developing. I don't think it is possible (Tutu, 56-year-old male, IDI). This remark reflects an understanding of the complexities of mental illness, suggesting that, like physical illness, it may arise despite preventive measures. The participant's viewpoint implies that while some factors contributing to mental health problems may be managed, others

may be inevitable or unpredictable. This idea was further emphasized, pointing to societal and behavioral causes of mental illness:

> There is nothing we could do to prevent it... some people conspire against others... It can also be that some people smoke marijuana from infancy, and it does not lead to anything, but others take it, and they become abnormal (Keta Men FGD).

This view demonstrates the role of external factors, including social pressures and behaviors, in contributing to mental illness. It suggests that while some causes might be preventable, others may not be within an individual's control, adding complexity to the idea of prevention.

Other participants took a more moderate stance, acknowledging that while not all mental illnesses can be prevented, the risks can be minimized: I think it cannot be prevented, but it can be minimized because... some are through our behaviors, so if we are educated on the dangers of smoking and the likes, it can be minimized (Keta Youth FGD). This perspective highlights the potential of education and awareness in reducing the incidence of mental illness. By informing individuals about the risks associated with certain behaviors, such as substance use, the participant implies that prevention efforts can still reduce the likelihood of developing mental health issues.

On the other hand, some participants disagree with the above assertions and believe that mental illness can be prevented. For example, this participant offers a more assertive stance on the preventability of mental illness: Though our brother stated earlier that it cannot be prevented, I think it can be... If we work hard to prevent those things, most of the mental illnesses will be eradicated (Tutu Youth FGD). Here, the participant challenges the belief that mental illness is inevitable, arguing that individual and collective efforts, such as avoiding harmful behaviors like

drug use, can significantly reduce its occurrence. The statement highlights personal responsibility and self-awareness as key factors in prevention. Another participant emphasizes the role of personal choices and actions in prevention: As my mother said, if you take illegal drugs... if you are given advice and you listen and stop using such drugs, any treatment you are given should stop it (Tutu Elders FGD). This view underscores the importance of individual responsibility and proactive behavior, such as avoiding harmful substances and following advice, to prevent potential mental health issues. The participant also acknowledges the role of generational advice and cultural norms in shaping health practices. Similarly, another participant stressed the role of avoiding harmful behaviors in preventing mental illness: One should not engage in such activities with the use of illegal drugs, alcohol abuse, and overthinking. I believe that if you reduce all these things, it will help your body and help your mind as well (Tutu, 60-year-old woman, IDI). This perspective advocates for adopting positive lifestyle choices and avoiding substances and behaviors that could harm both physical and mental health. The speaker suggests that self-care and responsible behavior can reduce the risk of mental illness, emphasizing the connection between bodily and mental well-being.

Participants also noted the importance of addressing thoughts and seeking help as preventative measures against mental illness. For instance, they mentioned that, we can do that by not ruminating and thinking about unnecessary things. Like, for example, when a person argues with someone else, he/she will continuously think about it. That is unnecessary (Tutu Youth FGD). This remark highlights the significance of managing one's thoughts, particularly avoiding rumination on trivial or negative matters. It points to an understanding of the cognitive aspects of mental health, suggesting that regulating thought patterns may play a role in preventing mental distress. Building on this point, one added: As we sit here with no mental

illness and know the things that cause mental illness, you must stay away from such things... there is even a saying that overthinking kills the spirit (Tutu Youth FGD). This underscores the importance of being proactive in mental health prevention by recognizing and avoiding behaviors known to contribute to mental illness. The cultural saying emphasizes the harmful effects of excessive rumination, reinforcing the need for self-awareness and mental discipline in maintaining well-being.

In addition, participants identified external support and self-care as important preventive strategies a seen here: If something hurts your feelings and you think about it to a point where you become helpless in life, there are talk shows on TV or books... It will then tell you what to do and help you gradually (Tutu Youth FGD), highlighting the value of seeking guidance from external resources like TV shows and books to cope with emotional pain. This perspective suggests that individuals can find solutions and comfort in accessible, external supports, which may help them manage distress and regain control over their emotions.

In summary, the participants' perspectives on mental illness prevention reflect a range of views, from personal responsibility and lifestyle choices to the acknowledgment of external and uncontrollable factors. These insights suggest the importance of adopting a multifaceted approach to mental health, combining individual behavior change, education, and broader social support systems.

Theme Three (3): Implications for Personhood in Context

This theme explored the connection between mental illness and personhood, focusing on how mental illness impacts an individual's sense of self and their overall experience as a person. It reflected participants' views on how individuals with mental illness perceive themselves, how they are viewed by others, and how they should be treated. Additionally, it highlights that, within

certain cultural contexts like the Ewe and Akan settings, actions that may appear as mistreatment toward individuals with mental illness could arise out of necessity. The theme also emphasized the positive role of performative elements in helping restore a sense of lost personhood.

Human Rights Abuses.

How people living with mental illness are treated reveals differing perspectives on some harsh measures employed. Participants recount instances that have necessitated the use of chains, starvation, and physical restraint. For example, it was explained that: … if the person rebels against people [community members] they chain him, but they are not starved. The chaining is done so that they can give them medication. But fasting and others, I have not heard it before (Keta Men FGD). Here, the participant highlights physical restraints to prevent harm to others, clarifying that it is not meant as punishment but to enable medication to be administered. This statement reflects an approach where physical control is seen as a necessary part of managing mental illness within the community. However, it also raises ethical concerns about the use of force and whether alternative, less restrictive interventions are being considered. The absence of awareness regarding practices like fasting further suggests a limited understanding of diverse mental health treatments within their cultural context. They also explained the need to disregard the person's autonomy under certain circumstances:

> … You can only talk about something if you have experienced it. The way they [Mentally ill] become, you cannot approach them. You have to use force to attack them. If you want to regard their personhood, you cannot excel in what you want to do, so, he must be chained before the medicine is given to him. When the medicine is given for the first time, he will be feeble. They are not chained always. Even if they are chained and

> the rebellion subsides, they leave them freely, but if you think that you are suppressing his personhood, you worsen the case (Keta Men FGD).

This statement presents a pragmatic view, where the aggressive and unapproachable nature of some mentally ill individuals is seen as justification for using forceful methods like chaining to ensure effective treatment. The participant argues that if one focuses too much on respecting the person's autonomy, it may hinder necessary interventions, implying a perceived trade-off between effective management and respecting personhood. It was also agreed that:

> It depends on the kind of illness they are suffering from. In case someone is sick, and he is calm but others come, and they start beating you. As the one curing the illness, will you allow him to beat you? You will surely beat him or tie him (Keta Women FGD).

This above illustrates the use of force as a reactive measure, where the perceived threat posed by the individual with mental illness calls for intervention, such as physical restraint. It acknowledges that the type of mental illness and the severity of the individual's behavior may necessitate varying degrees of control to protect both the individual and those around them.

While forceful methods like chaining are viewed by some as necessary to protect others and ensure treatment, there is a tension between these practices and the respect for the personhood of individuals living with mental illness. Participants express different opinions about the treatment of individuals with mental illness, revealing a mix of acceptance and condemnation of these practices. Some consider these methods as necessary to facilitate treatment, while others view them as degrading and inhumane, essentially violating their human rights. A key issue highlighted is the impact of delayed or insufficient medical intervention, which may lead communities to adopt alternative, sometimes harmful, strategies for managing

the behaviour of those with mental health conditions. For instance, a nuanced view on treatment methods is seen here: To me, the marking aspect I think is ok, but the beating is not good, and chaining is not an abuse because if not, you cannot be cured (Keta Youth FGD). This statement suggests that while certain actions, like marking or chaining, might be acceptable in the context of treatment, physical violence is seen as crossing a line. The distinction made between what is appropriate and inappropriate reflects a cultural perspective where some restrictive measures are justified as necessary for the individual's recovery. This belief highlights the tension between ensuring effective treatment and upholding ethical standards in mental health care. Similarly, the notion that chaining diminishes personhood was dismissed: They are not humiliating his personhood (Keta Women FGD). Here, chaining is framed as a practical step rather than an affront to the individual's dignity. This perspective implies that even though such measures may appear extreme, they are considered necessary to safeguard the well-being of the person and those around them. This is further supported by the statement: Yes, if it is not done, the treatment they are to give them cannot be given. So, it is not an abuse (Keta Youth FGDs). This participant suggests that restrictive measures are justified as they enable treatment, implying that the ends (delivering care) justify the means, even if those means might appear restrictive or harsh.

In contrast, other participants express concerns about the ethical implications of such treatment. For example: Please, no. It is not right to allow a person with such a condition to starve or to keep them in chains. It will not help the recovery (Tutu Elders FGD). This participant opposes starvation and chaining, emphasizing that these practices do not support recovery and suggesting that they violate the individual's dignity as a person. The emphasis here is on humane treatment and the need for care approaches that promote well-being rather than causing harm. This sentiment is echoed here:

> Yes, it is a violation... But because we don't take them to the hospital and rather take them to prayer camps... the pastor doesn't want the person to cause problems due to their misbehaviour and so would chain their legs (Tutu Youth FGD).

The participant above points to a specific context (prayer camps) where chaining is used in place of medical treatment. They argue that the lack of access to appropriate medical care leads to the use of harmful practices, such as chaining, which not only restricts personal freedom but also violates the rights of individuals with mental illness. Further emphasizing the human rights aspect, it was said that: That is starving the person and a form of abuse because no one knows what the cause of the illness is. So, refusing to give the person food can worsen the sickness (Keta Youth FGD), highlighting the harmful effects of denying basic needs, such as food, to individuals with mental illness. The participant suggests that such actions, without a clear understanding of the illness, may worsen the individual's condition, underscoring the importance of comprehensive care that includes proper nourishment and support.

The implications of these perspectives reveal a complex understanding of personhood and the management of mental illness in settings where medical resources may be limited, and cultural beliefs play a significant role. This accentuates the need for a more comprehensive and humane approach to mental health care that balances traditional practices with ethical standards, ensuring that the rights and dignity of individuals with mental illness are upheld.

Participants also discussed the reasoning behind the use of some inhumane treatments, such as chaining, as a means of protection for both the individuals and those around them. For instance: They are put in chains because the person might be a bit unstable and would hit someone with any object in sight, causing an injury. That is why they put them in chains (Tutu Elders FGD). This statement reflects a safety concern, indicating that chaining is perceived as a

necessary precaution to prevent harm to others. Another added: Some of them can run away. They can run away and cause problems for you (Tutu Elders FGD), suggesting that chaining is also used to prevent individuals from escaping, which could lead to further complications or harm to the community. This approach was further justified: Due to the illness, the person is misbehaving... you have to put them in chains... till you observe that they are no longer behaving the way they used to. Then you have to release them (Tutu Elders FGD). This highlights a belief that chaining is a temporary measure, necessary to protect both the individual and caregivers, until the individual shows signs of improvement. The rationale behind such actions is framed as protective rather than punitive.

Another recurring theme was that many individuals placed in chains may not be fully aware of their circumstances due to a diminished state of consciousness. For instance, they stated, If they put me in chains, I will not realize it (Tutu Elders FGD). This highlights a form of psychological detachment or lack of awareness, where the individual may not recognize the constraints placed upon them during their mental illness. Another echoed this sentiment: Unless you regain some form of awareness. That is when you will realize that you are in chains (Tutu Elders FGD), suggesting that once individuals regain awareness, they become more conscious of their surroundings and may feel the impact of the limitations imposed on them, which could lead to feelings of humiliation or a loss of dignity. The condition itself seems to impair the ability to perceive external restrictions, as noted here: As an ill person, how would you know you have been chained at that time? You wouldn't know. A mentally ill person at that time would not know (Tutu Youth FGD). This points to the significant challenge that individuals with mental illness face in recognizing their circumstances, including any imposed constraints, further complicating the management of their condition.

Beyond treatment, participants expressed their views about the reintegration of individuals with mental illness into society. In terms of employment, Participants shared varying perspectives on the reintegration of individuals with mental illness into society, particularly concerning employment. Some participants expressed a willingness to offer jobs to individuals who had received treatment, as illustrated by the statement: Yes, I will give the person a job because now I see that he/she is normal, and if I give them the job, they can do it (Keta Youth FGD). This view suggests that the individual's mental health history is not seen as an obstacle to employment; the focus is instead on the person's skills and potential contributions. Similarly, another stated, If the person has received treatment and has been cured, then yes, I would (Tutu, 56-year-old male, IDI), and another agreed, saying: Once the person is cured, why not? (Tutu, 60-year-old female, IDI). These responses reflect an openness to reintegrating treated individuals into the workforce, recognizing their capacity to contribute after receiving proper care.

Some participants expressed cautious perspectives on employing individuals with a history of mental illness, suggesting that while jobs should be offered, they should primarily be menial. This indicates a reluctance to allow these individuals to occupy roles deemed 'important' or high-risk which is evident here:

> I will give the person a job. But it depends on the type of job. If a doctor develops a mental illness and is cured, he/she cannot just go back to doing the same job. He/she might kill somebody. Because, with mental illness, there is a saying that 'though cured, there is still a little remaining to scare little children'. So, it depends on the type of job you will be given (Tutu Youth FGD).

This reflects concerns about individuals returning to professions that carry significant responsibility, particularly in fields like medicine, where the implications of errors can be severe.

The reference to the saying underscores a lingering apprehension about the potential for relapse or residual effects of mental illness, highlighting societal unease. Another participant agreed with the cautious approach, suggesting that while reintegration into the workforce is important, it should not be immediate:

> …As for mental illness, curing it is a gradual process. So, you do not give a person a job the minute he or she is cured of a mental illness. Like they said, the behavior they will exhibit will determine whether the person no longer has a mental illness (Tutu Youth FGD).

This perspective suggests that participants believe observable behaviours can indicate an individual's readiness for reintegration into the workforce, emphasizing the complexity of mental health recovery. Similarly, a participant remarked:

> As my brother said when he was talking, curing mental illness is gradual. So, you cannot give the person a job immediately they are cured. Even for an illness like madness, though cured, it manifests once in a while. Someone can even ask if the person has had a mental illness before and you will confirm it. It doesn't mean that the person has not recovered but he/she can exhibit some behavior that is due to the mental illness. Once in a while, it will manifest some behavior in the human body and make it very clear that the person has had a mental illness before. Due to that, you cannot give the person a very prominent job in the society (Tutu Elders FGD).

These views reveal a dual perspective: an openness to offering employment to those with a history of mental illness, balanced with caution based on recovery concerns. They highlight the need for reintegration strategies that consider individual capabilities alongside job demands.

Additionally, these insights indicate the importance of public education regarding mental illness and recovery, aiming to dispel fears and promote more inclusive attitudes toward employing individuals with mental health histories.

On the other hand, participants voiced strong reservations about hiring individuals with a history of mental illness, fearing the condition may resurface and cause problems. For example, one stated: If I am a manager and I hear something like that, I will not employ the person... if there's a mistake which causes a big issue, the manager will be blamed (Keta Men FGD). This reflects concerns about accountability and the perceived risks of employing someone with a history of mental illness. Another participant added: No because the person will show signs of mental illness again (Keta, 74-year-old male, IDI). This perspective assumes that mental illness is likely to recur, making individuals with such a history unsuitable for employment. Similar sentiments were expressed in the following statement: I will not employ the person... if it should come out, it may probably bring chaos (Tutu Youth FGD), highlighting the perceived unpredictability associated with mental illness, which discourages employers from taking the perceived risk of hiring individuals who may have once experienced mental health challenges.

These views underscore the stigma and fear that people with mental illness face within their communities. The perceived need for restraint and protection, combined with the reluctance to offer employment or social acceptance, reflects broader cultural and social barriers. These barriers are shaped by a deep-seated concern about the unpredictability of mental illness and its potential recurrence, as well as by persistent misconceptions about the recovery process.

Participants expressed mixed feelings and a range of beliefs regarding fear of people with mental illness. Some participants voiced the opinion that individuals with mental illness should be feared, citing concerns about unpredictable behavior and potential harm. For example, one

shared that, we are afraid of them because, if you are not careful, they will harm you (Tutu Elders FDG), implying that unpredictability and perceived danger contribute to the stigma surrounding mental illness. Similarly, another participant shared, yes, they are people we should be afraid of because they do not know what they are doing. If they throw a stone at you, they are not aware that that is what they are doing. So, we have to fear them a little (Tutu, 56-year-old male, IDI). This perspective reinforces the idea that individuals with mental illness may act without awareness, which fuels fear within the community. A personal experience that shaped the fear of people with mental illness was shared:

> For those people, I fear them because their mind is no longer the same as mine. One day, I was moving with my friends, and they offended a mad person, one of them was hit by a stone and the stone hurt her in the head (Keta Women FGD).

This account underscores how personal encounters with individuals exhibiting violent behavior can reinforce fear and contribute to the broader stigmatization of mental illness. However, there are more nuanced perspectives, as some participants differentiated between people with mental illness based on their behavior. A 60-year-old female participant explained,

> In one way yes and in another no. Some of them are erratic and can harm you if you go close to them. Others may equally have a problem with their mind but not erratic. For those who are not erratic, you can go close to them. But for the violent ones, you cannot go near them (Tutu, 60-year-old female, IDI).

Her view suggests that fear is context-dependent, based on the behavior of the individual, with erratic or violent tendencies eliciting fear, while those without such tendencies may be approached without fear.

Some participants expressed differing views, arguing that there was no need to fear individuals with mental illness. For example, one stated: I am not afraid, but I know because of their condition, they can harm me. So, I don't go too close to them. It doesn't also mean that I am afraid of them (Tutu Youth FGD), reflecting a more nuanced perspective, where the speaker acknowledges the potential for harm but emphasizes that their caution stems from an awareness of risk rather than fear. This approach suggests a balance between maintaining personal safety and not perpetuating fear or stigma. Similarly, a 60-year-old participant shared a more accepting view: We should not be afraid of them (Tutu, 60-year-old female, IDI), reinforcing the notion that fear is unnecessary. Another participant elaborated:

> As for me, I am not afraid of them. I usually chat with mad people. When you have a conversation with them, they can say things that make sense. It is not every day that their mind is crazy. So, I can chat with them. They can say things you least expect them to (Tutu, 56-year-old male, IDI).

This statement highlights the belief that individuals with mental illness are not always detached from reality and can engage meaningfully in conversation. It suggests that building rapport and interaction with those facing mental health challenges can break down barriers and reduce fear.

Participants' views seem to reflect a rejection of fear or discrimination against individuals with mental illness. They advocate for a more compassionate approach that acknowledges both the potential risks associated with certain mental health conditions and the personhood of those affected. These perspectives suggest the importance of fostering a more inclusive and understanding attitude towards mental health in the community, which may help reduce stigma and promote healthier social interactions.

Participants described several discriminatory terms used to address individuals diagnosed with mental illness. For instance, one participant mentioned: His/her chain is torn. He/she has lost his/her key (Tutu, 60-year-old female, IDI). This metaphorical expression appears derogatory, likening a person with mental illness to a broken object, suggesting that they are somehow "defective" or incomplete. Such language can reduce individuals to their condition, implying they are incapable of functioning normally in society, and reinforcing harmful stereotypes. She elaborated on this metaphor, adding: He/she has stepped into town. Once your key is missing, you will look for it, and so you will roam (Tutu, 60-year-old female, IDI). Here, the phrase "stepped into town" seems to imply confusion or erratic behavior, reinforcing the idea of someone being lost or aimless due to mental illness. The reference to a "missing key" further emphasizes a perceived lack of control or stability, as though the person has lost their capacity to manage their behavior. Similarly, mentally ill individuals were described here: Sometimes we say the person does not have a head and sometimes we say, let's leave that mad person (Keta women FGD). This statement suggests a dismissive attitude toward individuals with mental illness, portraying them as lacking rationality or sound judgment. It also reflects an underlying desire to distance oneself from those perceived as mentally ill, contributing to their marginalization and exclusion from society. Finally, some of the terms shared were ‘Wagye nsa mu’, “wei, wayi” and ‘n’adwene nni fie’ (Tutu Youth FGD), which were also identified as derogatory terms used to stigmatize individuals with mental illness. Such language perpetuates stigma, reinforcing negative perceptions and creating barriers to social inclusion.

The implications of these descriptions suggest that dehumanizing language contributes to the stigma and discrimination faced by individuals with mental illness. These terms reduce people to their condition, portraying them as broken or deficient and perpetuating the idea that

they are unpredictable or dangerous. This, in turn, reinforces social exclusion and marginalization, making it more challenging for those with mental health conditions to be accepted within their communities or to access the support they need. Addressing the use of such language could be a critical step in reducing stigma and fostering more compassionate and inclusive attitudes toward mental health.

Some participants discussed the profound effects of stigma, discrimination, and feelings of shame experienced by individuals living with mental illness. They noted that,

> At some point when they recover, they become shy to be in public because they hear all the things people say. And so, when they come into the public, it sticks with the person. The thought of that alone, even though the person has recovered, can send a person to their death. Because a person can ruminate to the point of death. Shame can kill a person (Tutu Youth FGD).

This statement highlights the psychological toll of societal stigma, suggesting that the fear of public scrutiny and shame can lead to severe emotional distress, potentially resulting in self-destructive behavior. The phrase "shame can kill a person" emphasizes the serious mental health ramifications of being subjected to stigma and discrimination. Another elaborated further on this experience:

> When they recover, they become shy to be in public because they hear all the things people say. They ask, 'Ei, so my legs were put in chains.' It sticks with the person, and now when they come into public, they are ashamed (Tutu Youth FGD).

This reflects an understanding that, even after recovery, the lingering effects of stigma can hinder social reintegration, as individuals may internalize negative perceptions and feel ashamed of their past experiences. They also added that:

> At times, the reason why people with mental illness are chained or kept in a room is that if you leave them to roam in the community, the kind of things people would say upon their return can cause them to go mad again. But when they are kept at home or started at work and brought home for treatment, even if people hear about it, it will not be as bad as leaving them to roam the entire community (Tutu Youth FGD).

This perspective suggests a protective measure aimed at shielding individuals from potential public ridicule or harsh judgment, highlighting the community's concern about the consequences of stigma. However, it also implies that such measures may inadvertently reinforce feelings of shame and isolation, preventing individuals from fully reintegrating into society.

Spotlighting occupational therapy.

This sub-theme explores the role of occupational therapy in restoring personhood, emphasizing that recovery from mental illness enables individuals to reclaim their identity by resuming meaningful roles and activities. Reintegration into society is a gradual process, requiring structured interventions that promote skill development, social engagement, and role restoration. As one participant noted, when such a person goes to the hospital, he/she can be cured and then come back into society. He/she can go back to his/her normal functions in life (Tutu, 60-year-old woman, IDI).

Occupational therapy is crucial in this process as it facilitates the transition from illness to functional independence. The role of structured rehabilitation is described here: For example,

some people were mentally ill and roaming the streets. Once the origin of the sickness was determined, they were cured. They returned to school and are among their friends (Keta Men FGD). This reflects the effectiveness of interventions that focus on skill-building and social reintegration. This view is reinforced here: If they get someone to treat the illness for it to stop, then they can return to normal life or fullness as persons (Tutu Elders FGD), suggesting that recovery is not just about symptom relief but also about regaining social functionality.

The ability to resume roles and responsibilities is a key marker of restored personhood as observed in the comment: once they return to their normal state, they can be enstooled as kings (Tutu, Elders FGD), emphasizing that mental well-being is a prerequisite for leadership and full societal participation. This aligns with the goals of occupational therapy, which seeks to help individuals rebuild their competencies and confidently reintegrate into their communities. However, recovery is not immediate. Another noted: When a person is cured of mental illness and he/she returns to society, the individual is a person, but it is not immediately after. It takes time (Tutu Youth FGD). This underscores the need for ongoing therapeutic interventions, including vocational training and psychosocial support, to facilitate lasting reintegration.

A compelling example of occupational therapy's impact is captured in the story of a formerly influential individual: There is someone who used to be a 'big man' of an organization before he was mentally ill. He used to help the family and society, but all that stopped when he was unwell. However, after getting cured, you could see all the good things he used to do again. He gets back his glory and is now considered a person (Tutu Women FGD). This narrative highlights how purposeful engagement in work and social roles is central to regaining dignity and recognition.

These insights reinforce the importance of occupational therapy in mental health recovery, illustrating that treatment alone is not enough: rehabilitation, skill-building, and community support are essential for restoring personhood. The journey toward recovery requires structured interventions that address cognitive, emotional, and social reintegration, ensuring that individuals regain their health and sense of purpose and belonging.

Collaborative engagements and Culture competence for practitioners.

This sub-theme observes that in the management of mental illness, many interactions of care are necessary. Participants highlight the interaction between conventional/biomedical approaches and unconventional/spiritual and herbal approaches in the treatment of mental illness. Some participants reported that if they or a family member were to suffer a mental illness, they would seek treatment at the hospital, while others believed seeking treatment from spiritual healers (pastors, traditional healers, or herbalists) or a combination was appropriate. From the participants' views, it was evident that beliefs about the etiology of the illness will determine treatment options. For instance, the willingness of participants to seek help from psychiatric hospitals indicates an acknowledgment of the value of professional mental health care. Statements like, I would go to a psychiatric hospital (Tutu Elders FGD), I would see a psychiatrist (Tutu Youth FGD), and the first thing I would do is to take them to the hospital, a psychiatric hospital for them to be examined. I will then take my next step based on what the doctor will say (Tutu Youth FGD) reflect a readiness to engage with the healthcare system, underscoring the recognition of psychiatric facilities as sources of specialized care for mental health challenges. This openness suggests a belief that trained professionals can provide the necessary guidance and support for those experiencing mental health issues.

Conversely, some participants expressed their preference for spiritual or herbal interventions;

> All of us here are all Christians, so we will go to the hospital for the doctor to check me if they cannot do it before I go to herbalist. Another person also says she will be going to God and pray and give her sickness to God before she goes to the hospital (Keta Elders FGD).

This illustrates a perceived inadequacy of conventional medical establishments in addressing certain conditions. The reference to hospital referrals to traditional healers raises the possibility of collaborative care, indicating a potential for integrative health practices where both medical and traditional healing approaches could coexist. Similar sentiments were shared ass seen below:

> I would go to a traditional healer. There are a lot of sicknesses that we are suffering from, but most Doctors and nurses cannot determine them, so they refer people to traditional dealers for help. There are some hospitals, when you go, they know that that sickness is not meant for hospital, but they keep on telling people to bring money and at the end the person dies from what he is suffering from (Keta Women FGD).

This statement implies a perception that some illnesses are beyond the scope of conventional medical treatment and may be better addressed by traditional healers. It also suggests a mistrust of hospitals, where the participant feels that certain illnesses are not properly handled, leading to unnecessary expenses and worsening health outcomes. This participant believed that going to church is appropriate: For me, I will go to church first, or I will take them to my pastor for prayers because that is what I believe in. If I go, I'll do what the pastor says because I believe God has power over all sicknesses (Keta Youth FGD), reflecting a strong personal belief in the efficacy of spiritual intervention, specifically through prayer and guidance from a pastor, in addressing health issues. It suggests that the individual prioritizes spiritual practices as a

fundamental part of their approach to health and healing, viewing them as powerful and potentially effective in managing illness.

Others mentioned that they would explore both biomedical and spiritual or herbal interventions. This brings to bear the practice of 'healer shopping'[4] where they would consult multiple healers to find suitable remedies. Participants' inclination to shift between various types of healers reflects a cultural reliance on traditional knowledge and practices, highlighting a need for mental health practitioners to understand and navigate these complexities. It was stated that:

> That is what we are saying that our grandfathers received some deity, and at times it comes from what we eat but in case a sickness just befalls someone and its whereabouts are not known, those in the field of traditional worship trace the route of the sickness (Keta Men FGD).

The statement highlights the role of traditional beliefs and practices in understanding and managing health issues within the community, alongside or in conjunction with modern medical approaches. A similar perspective is seen in the extract below:

> I will say for some of them, it's not that nothing can be done about it because some of them are psychological so counselling and talking to them can help solve the problem and the person can equally go to the hospital for those in the psychiatric hospitals to help them. And some local or traditional herbalists also cure those illnesses (Keta Youth FGD).

[4] Healer shopping, a term derived from doctor shopping, has been defined as "the use of a second healer without referral from the first for a single episode of illness." (Kroeger, 1983)

The participant above acknowledges that psychological issues can benefit from counselling and psychiatric hospital treatment and also recognizes the role of traditional herbalists in treating certain illnesses. This emphasizes the coexistence of psychological counselling, psychiatric hospital care, and traditional herbal remedies as viable options for addressing mental health concerns. It was equally noted that I think the first step is to take the person to the psychiatric hospital to be tested and if the result shows that he/she is intact then we can seek a solution in the spiritual realm (Keta Youth FGD), equally reflecting a blend of modern medical practices and spiritual beliefs, recognizing the importance of both in addressing mental health challenges effectively. Other comments include:

> The first thing is that you have to sit down and think about the origins of the problem, and if it has happened before. After that, you will know the step to take. Then you can approach the psychiatrist or herbalist for help (Keta Elders FGD).

> Our fathers consult oracles to determine the source or the type of sickness it is. They put what they hear into practice and solve the problem. At times, they solve the problem traditionally before sending the person to a psychiatric hospital to be put on medication, if it happens like that some recover others don't (Tutu, 74-year-old man, IDI).

Participants' narratives suggest a pluralistic approach to treatment, where biomedical and spiritual/herbal interventions are viewed as potentially complementary rather than mutually exclusive. This perspective is shaped by cultural factors, such as the influence of ancestors and deities, which inform individuals' decisions to seek help from different sources. Acknowledging diverse treatment avenues illustrates a holistic understanding of health and healing, emphasizing the importance of incorporating cultural beliefs and practices into mental health care.

Summary of Findings

The study reveals that among the Ewe and Akan, personhood is conceptualized through three interwoven dimensions: prescriptive expectations, where individuals attain personhood by adhering to societal norms; the corporeal dimension, which acknowledges biological attributes essential to human existence; and the numinous dimension, which recognizes personhood based on spiritual or transcendental qualities. These dimensions may interact, and a challenge to any—particularly in cases of mental illness—can lead to a diminished or even lost societal status. Personhood is thus perceived as an evolving process, shaped by continuous social engagement and cultural validation.

Mental illness in these communities is broadly characterized by erratic behaviour, commonly described as being "mad" or acting "anyhow," while mental health is largely framed as the absence of illness and the ability to perform self-care. The terms "mental health" and "mental illness" are often used interchangeably. Mental illness is primarily attributed to spiritual causes, including breaking taboos, offending a deity, curses, or divine punishment. It is also linked to biological factors (e.g., genetic predisposition, brain damage, prenatal complications) and environmental influences (e.g., substance abuse, trauma, diabolism, and daily life stressors). Its manifestations are perceived through speech, behaviour, and physical appearance.

Divergent views exist regarding treatment and prognosis. Some believe mental illness is treatable, while others question the possibility of full recovery. Treatment choices—ranging from biomedical interventions to traditional medicine and spiritual healing—are shaped by beliefs about causality. The study also highlights debates over whether mental illness can be prevented, with opinions split between those advocating for early interventions and those who see it as inevitable.

Findings underscore the profound implications of personhood and mental illness, including human rights violations and the stigmatization and humiliation of affected individuals. The role of occupational therapy emerges as critical in restoring personhood through societal reintegration post-recovery. The study further underscores the need for collaborative stakeholder engagement and cultural competence among mental health practitioners to ensure contextually relevant care.

Chapter Five

Discussion

Introduction

This study explored conceptions of personhood among the Akan and Ewe cultures in Ghana, examining their influence on perceptions of mental illness and care practices. It also investigated whether individuals living with mental illness are regarded as "persons" within these cultural frameworks and explored the connections between spirituality, human rights abuses, and notions of personhood. Three central themes emerged*: Conceptualizing personhood, Subjectivizing Mental Illness, and the Implications for Personhood in Context*.

Conceptualizing personhood (Who is a person?)

One of the study's objectives was to explore the conceptions of personhood among the Akan and Ewe cultures. These cultures seemingly share similar views of personhood, rooted in understanding individuals as inherently social beings (Ameka, 2018). Personhood emerges as a multifaceted and evolving concept shaped by cultural, philosophical, and scientific perspectives, grounded in personal identity, moral responsibility, and social expectations (Wingo, 2006). Three interconnected sub-themes were highlighted: prescriptive 'performativities', corporeal, and numinous dimensions. These dimensions collectively shape how personhood is recognized and validated within Akan and Ewe cultural contexts.

Prescriptive 'Performativities'

Among the Akan and Ewe cultures, personhood is seen as a status attained through adherence to social norms, reflected in behavior, relationships, civic responsibilities, and social roles. This view is grounded in the concept of 'moral beingness,' where personhood is assessed based on one's conduct or performance within the community (Majeed, 2017). This aligns with

scholars like Gyekye (1984), Ikuenobe (2006), Wiredu (1992), (Oyowe, 2018), Gavi et al. (2022), and Ameka (2018), who argue that a mentally competent individual demonstrates personhood through active social participation and an appreciation of their society's moral and social principles, as recognized by others. Rooted in traditional African beliefs, this perspective emphasizes moral capacity and the ability to live by societal norms and fulfill communal duties (Gavi et al., 2022).

Wiredu, as cited in Molefe (2021), highlights personhood as a key aspect of communalism, with culture-specific criteria for excellence in traditional African societies. Idoko and Turman (2022) also note that personhood is relational, attained through fulfilling social roles and meeting communal expectations. For Akans and Ewes, these may also include social prominence, economic status, achievements, gender, and roles. Wiredu (1992) suggests that traits like wealth and fulfilling communal obligations contribute to personhood, while Gyekye (in Wingo, 2006) argues that status alone is insufficient, emphasizing moral conduct over social standing. Drawing on Kant's categorical imperative, Gyekye asserts that attributes like gender, age, or social standing do not define personhood, nor is identity solely determined by achievements (Rainsborough, 2021; Wiredu & Gyekye, 1992). The normative view emphasizes a balance between fulfilling communal expectations and upholding moral integrity. While social roles and achievements are important markers of personhood, its essence is mainly grounded in an individual's capacity to embody shared values and contribute meaningfully to the collective well-being of the community.

This implies that personhood among the Akans and Ewes is not inherent but conferred by society, shaped by cultural norms and expectations. What is deemed "normal" or "acceptable" defines the boundaries of personhood. As a result, individuals who do not meet societal

expectations risk losing their recognized personhood. Oyowe (2018) argues that failing to adhere to these norms equates to failing to fully attain personhood. It is equally evident that among the Ewes and Akans, those who deviate from the prescribed norms are often marginalized, given derogatory labels, and, in extreme cases, compared to animals. This underscores the influence of communal validation in shaping and sustaining personhood (Asafo et al., 2025).

Corporeal dimension of personhood

The corporeal dimension of personhood refers to the recognition of the human body as central to identity and social validation. It goes beyond viewing the body as a biological organism, instead positioning it as a cultural and moral symbol through which social belonging, moral worth, and communal obligations are expressed. Within African thought, the body is not simply material but is interwoven with spiritual and social life, serving as a medium for demonstrating moral conduct, health, productivity, and capacity for social roles (Mbiti, 1990; Gyekye, 1997). Among both the Ewe and Akan, bodily comportment, strength, and the ability to fulfill responsibilities such as farming, childbearing, or participation in rituals are often regarded as essential markers of full personhood. Conversely, when the body is compromised—through illness, disability, or perceived inability to meet communal expectations—an individual's personhood may be questioned or diminished (Dzokoto & Okazaki, 2006; Wiredu, 1992). This framing highlights that corporeality, far from being a purely private matter, is deeply embedded in cultural values that connect health, morality, and communal belonging.

In Ewe and Akan cultures, physical traits — especially those linked to birth and bodily integrity — are integral to personhood. Bodily features and physical appearance were described as factors that influence how personhood is perceived, though they were not regarded as its sole defining elements (Menkiti, 1984). Birth is not merely a biological event but a profound cultural

and social milestone that marks the beginning of personhood. Factors like timing, location, and rituals influence social status, while being born into a significant lineage or on an important day can confer specific roles and responsibilities (Ohaja & Anyim, 2021). These rituals help integrate the newborn into familial and community networks, shaping their future identity and place in society.

Majeed (2017) describes personhood as ontological, tied to the essence of being human, while White (2013) argues that existential personhood is intrinsic to life and independent of social status. Adjei (2019) observes that this view aligns more with individualistic cultures, like those in Western, Educated, Industrialized, Rich, Democratic (WEIRD) societies. Idoko and Turman (2022) add that personhood and rights are inherent to being human, regardless of societal roles or status. Physical traits like skin colour, facial markings, and body adornments can signify tribal affiliation, status, or personal history (Kling et al., 2018), shaping identity and community perception (Fowler, 2004; Tirosh, 2007).

Physical impairments, however, can complicate this understanding of personhood. An individual's ability to fulfill expected social roles can be affected, potentially diminishing their perceived personhood within the community (Agmon et al., 2016). For instance, someone with a disability may struggle to meet the communal expectations tied to their age or gender, leading to marginalization. When societal recognition of personhood is withheld, dignity can feel contingent on external validation (Fazio et al., 2018). Chapman et al. (2024) highlight that while personhood is inherent, dignity often relies on social acknowledgment, making it vulnerable to societal perceptions.

Agmon et al. (2016) explored how disability impacts personhood in Israeli culture, noting that adults who developed disabilities later in life often faced reduced social status and exclusion,

transitioning from being seen as "complete" to being defined by their impairments. To challenge this reductionist view, they proposed a holistic anthropological perspective that restores full recognition of personhood beyond physical limitations. This approach aligns with the need to reconcile traditional African notions of personhood with contemporary understandings of human dignity, fostering more inclusive and compassionate care for individuals with disabilities.

Numinous dimension of personhood

The concept of the numinous dimension, as articulated by Rudolf Otto (1923), captures the human experience of encountering the sacred: an overwhelming sense of awe, mystery, and reverence in relation to powers beyond the ordinary. This dimension highlights that human well-being is often interpreted not only through biological or psychological lenses but also through spiritual encounters with the divine, ancestral, or mystical forces (Kpobi & Swartz, 2018; Sefah-Dede, 2014).

In Ewe and Akan cultures, personhood has a spiritual and transcendent dimension, reflecting connections with ancestors, nature, and the divine. Despite modernization, these cultures continue to integrate their spiritual heritage into modern life, showing its lasting importance (Nwoye, 2017). For the Ewe and Akan, personhood involves the body, soul, and spirit, reflecting divine qualities and a belief in returning to the spiritual world. These views are rooted in a strong cosmology that sets humans apart from animals (Gavi et al., 2022). The Akan links personhood to concepts like "Sunsum" (spirit) and "Kra" (soul) while Ewes emphasize the “Bome” and “Se” (life driving force of God) (Gyekye, 1995; Ameka, 2018; Gavi et al., 2022).

Spirituality shapes personhood and identity, connecting individuals to ancestors, deities, and nature, to promote communal harmony (Mbiti, 1991). Ancestors are believed to influence descendants, offering guidance and protection through rituals and storytelling (Singh &

Bhagwan, 2020). Spirituality also shapes moral frameworks and deviations from it led to consequences like curses, sometimes believed to manifest as mental illness (Gyekye, 2010). This often leads people to seek spiritual help for issues, including health.

Different spiritual and religious traditions shape beliefs about existence, purpose, and the self (Callister et al., 2019). Spirituality highlights a connection to a higher power or universal essence, suggesting individuals have a transcendent dimension beyond the physical, such as the soul or spirit (de Brito Sena, 2021; Niemiec et al., 2020). These beliefs provide meaning, integrating personhood into a cosmic order with moral guidelines emphasizing compassion and altruism (Gyekye, 2010). Spiritual practices like meditation or prayer connect with the spiritual self, emphasizing mental and spiritual well-being.

In Ghana, spirituality influences many aspects of life, including how mental illness is approached (Opoku, 2018). Although this is a fact, it is also important to highlight the connection between perceptions of personhood and understandings of mental illness in the African context. In many Ghanaian cultures, personhood is not viewed solely as an individual attribute but as something constituted through relationships with family, community, ancestors, and the spiritual realm (Gyekye, 1997; Wiredu, 1992). Consequently, mental illness may be interpreted not only as a disruption of biological functioning but also as a disturbance in these relational and spiritual dimensions of being (Sefa-Dedeh, 2014; Osei, 2003). This relational view of personhood helps explain why healing practices often extend beyond the individual to include family involvement, community rituals, and spiritual interventions alongside biomedical care (Kpobi & Swartz, 2018; Quinn, 2007).

Subjectivizing Mental Illness (What is the knowledge of mental health/illness among the Akans/Ewes?)

For the Ewe and Akan, mental health and illness are understood not just as individual experiences but as part of a broader cultural framework that informs beliefs about their causes, expressions, and methods of treatment. Cultural interpretations influence symptom recognition, illness trajectories, and the integration of social and spiritual interventions alongside—or instead of—biomedical care (Ae-Ngibise et al., 2010; Jenkins, 1998; Kleinman, 1988; Ofori-Atta et al., 2010). Research shows that mental health interventions are more effective when they honour patients' cultural and spiritual beliefs, enhancing engagement, adherence, and outcomes (Codjoe, 2021; Malviya, 2023). A shared understanding between patients and clinicians fosters trust and improves treatment success, while misalignment can lead to disengagement and eroded trust (Krist et al., 2017). Recognizing the cultural dimensions of mental health within Ewe and Akan contexts is essential for developing culturally sensitive care. By embracing these perspectives, clinicians can build trust and create holistic strategies that reflect patients' values, leading to more effective and meaningful mental health support (Shimbre & Tanga, 2024).

Construing mental health and mental illness

Mental health among the Ewe and Akan people is viewed as more than just the absence of illness, highlighting the importance of active self-care, emotional well-being, and social harmony. Drawert (2013) similarly observes that traditional understandings of mental health generally encompass both the lack of psychopathology and the presence of positive mental health attributes. Haymovitz et al. (2022) identified eight overarching themes that represent the conceptualization of mental health among diverse Americans. These themes include ‘well-being’, ‘balance’, ‘coping’, ‘adaptability’, ‘relational’, ‘self’, ‘absence of mental illness’, and

'physical'. However, 'absence of mental illness' was rated as the least crucial construct of mental health.

The similarity in how these cultures understand mental health shows that it's a shared human experience. It emphasizes well-being, balance, and coping as key to a healthy life. Many cultures recognize the connection between mind and body, highlighting the importance of a balanced lifestyle for overall wellness. As societies become more connected and information spreads globally, definitions of mental health expand to include more aspects (Jenkins et al., 2011). This shows a growing agreement on the need for a holistic view of mental health. Increased research and advocacy have helped deepen understanding and acceptance of mental health as a complex concept. Galderisi et al. (2015), Haymovitz et al. (2022), and Gautam et al. (2024) highlight shared themes in mental health, connecting cultural perspectives and enriching global discussions on well-being.

Mental illness in these communities has often been misunderstood and seen as a sign of character flaws or spiritual afflictions rather than a condition that can affect anyone (Adzedu, 2025). This perception fuels stigma, making it difficult to seek help. Rossler (2016) highlights how stigma affects language with statements like 'I am afraid of schizophrenics because they are unpredictable and dangerous', reducing a person to their diagnosis. Mental illness has also been framed as a dysfunction of the brain, a view Jefferson (2023) argues is valid only when a clear brain dysfunction is identified. In contrast, Fuchs (2012) contends that mental illness cannot be reduced to purely biological explanations. Additionally, it has been labeled as dysfunctional or abnormal behavior, a concept historically tied to beliefs in supernatural causes like spirits, demons, or witches. However, this framing is problematic, as what is considered "abnormal" varies widely across cultures. Ozen and Tasdemir (2022) caution that relying on such definitions

risks reinforcing cultural bias and overlooking the complex, context-dependent nature of mental health.

Among the Ewe and Akan, mental illness is often viewed through a spiritual lens, attributing it to supernatural forces—a belief that is also found in other cultures and historical contexts. These explanations provide a culturally coherent framework for understanding and managing mental illness and reflect a broader pattern of interpreting mental health issues through specific cultural beliefs and values. Additionally, the global debate between viewing mental illness as a brain dysfunction and rejecting this reductionist view mirrors the arguments made by Jefferson (2023) and Fuchs (2012), highlighting a worldwide struggle to balance biological, psychological, and social perspectives in understanding mental health.

Among the Ewe and Akan, there is often confusion between mental health and mental illness, making it difficult to distinguish between the two. This confusion reflects a broader pattern found in literature, where these terms are frequently misunderstood or used interchangeably (Dogra & Cooper, 2017; Dogra et al., 2005; Leighton, 2008). Mental health refers to a person's overall emotional, psychological, and social well-being (W.H.O., 2022), while mental illness involves diagnosable conditions that affect thoughts, emotions, mood, and daily life (A.P.A., 2022).

The overlap in understanding can be traced to several factors. The inherent complexity of mental health — which includes self-esteem, competence, and relationships (Wren-Lewis & Alexandrova, 2021) — makes it harder to draw a clear line between well-being and illness. The historical merging of the terms in the 1960s, aimed at reducing stigma (Leighton, 2008), has contributed to their interchangeable use, even among experts (Dogra & Cooper, 2017). In Ewe

and Akan communities, cultural interpretations often blend spiritual, emotional, and psychological dimensions, further blurring the distinction between these concepts.

Limited knowledge and educational gaps also play a role, as inconsistent messaging about mental health and illness reinforces misconceptions. Media representation of these concepts is either accurate or sensationalized, reinforcing stereotypes and blurring the lines between mental health and mental illness (Dogra & Cooper, 2017). These factors collectively contribute to the difficulty in differentiating between mental health and mental illness, both in these communities and in wider contexts.

Inconsistent views and confusion between mental health and mental illness can contribute to stigma, discouraging people from actively maintaining their well-being. Myths and misconceptions further highlight the need for better mental health education, stigma reduction, and accurate media representation (Srivastava et al., 2018). Scholars suggest incorporating psychological theories from Maslow, Rogers, Jung, and Allport to deepen our understanding of mental health and improve outcomes (Schneid & Brown, 1999; Connor, 2017). Cultivating a more compassionate and informed community requires exploring both global and local perspectives. Developing indigenous understandings of mental health is essential, as it can bridge the gap between traditional beliefs and Western medical approaches, enhancing communication and care (Asafo, 2021).

Etiological reflections

Ewe and Akan cultures have shared beliefs about the etiology of mental illness. From the both perspectives, mental illness can arise from biological, psychological, and environmental factors, or a combination of these. Some causes may be within an individual's control, while

others may lie beyond their influence. This reflects the complex nature of mental illness etiology (Gautam et al., 2024; Sui et al., 2022) and highlights the need for a holistic understanding of both internal and external influences. Scholars agree on this complexity — Kirsten (2012) asserts that mental illness can stem from multiple, interconnected causes. Biological factors implicated in mental illness include genetic predisposition, brain defects or injuries, and complications during pregnancy and early development.

In Ewe and Akan communities, mental illness is often believed to be hereditary, echoing findings from Aghukwa's (2012) study in Kano, Nigeria, where 75% of participants attributed mental illness to genetics. Research supports this belief, showing that mental illness can run in families, increasing the risk for conditions like schizophrenia, autism, ADHD, and bipolar disorder, each with an estimated heritability of up to 80% (Doherty & Owen, 2015; Bondy, 2022; Gatt et al., 2015; National Institute of Mental Health [NIMH], 2020).

Brain injury is another commonly cited cause of mental illness. In some cases, traumatic brain injuries (TBI) can trigger psychiatric symptoms, with one in five individuals experiencing mental health issues for up to six months post-injury (Stein et al., 2019). A well-documented example is Phineas Gage, whose personality drastically changed after an iron rod damaged his frontal lobe (Schwarzbold et al., 2008). TBI has been called a "silent epidemic" due to the lack of public awareness, as symptoms may not appear immediately (Krishna et al., 2012).

Certain prenatal and birth-related factors have also been linked to mental health outcomes. Maternal risk factors, such as substance use during pregnancy, can impact a child's neurodevelopment and increase the risk of mental illness (Stone, 2015; Tearne et al., 2015). Sandtorv et al. (2017) found that children exposed to alcohol or drugs in utero had a higher risk of mental health issues compared to non-exposed children. Additionally, maternal stress and

anxiety during pregnancy have been associated with childhood anxiety, depression, ADHD, conduct disorders, and autism spectrum traits (Newman et al., 2016; Glover, 2020). Birth injuries, especially those related to assisted deliveries, may cause subtle brain trauma, potentially increasing the likelihood of mental illness later in life (Liang & Chikritzhs, 2012).

Mental illness has also been attributed to psychosocial and environmental factors, such as substance use, stress, and trauma. Research shows a strong link between substance use disorders (SUDs) and mental illness, with each condition increasing the risk of developing the other (National Institute on Drug Abuse [NIDA], 2022). Richert et al. (2020) found that severe substance use is associated with heightened anxiety, concentration difficulties, aggression, hallucinations, and mental distress, often rooted in past traumatic experiences. Psychosocial stressors have been identified as major contributors to mental illness, with Choudhry et al. (2016) noting their significant impact on modern health. Traumatic life events — such as divorce, losing a loved one or property, or witnessing injustice — can trigger persistent negative emotions like sadness and anger. These emotions may lead to rumination, increasing the risk of mental health conditions. An individual's available resources can influence how they navigate mental health challenges. Resources can either protect against stress by promoting effective coping strategies or, when lacking, leave individuals more vulnerable to mental illness (Choudhry et al., 2016).

Mental illness is also believed to stem from supernatural causes or as a form of punishment for wrongdoing or violating societal norms, divine will, or the expectations of ancestors and spirits. It was thought that offending God or another person could lead to curses being invoked, resulting in mental illness. Choudhry et al. (2016) identified spiritual and supernatural causes as the second most commonly cited explanations for mental illness across multiple studies. Similarly, research by Choudhry et al. (2013), Kyei et al. (2014), and Liu et al.

(2015) highlights that many participants attributed mental illness to spiritual or supernatural forces. Hailemariam (2015) also noted that mental illness was often seen as a manifestation of divine anger, curses, or demonic influence, linked to disobedience to religious principles or the breach of social taboos.

Despite awareness of alternative causes of mental illness, the predominant belief among the Ewes and Akans is that mental illness results from possession, a spiritual curse, or punishment for wrongdoing, or diabolic manipulations by others. These beliefs hold that mental illness can arise as a form of retribution for misdeeds or without any justifiable cause. Opare-Henaku and Utsey (2017) highlight similar findings among the Akan ethnic group, where the dominant belief was that mental illness is a 'retributive or spiritual illness,' despite acknowledging the roles of genetics, drug and substance use, and the effects of daily challenges. Subu et al. (2022) also report similar findings in a study aimed at understanding traditional, religious, and cultural beliefs and the application of traditional treatments. Evidently, mental illness has other etiological explanations that are not associated with one's misdeeds (Uher & Zwicker, 2017).

Understanding the causes of mental illness is essential for individuals to better manage their conditions. For mental health professionals to build trust and encourage treatment adherence, they must understand and respect their patients' beliefs about the origins of mental illness (Laranjeira et al., 2023). Although the causes of mental illness are not fully understood, exploring these beliefs can be crucial for effective prevention and treatment (Uher & Zwicker, 2017). The debate between psychological and biological explanations of mental illness persists, influencing research, clinical practice, and public discourse (Phelan, 2002). Some argue that biological explanations help de-stigmatize mental health conditions, while others contend that

psychological explanations offer a more holistic view (Ahn et al., 2009; Lam et al., 2005). These differing perspectives shape treatment approaches, with ongoing tensions between pharmacological interventions and cognitive-behavioural techniques.

Beliefs about the causes of mental illness significantly impact help-seeking behaviours, treatment choices, and stigma (O'Connor & Vaughn, 2021). In Ghana, the belief in supernatural or spiritual causes of mental illness may contribute to the underutilization of conventional mental healthcare services, highlighting the vital role of religious and spiritual healers (Arias et al., 2016; Lambert et al., 2020; Kpobi & Swartz, 2018). Opare-Henaku and Utsey (2017) suggest that diverse etiological beliefs promote varied help-seeking practices, including hospital visits, prayer retreats, herbalists, and traditional healers. Etiological beliefs also shape treatment preferences, influencing individuals' choices between and within different treatment modalities (Mannarini et al., 2020). Promoting certain treatment approaches in professional or public discourse may have unintended consequences, such as reinforcing stigma, overemphasizing medication, neglecting holistic care, limiting informed decision-making, and perpetuating a one-size-fits-all mindset (Nolan & O'Connor, 2019). It is essential to foster collaborations between biomedical and faith-based practices to address these challenges, creating an integrative care model that respects cultural beliefs while providing effective, evidence-based care.

***Representations** (Unipolar conceptions of the presentations of mental illness)*

Mental illness, in Ewe and Akan discourse, is believed to manifest in diverse ways, with symptoms varying widely between individuals. These variations depend on the specific disorder, its severity, personal factors, and the influence of cultural and societal contexts (Amuyunzu-Nyamongo, 2013). Common signs identified include aggressive behaviour, neglect of personal hygiene, incoherent speech, excessive talking, wandering, and a loss of agency. Kabir et al.

(2004) observed similar perceptions in Northern Nigeria, where community members identified public displays of distress as markers of mental illness. Opare-Henaku and Utsey (2017) also noted that poor self-care, impaired social functioning, and disordered behaviours are often seen as defining features of mental illness, suggesting that symptoms must be outwardly visible or attract public attention to be recognized as such. However, more subtle signs and internal distress may go unnoticed, demonstrating the complexity of mental illness manifestations (Lahey, 2021).

Mental illnesses are typically classified into diagnostic categories based on symptom patterns, as outlined in manuals like the DSM (Shahvaroughi Faharani et al., 2020). These classifications guide treatment decisions, but applying Western diagnostic criteria to African contexts can present challenges, as not all symptom expressions translate seamlessly across cultures (Opare-Henaku & Utsey, 2017). Historical and cultural factors, including the legacies of colonialism and indigenous healing practices, have shaped local understandings and responses to mental illness. For instance, behaviours deemed "abnormal" in one cultural setting might be interpreted through spiritual or supernatural lenses in another, influencing help-seeking behaviours and treatment preferences (Pang et al., 2018).

The impact of globalization has introduced Western mental health frameworks to African contexts, sometimes clashing with local traditions, but also creating opportunities for integrated care models (Arias et al., 2016). Comparative studies reveal the challenges and potential of blending these perspectives to improve mental health outcomes. Understanding how cultural beliefs shape symptom expression and treatment preferences is essential for developing inclusive, contextually sensitive mental healthcare systems (Opare-Henaku & Utsey, 2017). Case studies and personal narratives from various cultural contexts provide valuable insights. For instance, Kabir et al. (2004) found that perceptions of mental illness in Northern Nigeria differed

significantly from Western biomedical views, often emphasizing spiritual and social explanations. Similarly, Opare-Henaku and Utsey (2017) showed that among the Akan in Ghana, poor self-care, deficits in social functioning, and disordered behaviours are viewed as defining characteristics of mental illness, reflecting culturally grounded understandings that extend beyond biomedical criteria. These narratives offer a more relatable perspective on how mental illness is experienced and managed. It is essential to examine these manifestations in greater detail and develop interventions for mental health promotion and care that are culturally appropriate (Fogel, 2024).

Treatment regime

The Akans and Ewes held differing beliefs about the curability of mental illness. While some believed mental illness could be cured, others viewed it as a lifelong condition that could only be managed. This aligns with findings from Sadik et al. (2010), who reported that nearly half of the participants in an Iraqi study believed recovery from mental illness was possible, rejecting the notion of permanent illness. Conversely, Kishore et al. (2011) observed that 40.2% of rural participants, 33.3% of urban participants, and 7.9% of professionals in Delhi, believed mental illness was untreatable. These differing perspectives reflect how mental health and recovery are understood.

Reports from these communities reveal a diverse range of treatment approaches, blending medical, religious, and traditional methods. Among the Akan and Ewe, conventional treatments like psychotherapy are often seen as valuable, while medication is typically reserved for symptoms believed to have a biological or medical basis. This suggests a preference for psychotherapy over pharmacotherapy, reflecting broader trends observed in mental health research. McHugh et al. (2013) found that 75% of patients preferred psychological treatments

over medication, a preference linked to concerns about side effects, the risk of drug dependence, and a desire for a more active, talk-based approach to healing. In some cultures, stigma surrounding psychiatric medication may further influence this preference, as psychotherapy is perceived as less "medicalized" and more socially acceptable (Gosselin, 2019). Psychotherapy also fosters a sense of agency and self-efficacy, empowering individuals to actively participate in their recovery, while medication can sometimes be seen as a passive approach, where well-being is dependent on external substances. Moreover, the coping strategies and emotional regulation skills developed in therapy can support long-term mental health maintenance, reinforcing the enduring value of psychological treatments (Ryan et al., 2011). The varied treatment preferences make it imperative to combine psychotherapy with culturally sensitive education on pharmacotherapy, allowing individuals to make informed decisions while respecting local beliefs and values.

Beyond accessibility, cultural and spiritual beliefs strongly influence help-seeking behaviours. In Ghana, where religiosity is high, mental health symptoms are often attributed to supernatural causes, such as evil spirits, divine punishment, or curses (Salifu Yendork et al., 2018). This perception frames mental illness as a spiritual problem, necessitating spiritual solutions (Ae-Ngibise et al., 2010). Lack of awareness about biomedical treatment options further compounds the issue. Daliri et al. (2024) found that lack of insight was a significant barrier to mental health service utilization in Ghana's Bolgatanga Municipality, echoing findings from Rwanda, where similar barriers exist (Muhorakeye & Biracyaza, 2021). Globally, research suggests that public awareness of effective mental health treatments remains low, preventing individuals from accessing appropriate care or making informed treatment decisions (Harvey & Gumport, 2015).

There were also diverse opinions regarding who was best suited to treat mental illness and where individuals would seek help if they experienced mental health challenges. While some favoured health professionals, such as general practitioners and psychiatrists, others preferred traditional and faith-based healers, including traditionalists, herbalists, and pastors. This aligns with findings by Burns and Tomita (2015), who reported that nearly half of individuals in Africa seeking formal healthcare for mental disorders initially turn to traditional or religious healers. This preference reflects a strong inclination toward faith-based and biomedical treatments, often overlooking psychological therapies. It also highlights the significant influence of causal beliefs about mental illness on treatment choices and preferences.

Among the Ewes and Akans, reliance on social support during mental illness appears to be limited. Read and Nyame (2024) suggest that shifts in family life, economic pressures, and migration can undermine families' ability to care for a severely ill relative and uphold cultural ideals of solidarity and responsibility. This contrasts with findings by Morgan et al. (2014), who observed a stronger belief in the supportive role of family and friends in mental illness treatment. In Ghana, cultural beliefs contribute to pervasive stigma around mental illness, discouraging individuals from seeking social support. Mfoafo-M'Carthy and Sossou (2017) highlight that stigma can lead to social isolation, as people with mental illness may be perceived as a source of shame or fear, and negative judgments from others.

Despite Ghana's traditionally collectivist culture, social networks often prioritize practical or material assistance over emotional or psychological support for mental health issues (Asiamah, 2024). Families may help with caregiving or financial needs, but mental health concerns are sometimes treated as "private family matters" (Petrakis et al., 2014), deterring individuals from seeking help to avoid public scrutiny or judgment. This dynamic may push

people toward alternative treatment methods, such as traditional or faith-based practices. These findings emphasize the need to strengthen social support systems within mental health care. Integrating family and community involvement with professional treatment could enhance intervention outcomes by offering a more holistic approach to care (Ong et al., 2021). Raising awareness and providing comprehensive information about diverse treatment options, including psychological therapies, can empower individuals and their families to make informed decisions (Pieterse et al., 2022). Bridging formal mental health services with existing social networks could foster a more inclusive and supportive mental health care landscape.

Mental illness prevention

The Akans and Ewes predominantly believed that mental illness could not be prevented, though some acknowledged the possibility of prevention. This aligns with findings by Eccles et al. (2021), where participants viewed depression as unpreventable, resulting in hesitancy toward prevention-focused programs. Similar misconceptions have been shown to obstruct the adoption of preventive measures (Wang et al., 2016). However, the Mental Health Foundation (2021) emphasizes that while not all mental health issues can be prevented, many can be mitigated through appropriate strategies. This suggests that increasing awareness of evidence-based prevention approaches could shift perceptions and promote proactive mental health care.

Among those who believed mental illness could be prevented, suggested strategies included avoiding excessive drug and substance use, maintaining social connections, managing stress, and adhering to societal norms to avoid offending deities or ancestors. Notably, many perceived these options as limited and expressed disagreement about the effectiveness of stress avoidance as a preventive measure. These findings echo Jorm et al. (2010), who identified physical activity, social engagement, substance avoidance, and relaxation as perceived

preventive measures. In contrast, Singh et al. (2022) note challenges in implementing these prevention strategies, especially in low-resource settings like Ghana, where intervention delivery remains inadequate. This discrepancy suggests that while prevention strategies exist, systemic barriers may hinder their application, emphasizing the need for culturally relevant, accessible prevention programs.

The economic impact of poor mental health is significant, emphasizing the need for effective prevention strategies and improved mental health outcomes. Despite the high costs associated with mental illness, prevention often lacks sufficient attention and resources (McDaid & Wahlbeck, 2019). Furber et al. (2015) highlight that, unlike cardiovascular disease and cancer, mental illness prevention remains notably underemphasized. As such, while mental illness is only partially preventable, early intervention is possible, as many conditions originate in infancy, childhood, adolescence, and early adulthood. Approximately 50% of mental illnesses begin by age 14 and 75% by age 24. Recognizing early warning signs can enable timely intervention and potentially prevent the onset of illness (Colizzi et al., 2020). Purgato et al. (2020) emphasize that mental health exists on a continuum, from wellness to illness, progressing through at-risk status, distress, sub-syndromal symptoms, and ultimately, clinical illness. This highlights the importance of mental health promotion and preventive interventions to reduce future risks. Strengthening protective factors that enhance resilience is key to preventing mental illness and improving outcomes for those affected (Singh et al., 2022). Min et al. (2013) propose preventive strategies such as lifestyle modifications, stress management training, preventive consultations, positive psychotherapy, and community-based initiatives. These efforts can increase mental health awareness, support early identification of symptoms, and encourage appropriate help-seeking behaviors.

Ghana, like many nations, faces distinct mental health challenges that necessitate effective prevention strategies to improve individual and societal well-being (Weobong et al., 2023). Implementing such measures can substantially reduce the prevalence of mental illness, easing the emotional, social, and economic burdens associated with these conditions (Singh et al., 2022). These efforts align with a holistic healthcare approach that acknowledges the interconnectedness of mental and physical health (Shafran et al., 2017). Reupert (2022) emphasizes the need for a dual approach, recognizing that mental illness affects not only individuals but also their families and communities. Integrating mental illness prevention into general healthcare practices is vital for reducing the strain on Ghana's healthcare system, which is already burdened by both physical and mental health challenges (Thomas et al., 2016). Achieving meaningful mental health promotion requires collaboration among government bodies, healthcare professionals, non-governmental organizations (NGOs), and community stakeholders (Alderwick et al., 2021). By fostering these partnerships, Ghana can progress towards a population that is healthier, more resilient, and better equipped to thrive.

Implications for Personhood in Context (How does mental health/illness affect personhood?/ Can personhood explain stigma and discrimination among people living with mental illness?)

Mental illness profoundly affects an individual's identity, autonomy, and well-being, with unique implications for personhood in Ghana, where cultural norms and societal perceptions shape mental health experiences (Lorenz-Artz et al., 2023; Opare-Henaku & Utsey, 2017). This provides a foundation for exploring how mental illness challenges and reshapes the concept of personhood in Ghana, shedding light on the cultural, social, and systemic factors at

play (Asafo et al., 2025). Understanding this intersection emphasizes the urgent need for culturally sensitive and inclusive mental health care approaches in Ghana.

Mental illness is widely believed to impact personhood among the Akan and Ewe communities, often leading to diminished social status and exclusion. Individuals with visible symptoms, such as aggression or disordered behaviour, may be perceived as having lost their moral and social integrity—key aspects of personhood. Additionally, within these cultural frameworks, mental illness is sometimes seen as a severed connection with spiritual entities or ancestors, affecting both social standing and spiritual identity (Mbiti, 1991; Gyekye, 1995).

However, alternative perspectives assert that personhood remains intact despite mental illness, emphasizing intrinsic human value beyond social conformity. African conceptions of personhood integrate both social and inherent dimensions, recognizing moral standing and community participation while affirming an enduring human essence (Ozoemena et al., 2022). This view aligns with Ikuenobe (2018), who argues that African communalism upholds human dignity as fundamental, advocating for empathy and support rather than exclusion. Mbiti (1991) further underscores the spiritual dimension of personhood, suggesting that individuals, even when facing mental health challenges, retain their connection to the living and the ancestral, reinforcing their inherent worth.

Personhood also informs the stigma, discrimination and abuse experienced by individuals with mental illness in Akan and Ewe societies. Since personhood is linked to moral integrity and social conformity, those who do not meet these expectations are often marginalized and lose certain rights (Gavi et al., 2022). Stigmatization manifests in derogatory labels, social exclusion, limited employment opportunities, and restrictions from leadership roles (Mfoafo-M'Carthy & Sossou, 2017). Additionally, the belief that mental illness stems from spiritual retribution or

possession reinforces exclusionary practices and negative stereotypes (Opare-Henaku & Utsey, 2017). These cultural perceptions highlight the need for inclusive approaches that integrate social, spiritual, and psychological support for individuals with mental illness.

Human Rights Abuses

In Ewe and Akan communities, individuals living with mental illness often face severe abuse, including shackling, starvation, physical assault, and involuntary confinement in rooms or prayer camps. While undeniably inhumane, these practices are frequently justified as protective measures to prevent harm, facilitate medication administration, and manage violent behaviour. Some even argued that abuse was inconsequential, assuming individuals with mental illness might not recognize their mistreatment. Lambert et al. (2020) document similar practices in Ghana's traditional and religious settings, where abusive methods are seen as necessary despite evidence that they may worsen mental health. Benyah (2022) calls for harmonizing religious views with human rights efforts to transform care for people with mental illness. Verbal abuse is also widespread, with derogatory terms like "w'ayi," "wabodam," "ametsibome," and "eda afo" — translated as "mad," "lazy," or "ruffian" — reinforcing stigma and social exclusion. Grover et al. (2020) highlight how such labels intensify distress, while Corrigan et al. (2014) argue that stigma discourages help-seeking, as individuals fear facing judgment and rejection. Addressing these harmful practices and pervasive stigma is essential for fostering a more compassionate and supportive mental health landscape in Ghana.

From community perspectives, people are reluctant to associate with, employ, or work alongside individuals with mental illness, even after treatment, due to fears of relapse or costly mistakes. There's also a widespread belief that those with mental illness are unsuitable for esteemed roles, like chieftaincy titles, due to perceived diminished reasoning and personhood.

This reveals substantial barriers to employment for individuals with mental illness. Chapman et al. (2024) similarly found that individuals with disabilities face a lack of dignity in job searches, fostering feelings of vulnerability. High unemployment rates among people with severe mental illness are fuelled by misconceptions of unfitness for work, leading to self-doubt and workplace identity crises (Nirmala et al., 2020; Khalid & Syed, 2023). Yet, employment is crucial for social inclusion, boosting self-esteem, community participation, and quality of life (Frank et al., 2021). Stigma creates barriers like reluctance to disclose mental health conditions, work-related stress, and reduced job longevity — but these challenges are addressable (Ebuenyi et al., 2019). Achieving justice for people with mental illness requires efforts beyond service development to dismantle social, structural, and political barriers (Mezzina et al., 2022). By amplifying the voices of those with lived experiences and fostering cross-sector collaboration, there can be a push for systemic change, ensuring mental health and human rights are championed through both legislation and advocacy (Read et al., 2020).

Other forms of abuse include denial of education, marriage, reproductive rights, economic exploitation, and involuntary medical treatment (Kishore et al., 2011; Ssengooba, 2012). These abuses are deeply influenced by cultural beliefs that shape societal perceptions of mental illness, sometimes justifying harmful practices (Msuya, 2019). For instance, entrenched norms that sustain practices like child marriage and female genital mutilation also contribute to the marginalization and mistreatment of people with mental illness (Mfoafo-M'Carthy & Sossou, 2017). Despite progress in Ghana's human rights landscape, the mistreatment of individuals with mental illness remains a critical yet overlooked issue (Harden et al., 2023). Safeguarding the personhood of these individuals requires more than legislation — it calls for a coordinated, multi-sectoral approach involving governments, communities, and advocacy groups (Burns,

2009; Irmansyah et al., 2009). This approach should prioritize dignity, autonomy, and well-being while actively dismantling systemic discrimination and abuse (Dixon et al., 2016). Advocacy, education, and awareness campaigns are essential to combat stigma, abuse and foster inclusive attitudes (W.H.O., 2021). Additionally, evaluating the impact of anti-stigma efforts and developing culturally sensitive interventions can promote lasting change (Mascayano et al., 2020; Potts & Henderson, 2021). By merging human rights efforts with mental health initiatives, societies can move towards recognizing and affirming the full personhood of individuals with mental illness, ensuring their rightful place within the community

Spotlighting Occupational Therapy

Although mental illness is often seen as diminishing personhood, some members of the Ewe and Akan communities believe that personhood can be restored when individuals return to their premorbid lives — reengaging in activities, contributing to society, and adhering to societal norms. This emphasizes the performative nature of personhood and highlights the vital role of occupational therapy in the recovery process. Gavi et al. (2022) argue that within these communities, metaphysical recognition alone is insufficient to fully restore personhood without the ability to fulfill expected social roles. This view frames recovery as a multidimensional process involving empowerment and resilience, extending beyond symptom reduction (Woolley et al., 2020). It contrasts with traditional biomedical models that focus solely on pathology (Eiroa-Orosa & Tormo-Clemente, 2022). In this context, occupational therapy becomes essential not only for symptom management but for reintegration into community life, supporting individuals in reclaiming their sense of personhood (Valverde-Bolivar et al., 2022).

Occupational therapy is a holistic, client-centred healthcare profession that empowers individuals to engage in meaningful activities and occupations (Strong et al., 1999). Research

consistently highlights its effectiveness in mental health recovery, with interventions shown to improve self-esteem, quality of life, and overall functioning (Hohl et al., 2017). By focusing on personalized, meaningful activities, occupational therapy plays a vital role in restoring personhood for individuals with mental illness. Ikiugu et al. (2017) found that theory-based occupational therapy interventions significantly enhance occupational performance and well-being, advocating for its inclusion as a core component of mental health rehabilitation. Similarly, Gibson et al. (2011) conducted a systematic review demonstrating the effectiveness of occupation- and activity-based interventions in fostering community integration and normative life roles. This uniquely position occupational therapy practitioners to assist in restoring personhood for individuals with mental illness.

Occupational therapy (OT) practitioners adopt a person-centred approach, prioritizing individuals' goals and values while tailoring interventions to meet their unique needs and desires (Brown, 2013). This approach, grounded in respect and partnership, empowers individuals to actively participate in their recovery, reinforcing their sense of personhood (Centre for Addiction and Mental Health, 2023). By collaboratively selecting meaningful activities and routines, occupational therapists help individuals rebuild a sense of purpose and identity (Mack et al., 2023). OT interventions also focus on developing essential life skills, such as coping strategies, emotional regulation, and social skills, which are crucial for restoring competence and self-worth (Gibson et al., 2011). Additionally, therapists support community reintegration by encouraging participation in social and recreational activities, reducing isolation, and fostering belonging (Rocamora-Montenegro et al., 2021).

Despite OT's effectiveness in mental health care, widespread adoption faces challenges. Barriers include limited access to OT services — with fewer than 0.25 occupational therapists

per 100,000 people globally (Hoosain, 2022) — persistent mental health stigma, and inadequate recognition of OT's role in mental health treatment (Culleton, 2022; Ranjan et al., 2023). Addressing these barriers through policy reform, education, and advocacy is essential to expanding OT's impact. By focusing on person-centred care, skill development, and community integration, occupational therapy becomes a pivotal force in restoring personhood for individuals with mental illness (Woolley et al., 2020). Moreover, therapists should remain attuned to each individual's vision of recovery, recognizing that well-being may not always mean returning to a premorbid life but rather finding new ways to thrive (Jafari & Groblena, 2023). Amplifying OT's contributions within mental healthcare systems can enhance overall care quality and improve outcomes for individuals striving to reclaim their sense of self and belonging (Nugent et al., 2017; Dogu & Ozkan, 2023).

For successful therapeutic outcomes, compliance is a critical factor, referring to the extent to which individuals adhere to prescribed therapeutic interventions (Chakrabarti, 2014). In mental health care, compliance involves attending therapy sessions, actively participating in activities, and following treatment plans — all of which significantly influence the course and outcomes of mental illness (Laranjeira et al., 2023). Non-compliance can impede progress and hinder the restoration of personhood, making it essential to understand and address the factors that shape adherence. Compliance in mental health occupational therapy is influenced by various factors, including patient motivation, therapeutic rapport, treatment acceptability, and environmental conditions (Swarbrick & Noyes, 2018). Tailoring interventions to individual needs and preferences through client-centred approaches, realistic goal-setting, and collaborative activity selection can enhance compliance and promote recovery (Baker et al., 2015). Additionally, addressing challenges like resistance to therapy or ethical dilemmas helps

therapists navigate complex situations while upholding professional integrity (Durocher & Kinsella, 2021). By addressing the factors influencing compliance, occupational therapists can strengthen the impact of their interventions, empowering individuals to actively engage in their recovery journey and rebuild their sense of personhood (Kelly et al., 2010).

Collaborative engagements and cultural competence for practitioners

Among the Akan and Ewe groups, it is common practice to investigate the cause of mental illness before selecting a treatment approach. Those who prefer hospitals consult mental health professionals, while others seek guidance from deities, religious leaders, or faith-based experts to determine the underlying cause. Treatment options are then considered based on these investigations. Some individuals begin with faith-based practitioners and turn to hospitals only when spiritual interventions prove ineffective, while others prioritize biomedical care but explore traditional alternatives if clinical treatments fall short.

The use of traditional or faith-based healers is deeply rooted in the African context, where they are often the primary healthcare providers, especially in low- to middle-income countries (LMICs) (Kpobi et al., 2019). In Ghana, nearly 80% of the population relies on traditional medicine for primary care, particularly in rural areas where biomedical services face challenges like limited accessibility and cost (Krah et al., 2017; Ampomah et al., 2023). The preference for traditional healing is also shaped by cultural beliefs that mental illness has spiritual underpinnings (Kwame, 2021). Because traditional medicine is embedded in cultural and moral value systems, effective mental healthcare in Ghana necessitates partnerships between biomedical and traditional practitioners (Krah, 2019; Ee et al., 2020). Countries like Japan, China, South Korea, and Singapore have successfully integrated traditional medicine into their healthcare systems (Kwame, 2021), offering a model for Ghana to follow. Collaborative

approaches in mental health care — built on shared decision-making, mutual respect, and recognition of lived experiences — empower individuals to actively shape their recovery journey (Guinaudie et al., 2020). Kpobi and Swartz (2019) argue that understanding the beliefs and practices of traditional healers is key to building effective partnerships. The 1978 Alma-Ata conference emphasized the importance of utilizing all available healthcare resources, a principle that remains relevant in LMICs where care options are limited (Kokota et al., 2022). Encouragingly, both traditional and biomedical practitioners in Ghana recognize the potential benefits of collaboration and express a willingness to work together (Green & Colucci, 2020).

Despite these positive attitudes, integrating traditional medicine into Ghana's healthcare system remains incomplete (Kwame, 2021). Traditional healers often lack formal training, their work is sometimes viewed as illegal by biomedical practitioners, and their services are not covered by health insurance (Kwame, 2021). Mutual suspicion persists, with biomedical professionals fearing for service users' safety, while service users and caregivers may view conventional care as inadequate (Nyame et al., 2021). Additionally, family and community support — while shown to improve outcomes (Aldersey & Whitley, 2015) — can also create stress or reinforce stigma (Ong et al., 2021). Engaging families through psychoeducation, assessment, and counselling is essential but still underutilized (Varghese et al., 2020; Hanson et al., 2022). Cultural competence is crucial for bridging these divides and delivering mental healthcare that respects the cultural, social, and linguistic realities of service users (Ihara, 2004; Henderson et al., 2018). In Ghana's diverse context, cultural competence involves recognizing how culture shapes mental health perceptions (Stubbe, 2020) and acknowledging the intersectionality of cultural and psychological factors (Gopalkrishnan, 2018). When practitioners demonstrate cultural humility and understanding, individuals are more likely to engage in

treatment, fostering a stronger sense of ownership over their mental health journey and contributing to the restoration of personhood. Thus, integrating collaborative care models with cultural competence is vital for delivering effective, person-centred mental healthcare in Ghana. Embracing the strengths of both biomedical and traditional approaches can bridge treatment gaps, ensuring individuals receive comprehensive care that respects their identities, honours their cultural backgrounds, and supports their full restoration of personhood.

Mental Health Education

The findings of this study reveal a significant gap in mental health education and awareness, underscoring the urgent need for increased public education. This lack of understanding often perpetuates stigma and discrimination against individuals living with mental illness (Siddique et al., 2022). Participants expressed various misconceptions about mental health and illness, revealing a pervasive lack of awareness that may explain certain attitudes and help-seeking behaviours in indigenous Ghanaian settings.

One common misconception is about who can develop mental illness. Many participants believed mental illness is a punishment for wrongdoing — either physical (e.g., drug abuse) or spiritual (e.g., curses for violating societal norms). Young adults were often perceived as the group most at risk, as they are viewed as more likely to break societal rules. Conversely, older adults were seen as immune to mental illness, contributing to the frequent oversight of mental health issues in aging populations. Ageism in mental health manifests in several ways: providers may infantilize older adults, assume they are incapable of experiencing suicidality or loneliness, or dismiss their struggles as a "normal" part of aging (Baruchman, 2023). In reality, mental illness is prevalent among older adults, with research indicating high rates of severe cognitive impairments, depression, and anxiety (Petrova & Khvostikova, 2021). The World Health

Organization (2017) reports that over 20% of adults aged 60 and above are affected by mental or neurological conditions, contributing to 6.6% of all disability-adjusted life years (DALYs) for this age group — a figure projected to double by 2030 (PAHO, n.d.).

The belief that mental illness is rare in older adults may stem from underreporting, as many seniors view mental illness as a weakness or fear losing their independence (de Mendonça Lima & Ivbijaro, 2013). Additionally, older adults may not recognize mental health symptoms, attributing sadness, confusion, or forgetfulness to natural aging (CDC, 2022; Rodda et al., 2011). In some cultures, including parts of India and Ghana, conditions like dementia are perceived as normal aging rather than medical concerns (Ashida, 2000). Misattributing late-life mental illness to neglect or lack of family love can further prevent older adults from accessing necessary support (de Mendonça Lima & Ivbijaro, 2013).

Another significant misconception was that children are not at risk of developing mental illness. This aligns with findings by Kishore et al. (2011) in India, where many believed children could not experience mental illness. The dominant view attributed mental illness to behavioural flaws or moral failure (Shah et al., 2017), with children perceived as innocent and thus incapable of actions that could trigger mental illness. Additionally, children are often thought to be inherently resilient and able to outgrow emotional or behavioural issues (Osofsky & Lieberman, 2011). However, research shows that mental illness affects nearly 15% of young people worldwide, with behavioural disorders, anxiety, and depression being the most common conditions (WHO, 2021). Alarmingly, suicide is the fourth leading cause of death among people aged 15 to 29. Left unaddressed, childhood mental health challenges can have long-term consequences on emotional development, physical health, and overall well-being (Abrams, 2023). Interestingly, participants acknowledged that neonatal incidents or maternal actions

during childbirth could impact a child's development, yet did not fully recognize that children could experience mental illness. This disconnect highlights the need for deeper conversations about child and adolescent mental health.

These misconceptions contribute to stigma, causing individuals to suffer in silence, fearing social consequences or judgment (Mehta & Edwards, 2018). Stigma can also exist within healthcare systems, with providers unintentionally reinforcing biases or experiencing stigma themselves for working with marginalized populations (Subu et al., 2021). Breaking this cycle requires community-driven education efforts that address cultural myths and promote understanding. Mental health education should highlight recovery stories and foster hope, rather than focusing solely on clinical knowledge (Walsh & Foster, 2021). Therefore, addressing mental health stigma and misconceptions requires culturally sensitive education, community involvement, and training for mental health professionals. Empowering individuals with accurate knowledge and fostering compassionate dialogue can help dismantle stigma, encouraging people to seek care without fear or shame. Ultimately, promoting mental health literacy across all age groups can pave the way for more inclusive, person-centred mental healthcare, ensuring no one is left behind.

Conclusion

This study offers a detailed insight into how personhood and mental health/illness are perceived within specific cultural contexts in Ghana. These insights build upon existing theories of personhood and mental health/illness by introducing dimensions that are frequently overlooked in Western-centric frameworks. This contributes to a broader understanding of how cultural perspectives shape individuals' views on mental health and illness, ultimately influencing treatment approaches. It equally emphasises the dynamic process of integrating

cultural knowledge with practical action to reform beliefs, attitudes, methods, and policies. This suggests that personhood and mental health/illness should not be considered static concepts but rather as fluid, evolving constructs influenced by cultural and societal factors. This framework challenges dominant biomedical perspectives by bringing to the forefront culturally competent, collaborative, and context-specific approaches to mental health/illness. The study further advocates for dialogue on incorporating human rights perspectives and emphasising occupational therapy and collaborative practices in mental health/illness. It suggests that theoretical models must account for diverse cultural settings and their implications for mental health care, highlighting the need for laws and policies that reflect this dynamic relationship between cultural and clinical understandings.

The conceptualisation of personhood as encompassing ethno-cultural, corporeal, and numinous dimensions provides a framework for understanding how Ghanaians perceive mental health and illness. This awareness necessitates that mental health practitioners integrate cultural competence into their practice, recognising that treatments must align with patients' cultural beliefs and values to be effective (Kpanake, 2018). For example, acknowledging spiritual or numinous dimensions in mental illness may promote the inclusion of traditional healing practices alongside biomedical approaches. Mboweni et al. (2023) emphasize the significance of culturally sensitive education in enhancing the acceptance and effectiveness of mental health treatments, particularly where traditional beliefs regarding mental illness are prevalent. Similarly, as underscored by Kirmayer et al. (2011), cultural competence in mental health care involves recognizing and incorporating clients' cultural values into treatment, which can improve therapeutic engagement and outcomes.

Secondly, by framing mental illness as not solely a medical condition but also a cultural and societal one, the findings advocate for a more holistic approach (Green & Colucci, 2020; Kotoka et al., 2022). Mental health in this context is not merely the absence of illness, but involves proactive self-care, emotional well-being, and social integration. The perception of mental illness is also evidently framed through both biomedical and psychosocial perspectives (Asafo, 2021; Benyah, 2023). This shifts the focus from mainly treating symptoms to fostering overall well-being and incorporating preventive measures that reflect the cultural environment. The findings of this study equally emphasise how mental illness is often personified in Ghanaian culture, associated with spiritual curses, dysfunctional behaviour, and brain function. Understanding these perceptions can assist health professionals in crafting more culturally resonant communication strategies. Rather than rely solely on biomedical explanations, treatment can encompass addressing stigma, reshaping public attitudes, and aiding patients and their communities in reconceptualising mental illness in more constructive terms (McGinty et al., 2018).

The emphasis on collaborative engagements among healthcare practitioners and the inclusion of culture highlights the need for multidisciplinary care. According to Kwame (2021), formal collaboration and patient referrals between healthcare systems (traditional and biomedical) are essential for strengthening local and informal partnerships. This will facilitate knowledge sharing, especially since many biomedical practitioners lack sufficient understanding of traditional mental health practices. Adu-Gyamfi (2024) opines that collaboration should be promoted among educational and training institutions, the Ministry of Health, and relevant international organizations such as the World Health Organization. Such partnerships should aim to evaluate and expand disciplines related to indigenous knowledge and biomedical practice,

offering contemporary perspectives on health, illnesses, and cultural orientations that are more relevant to the local context. By working with traditional healers, families, and community members, healthcare professionals can offer more comprehensive care that addresses the medical and cultural aspects of mental health. This collaborative model encourages the integration of occupational therapy and culturally informed practices, offering more personalized and effective treatments.

The findings underscore the significance of enacting laws and policies that reflect a deeper understanding of how personhood and mental health/illness are perceived in Ghana. Human rights abuses against individuals living with mental illness are highlighted, urging policymakers to develop mental health legislation that protects their dignity and ensures access to culturally competent care. This underscores a shift from a solely treatment-based approach to one that also encompasses advocacy and systemic change. Osafo (2018) advocates for a transition from cross-cultural thinking to cultural thinking in psychological research and practice in Ghana. He concludes that psychological science can more effectively support service users if its predominantly Western focus is re-evaluated and tailored to align with the Ghanaian cultural context.

Given the reflections on the aetiology of mental illness and the unipolar representations in the findings, the focus on prevention becomes more pronounced. Practitioners are encouraged to implement early intervention strategies that incorporate both scientific and cultural knowledge, helping to reduce the incidence of mental health issues by addressing them in their early stages within the context of Ghanaian values. Thus, these findings suggest that in the Ghanaian setting, treatment approaches must be culturally grounded, multidimensional, and

collaborative to be fully effective in addressing the unique ways mental illness is experienced and understood. This is summarized in Figure 1 below.

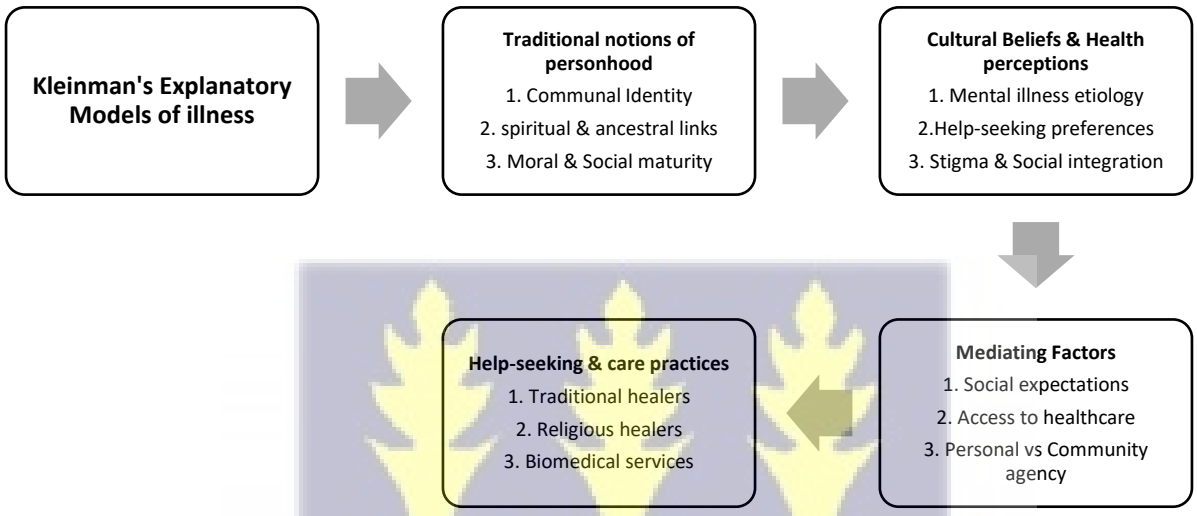


Figure 1

Dimensions of personhood in mental health/illness

Figure 1 illustrates the dimensions of personhood, subjective experiences of mental health, and their practical implications for treatment and practice. Understanding these aspects can enhance culturally sensitive mental health services, leading to more effective and personalized care. The framework extends Kleinman's Explanatory Models of Illness by situating them within African notions of personhood and cultural beliefs. Illness is understood not just biologically but through communal identity, spiritual and ancestral ties, and moral maturity. These notions inform cultural beliefs about mental illness causes, help-seeking preferences, and stigma. Mediating factors such as social expectations, access to healthcare, and

the balance between personal and community agency influence decisions about care. Consequently, people adopt plural help-seeking practices, often moving between traditional healers, religious healers, and biomedical services.

Overview of the study

This research aimed to understand the cultural conceptualisations of personhood and its relation to mental healthcare in Ghana. The objectives were to explore conceptions of personhood among the Akans and Ewes, ascertain whether individuals living with mental illness are regarded as "Persons" within this setting, examine notions of personhood and spirituality about help-seeking and care practices for the mentally ill, and elucidate human rights abuses of the mentally ill, considering Akan/Ewe interpretations of personhood and mental illness. The three primary themes identified include 1) *Conceptualization of personhood*, 2) *Subjectivizing mental illness,* and 3) *Implications for personhood in context.*

The findings of this study reveal a complex interaction between personhood, cultural narratives, and mental health/illness perceptions in Ghana, moving beyond a simple synthesis of previous literature. When viewed collectively, the themes suggest that mental health is deeply intertwined with notions of identity, spirituality, and communal belonging, challenging the tendency to compartmentalize mental health within purely biomedical frameworks. A core insight that emerges is the fluidity of personhood. The conceptualization of personhood as encompassing ethno-cultural, corporeal, and numinous dimensions illustrates that mental illness is not just experienced at the individual level but reverberates through familial, communal, and spiritual realms. This interconnected view of selfhood implies that healing is not just a clinical endeavour but a relational and spiritual one, where social reintegration and spiritual alignment are as crucial as symptom management. Moreover, the subjectivizing of mental health/illness

reflects a dynamic negotiation between traditional beliefs and evolving contemporary understandings. The perception of mental illness as both a biomedical and spiritual phenomenon underscores the importance of acknowledging multiple realities in mental health care. Rather than positioning biomedical and traditional practices as competing systems, the findings suggest that they are complementary, each addressing different aspects of the human experience. This positions collaboration not as a logistical necessity but as an epistemological imperative—an opportunity to create an integrative model of care that resonates more deeply with people's lived experiences.

The implications for treatment and practice, therefore, extend beyond cultural competence to cultural humility. Practitioners must not only understand cultural beliefs but be willing to engage in continuous learning, allowing their clinical practices to evolve alongside the cultural contexts they operate within. The emphasis on collaborative engagements and multidisciplinary care is not just a practical recommendation but a call to reimagine mental health systems as ecosystems of care, where diverse knowledge systems converge to offer more holistic and contextually meaningful support.

Crucially, the findings highlight that systemic change is essential. The call for policy reform, grounded in human rights and cultural understanding, reflects a broader need to align mental health governance with the lived realities of individuals and communities. Addressing stigma, promoting education, and fostering public discourse on mental health can gradually reshape societal attitudes, bridging the gap between clinical perspectives and community wisdom. In summary, the study's findings do not merely corroborate existing theories—they extend them. These perspectives highlight mental health as an evolving, multidimensional construct shaped by the interplay of individual agency, cultural identity, spiritual beliefs, and social structures.

Recognizing this complexity is essential, but it also presents challenges. For instance, the diversity of explanatory models can make it difficult to establish universally accepted definitions or standardized approaches to care. Moreover, gaps in research and limited integration between biomedical and indigenous systems constrain how effectively mental health care in Ghana can address people's lived realities. Acknowledging these limitations provides a basis for refining future studies and developing more contextually grounded interventions.

Limitations of the Study

Participant engagement may have been enhanced by the researcher's prior immersion in the setting; however, in contexts without such established interaction, engagement levels might have been lower. This dynamic raises the possibility of social desirability bias, as participants may have tailored responses to align with perceived expectations. Additionally, while the relatively large sample size enriched the study by providing diverse perspectives, it also lengthened the study period due to the extensive time required for in-depth transcript analysis. Future studies of this nature would benefit from an extended study timeline to ensure adequate depth without compromising analytic rigor.

Implications for Policy, Practice, and Research

Policy

The curriculum for mental health training and education should incorporate modules on spirituality and cultural competence to better equip providers with the skills necessary for delivering inclusive care. In addition, public mental health awareness campaigns need to go beyond biomedical framings by addressing stigma through broader understandings of mental illness that include spiritual and cultural perspectives. At the policy level, government

initiatives should actively promote inclusive mental health systems by integrating spiritual care into service delivery, thereby ensuring accessibility to resources that are both culturally and spiritually sensitive.

Practice

Healthcare providers should adopt a biopsychosocial approach that explicitly integrates spirituality into assessment and treatment, recognizing its significant role in shaping individuals' experiences of mental illness. In practice, this calls for culturally competent care, where practitioners honor and incorporate patients' cultural and spiritual values into therapeutic partnerships, thereby enhancing engagement and the effectiveness of interventions. Furthermore, mental health services should embrace a person-centered approach that respects diverse belief systems, fostering trust and ensuring that care remains holistic and comprehensive.

Research

Future research should focus on developing evidence-based interventions and awareness campaigns that reflect the diverse cultural and spiritual needs of individuals experiencing mental health challenges. In addition, examining the impact of spirituality-inclusive interventions on treatment outcomes will provide valuable insights to guide evidence-based practice and inform the design of more inclusive mental health care models.

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Appendix

INTERVIEW GUIDE - MENTAL ILLNESS AND PERSONHOOD

NOTE: probe all questions in context- thus what do they mean to the Ewes/Akans?

1. What is your understanding of health/being healthy?
2. What is your understanding of mental health?
3. What is mental Illness?
    a. What is likely to bring about mental illness? (Probe for spirituality as a cause)
    b. Do you have a friend or relation with mental illness? Have you ever experienced mental health challenges personally? Tell me more about that.
    c. How do you know if someone has mental illness? (Probe for mood and emotional substance related challenges)
    d. Who suffers from mental illness? Do children/elderly suffer from mental illness? (Probe further)
    e. Where can one get help for mental illness? Where will you go to get help for mental illness? (probe depending on answer).
4. Who is a person as understood in your community/among the Ewes/Akans? (Probe further)
5. Is every human being a person? (probe why)
    a. Is an individual a person if they have mental illness? (Probe why)
    b. If a person has suffered mental illness and is cured, will he/she be considered as a person? (Probe further)
        i. Can someone who has suffered mental illness regain their personhood? (Probe further)
        ii. If so, how?

c. What aspects of a person do you consider affected when he/she is mentally ill? (Probe further)

d. Is mental illness curable? (Probe further)

i. Who can cure mental illness?

ii. What methods are used in curing mental illness? (Probe for forced fasting, chaining, beating, starving, marking). Why are such methods used?

iii. Does any of these methods violate their human rights? (Probe further)

iv. If you were to suffer mental illness, will you like to be treated the same way? (Probe further)

v. What are the signs of cure? (Probe further)

vi. Is the cure permanent? If yes, explain. If no, why not?

6. Can mental illness be prevented? If so, how?

7. How does society perceive the mentally ill? (probe)

a. Words used to describe them. Why?

b. Whether they are avoided. Why?

c. Whether they are feared. Why?

d. Whether they are considered to be cursed people. Why?

e. "spoiled". Why?

f. Possessed. Why?

8. What sense are you making from all these questions we have been asking you?

UNIVERSITY OF GHANA

Ethics Committee for Humanities (ECH)

PROTOCOL CONSENT FORM

Section A- BACKGROUND INFORMATION

Title of Study:	Personhood, spirituality and mental illness.
Principal Investigator:	Seth Mawusi Asafo
Certified Protocol Number	

Section B– CONSENT TO PARTICIPATE IN RESEARCH

General Information about Research

The purpose of this study is to understand the Ewe/Akan conceptions of who a person is. We are also interested in understanding from your perspective the role of spirituality in mental illness and how personhood or the state of being a person is related to mental illness.

As a group discussion, this interview generally will last between one to two hours maximum. In this discussion, we are interested in your thoughts and opinions about the topic. There are therefore no right or wrong answers. Please feel at ease to express your agreements or disagreements about the opinions of others or the interviewer respectfully. If you wish to make a point regarding the discussion, kindly gesture the moderator and wait for your turn to share your point. For purposes of playback and analysis, this interview will be audio recorded. There will be no video recordings.

Benefits/Risks of the study

This study poses no direct physical, emotional or psychological risks. It basically wants to identify our opinions on happenings around us relating to who a person is and how that is related to spirituality and mental illness. The study will require us to share why our opinion on some things are the way they are around us. It will require that you share knowledge from your cultural perspective. Although there are no direct risks involved in this study, you are at liberty to discuss with the team any feelings of discomfort and we will work to find the best alternative to address it. You will be referred to see a psychologist, Edwin Boachie Yiadom, who will offer assistance when required. There will be no direct benefit from participating in this study.

Confidentiality

All interviews will be audio recorded. To ensure anonymity, pseudo names will be given to prevent individual identification challenges. No personal names will be used. In the course of the interview if you need to address or react to another interviewee's comments, please use their pseudo name. Only the gender and community of a contributor will be provided in giving voice to submissions by participants in the research report. No participant will be singled out when the results are being disseminated. All recordings and data collected, will be put in a secure laptop of which only the researcher and his supervisors will have access to. You will be given a snack (drink, water and pastry) or its equivalent in cash, in the sum of GH¢ 20.00 after the interview to compensate you for time and expenses for participating in this study. Compensation will be given to participants who participate fully in the study and will be given at the end of the interview. There will also be periodic breaks in the course of the interviews to prevent fatigue.

Compensation

There will be no direct financial reward or compensation packages if you agree to take part in the research. However, refreshment will be provided for participants as a gesture of thanks.

Withdrawal from Study

Participation in this study is completely voluntary. If at any point you no longer wish to continue with the discussion, you are permitted to leave without penalty. Upon agreement to be a participant in this study you will not be adversely affected if you later decline to participate or stop participating.
You will become a member of this study as soon as you agree to the conditions stated in this document. At the same time, you are free to leave the study as soon as you ask to withdraw without prior notice. However, your participation in the discussions may be terminated if you are found to persistently attack other participants' views unfairly to cause them embarrassment or make them upset.

Contact for Additional Information

If you have any questions, concerns or further contributions to make about this study, please contact:

Seth Mawusi Asafo

University of Ghana, Legon

Department of Psychology

E-mail: sethogh@live.com

Tel: 0244598402

If you have any questions about your rights as a research participant in this study you may contact the Administrator of the Ethics Committee for Humanities, ISSER, University of Ghana at ech@ug.edu.gh or 00233- 303-933-866.

Section C- PARTICIPANT AGREEMENT

"I have read or have had someone read all of the above, asked questions, received answers regarding participation in this study, and am willing to give consent for me, my child/ward to participate in this study. I will not have waived any of my rights by signing this consent form. Upon signing this consent form, I will receive a copy for my personal records."

_____

Name of Participant

_____ _____

Signature or mark of Participant Date

If participant cannot read and or understand the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

_____

Name of witness

_____ _____

Signature of witness / Mark Date

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

_____

Name of Person who Obtained Consent

_____ _____

Signature of Person Who Obtained Consent Date