Empirical–Qualitative

Representations of Mental Illness in a Ga Community in Southern Ghana

Journal of Black Psychology
2023, Vol. 0(0) 1–31

DOI: 10.1177/00957984231192141
journals.sagepub.com/home/jbp
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Abstract

This study explored lay concepts about and attributions of mental illness in a Ga community in southern Ghana. The study's sample consisted of 11 Ga men and 12 Ga women, ranging in age from 30-81. Participants completed one-on-one interviews. Participants ascribed to polyphasic attributions of mental illness including biomedical and spiritual explanations. Attributions informed understandings of help-seeking behavior. Stigma was recognized as an important factor in the lived experience of people with mental illness. The recognition of individual distress as a marker of mental illness seemed less prominent than social indicators. Our interviewees' narratives highlighted the importance of the social context in identifying and making meaning of mental illness in the community of study.

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Keywords
mental illness, stigma, Ghana, Ga community

Introduction

Mental illness representation refers to ways in which mental illness is framed, understood, or imagined (Miller et al., 2019). It includes labels, perceived etiology, social responses and perception, and decisions about help-seeking (Jodelet, 1991; Morant, 1998). Mental illness labels contain implicit and explicit messages about understandings of mental illness. Some labels focus on observable negative symptoms of mental illness, which can contribute to stigma and influence social responses to people with mental illness (Grover et al., 2020; O'Connor et al., 2022). Beliefs about causes of mental illness are varied, including environmental or hereditary causes, social-personal causes, and spiritual causes, and influence help-seeking (Chen and Mak, 2008; Yamada et al., 2019). Literature suggests that people often adopt a polyphasic narrative of etiology—in other words, a narrative that comprises different, and sometimes conflicting, beliefs about mental illness (de-Graft Aikins, 2012; de Rosa and Bocci, 2012; Jovchelovitch, 2002). These representations develop from social knowledge and vary across cultures.

Understanding how people in a given cultural context make sense of mental illness is essential to understanding the experience of people experiencing mental illness in that context, with implications for help-seeking, effective treatment, and mental health policy (Aikins, 2018). Increasing evidence demonstrates that understandings of mental illness can shape symptom presentation. Consensually shared cognitive representations of mental illness—sometimes called *cultural scripts for deviancy*—direct attention towards specific experiences, contributing to their emergence as symptoms (Chentsova-Dutton and Ryder, 2019). Finally, treatment programs have been found to be much less effective when there is a mismatch between the beliefs of the client and the mental health professional (Benish et al., 2011; Kirmayer, 2007). A better understanding of local beliefs can aid in the development of more effective services.

Mental Illness Representations in the African Diaspora

Several studies over the years have identified that social, historical, and cultural representations of mental health among people of African descent played an important role in how mental illness was experienced and treated (e.g., Gopalkrishnan, 2018; Irankunda et al., 2017; Jimenez Fernandez et al., 2018; Monteiro and Balogun, 2014). These socio-cultural representations of mental health influenced perceptions about the nature, cause, and course of

mental illness (Sodi and Bojuwoye, 2011) and have been reported to be prevalent among several African communities. For instance, mental illness representations in African communities have been found to include supernatural beliefs about causes of the illness (e.g., Simwaka et al., 2007 in Malawi), and have also been identified to emphasize the importance of social relationships in treatment and recovery ideals (Ayinde et al., 2021). What many of these studies have found suggests that a sense of spirituality and social connectedness are key considerations in understanding illness experiences and how they influence care decisions. In a qualitative synthesis of studies on explanatory models of depression in different Sub Saharan African countries, Mayston et al. (2020) found that a recognition of the importance of social and cultural determinants by health providers could positively influence help-seeking behaviors and consequently, outcomes. Mental illness representations are therefore driven by cultural experiences and expectations, and these have implications for care pathways and outcomes.

Similar studies have examined the role of social and cultural determinants of mental health and care experiences among Black people in the African diaspora. For instance, individual illness beliefs (such as social and self-stigma) and social relations have been identified as key influences in help-seeking among African American men in Midwestern United States seeking help for psychological distress (Cadaret and Speight, 2018), and for African American and Caribbean women making decisions about seeking help for depression in the United States (Nelson et al., 2020). Similarly, Venner and Welfare (2019) identified important socio-cultural influences in the experiences of Black Caribbeans accessing psychotherapy on the eastern coast of the United States, such as identification with the values of their cultures of origin. For both Africans on the continent and Africans in the diaspora, help-seeking behaviors have been argued to have developed as a result of both stigma and the ways in which mental illness is represented within their communities and through the health system. Unlike what is reported in some African countries, the hesitance and stigma surrounding mental health care utilization in the African American and Black Caribbean communities have resulted, not necessarily from animist beliefs, but more likely due to historical issues of distrust and feeling unsupported by the health system (Venner and Welfare, 2019). Mental health experiences and health care utilization in the Black community are therefore driven by an intersection of history, social context, and beliefs.

Mental Illness Representations in Ghana

Ghana has been the focus of a number of studies on culture and mental health over the past decade. This body of work has focused on beliefs about mental illness (Acquaye, 2011; Adinkrah, 2011; Arias et al., 2016; Kyei et al., 2012;

Quinn, 2007; Stefanovics et al., 2016a); prevalence rates (Addai and Andrees, 2015; Gold et al., 2013); mental illness experiences and associated explanatory models (Denham et al., 2010; Quinn and Evans, 2010); and stakeholders, including family and caregivers (Read, 2012), faith-based professionals (Osafo et al., 2015), and mental health professionals (Doku et al., 2011). These studies explored attitudes, perceptions, and responses to mental illness. Other themes studied include mental health legislation (Adjorlolo, 2016; Ame & Mfoafo-M'Carthy, 2016); mental health and human rights (Patel and Bhui, 2018; Read et al., 2009); and mental health care collaboration, particularly between health professionals and prayer camps or faith-based treatments (Ae-Ngibise et al., 2010; Ofori-Atta et al., 2018; Osafo, 2016).

Ghanaians adhere to a variety of meanings pertaining to mental illness, including biological, social, and spiritual understandings of etiology (Opare-Henaku and Utsey, 2017), although there is evidence that a spiritual conceptualization dominates (Kyei et al., 2012; Salifu Yendork et al., 2018). Yet, there are also conceptions of mental illness that correspond to a more biomedical model, such as describing mental illness as caused by impairment in brain functioning. Essentially, attributions of mental illness in Ghana tend to be cognitively polyphasic in nature. Cognitive polyphasia refers to the adoption of multiple, and sometimes seemingly contradictory, sets of knowledge or ideas by an individual or a group (Moscovici, 2005). This perspective posits that individuals can hold different modes of thought (e.g., scientific versus other, see, e.g., Falade and Bauer, 2018) within their minds without viewing them as contradictory—in other words, without experiencing cognitive dissonance. Some researchers, such as Jovchelovitch (2008) and Shein et al. (2014) have argued that cognitive polyphasia may be—in some societies—the norm rather than the exception. Previous research on health (Aikins, 2018) in Ghana suggested that conceptualization of chronic illness is viewed—possibly predominantly—through a cognitive polyphasic lens.

Studies conducted among stakeholders, including caregivers, faith-based professionals, and mental health professionals, have revealed meanings of mental illness that are consistent with the patterns observed in the general population (Ofori-Atta et al., 2018; Read et al., 2009). Caregivers of those with mental illness in Ghana, as well as policy makers and health professionals, were found to subscribe to the belief that mental illness is caused by a curse, witchcraft, or bad spirits (Stefanovics et al., 2016bStefanovics, Rosenheck, et al., 2016). Similar cultural constructions of mental illness have been found in faith-based care providers, pastors, and clergy members (Kale, 2005; Kpobi and Swartz, 2018; Osafo et al., 2015).

A few studies have examined mental illness representation with specific groups in Ghana (Aikins, 2012; Ofori-Atta et al., 2010; Opare-Henaku and Utsey, 2017; Salifu Yendork et al., 2017); correlates of mental illness

(Canavan et al., 2016; Dzator, 2013; de Mindel et al., 2012); and mental illness stigma (Barke et al., 2011; Lyons et al., 2015). Some of these have focused on lay perceptions of mental illness presentation in Ghana. For instance, in studies by Opare-Henaku and Utsey (2017) and Salifu Yendork et al. (2017), participants referred to mental illness as "madness" and used behavioral descriptors (e.g., thought disturbance, hallucination, inappropriate behaviors) which map most closely to psychosis and extreme disturbance. The varied conceptualizations of mental illness observed in Ghana give rise to pluralistic help-seeking behavior patterns (Ae-Ngibise et al., 2010; Ofori-Atta et al., 2018; Osafo, 2016). Notwithstanding, recent efforts have attempted to increase the public awareness of the biomedical model to increase formal mental health service utilization (Dzokoto et al., 2018).

Purpose of the Study

Thanks to the body of work reviewed above, there exists documentation and understanding of mental illness within Ghana. This knowledge has potential transcultural implications for understanding mental illness in Africa and its diaspora. However, gaps remain and more research is needed. For Ghana in particular, mental health research tends to focus on the general population, specific religious perspectives, or specific ethnolinguistic groups. The subset of research in this area focusing on specific ethnolinguistic groups has largely examined the largest group: the Akan (e.g., Brautigam and Osei, 1979; Opare-Henaku and Utsey, 2017; Read et al., 2009). Other ethnolinguistic groups have received limited specialized attention. While Ghana's multiple ethnolinguistic groups share many transcultural characteristics that inform Ghanaian and African identity, the extent to which they share beliefs about mental illness has not been adequately examined. Examining perceptions across a broader set of Ghanaian subgroups is vital as we build knowledge of the contemporary understanding of mental illness. The current study begins to address this gap by examining the local representation of mental illness in Ghana among the Ga ethnic group.

Getting global attention through elaborate, hand-carved fantasy coffins beloved by art collectors,[1] the Chale Wote Street Art Festival, and personalities such as Azumah Nelson (World Boxing Champion super featherweight, 1995–1997), Chris Hesse (filmmaker: Heritage Africa, 1989), Atukwei John Okai (PanAfricanist poet), and Ayi Kwei Armah (writer), Gas form part of the Ga-Adangbe ethnolinguistic group, which makes up 7.1% of Ghana's population (Ghana Statistical Service, 2021). Situated in Southern Ghana, traditional Ga society is organized into a patrilineal kinship system, which distinguishes it from the Akan. Due to urban sprawl, only fuzzy geographical boundaries exist between many of the historically traditional Ga settlements and the Accra-Tema metropolis. Nevertheless, distinctively Ga enclaves exist.

For instance, the La Traditional Area has a traditional ruler (paramount chief), eight sub-chiefs, 77 extended families organized into eight clans, and a high concentration (55.5%) of multi-generational households (Ghana Statistical Service, 2012). Not all Gas reside in traditional Ga settlements, but those even those who live outside them typically have family links to and thus, social obligations in these areas. Enclavity thus plays an important role in traditional Ga ways of life, and distinguishes Gas from other groups.

While a growing body of research has explored representations of mental health in specific Ghanaian communities such as Akan and Christian communities (e.g., Opare-Henaku and Utsey, 2017; Salifu Yendork et al., 2017), an explicit focus on mental health in Ga communities is a recent development (see, e.g., Agyei, 2020). The present study expands and extends this work to a Ga community in Southern Ghana.

Given the continued importance of the spiritual in making sense of and adapting to the challenges of everyday life in Ghana, vis-a-vis increasing exposure to western values, concepts, and ways of life through the media, education, and migration, it is important to examine how people in different Ghanaian communities identify and make sense of mental illness. This study focuses on the Ga ethnolinguistic group of Southern Ghana and examines social representations of mental illness, documenting associated local language labels, perceived etiology, and treatment and social implications of being mentally ill in a Ga sample.

Method

Participants

A total of 23 participants (11 men, 12 women) were interviewed in Jamestown, Chorkor, and La in Ghana's Greater Accra region. The inclusion criteria were limited to persons who identified as belonging to the Ga ethnic group who lived and/or worked in Jamestown, Chorkor or La communities. No specific expertise or other classification was required as the aim was to obtain lay representations of mental health. Table 1 is a presentation of participants' age and gender. Participants ranged from 30 to 81 years old (M = 54.4, SD = 14.89). Participants' level of education ranged from basic primary school to tertiary level education. Participants were from low to lower middle class socioeconomic backgrounds. No additional demographic information was collected.

Research Design

This study employed an exploratory qualitative approach (Marshall and Rossman, 2016) to understand the representations of mental illness in an

Table 1. Interviewee age and gender information.

Participant number	Gender	Age
Participant 1 (P1)	Female	56
Participant 2 (P2)	Female	33
Participant 3 (P3)	Female	49
Participant 4 (P4)	Female	37
Participant 5 (P5)	Female	42
Participant 6 (P6)	Male	45
Participant 7 (P7)	Male	65
Participant 8 (P8)	Female	31
Participant 9 (P9)	Female	73
Participant 10 (P10)	Female	30
Participant 11 (P11)	Female	53
Participant 12 (P12)	Female	41
Participant 13 (P13)	Male	65
Participant 14 (P14)	Male	45
Participant 15 (P15)	Male	50
Participant 16 (P16)	Male	58
Participant 17 (P17)	Female	69
Participant 18 (P18)	Male	78
Participant 19 (P19)	Female	57
Participant 20 (P20)	Male	66
Participant 21 (P21)	Male	59
Participant 22 (P22)	Male	81
Participant 23 (P23)	Male	68

urban poor context. As discussed above, much of the research on cultural concepts and understandings of mental health in Ghana has tended to focus on Akan culture. The Ga ethnic group of Ghana, while indigenous to the capital city, is a relatively small sub-population and less is known about cultural representations of mental health in this group. Using an exploratory qualitative approach allowed us to elicit cultural descriptions and subjective interpretations of mental illness from the perspectives of members of the Ga community, thereby providing broader and richer contextual understanding of mental illness representations in Ghana.

Study Site

This study was conducted in Jamestown, Chorkor, and La in Ghana's Greater Accra region. Due to its coastal proximity, fishing and supporting activities (such as fish processing) are the primary economic activities in the Ga Mashie

area, as is small-scale trading. The poorer parts of these neighborhoods qualify as urban poor communities. Residences are generally multi-generational and patterned on a patrilineal kinship system. However, middle class single-family homes (equipped with kitchens, bathrooms, etc.) are also found in the area. Due to the proximity of a sandy coastline and the "unfinished" nature of many residential neighborhoods, sand is a common sight in many Ga neighborhoods.

Interview Guide

We adapted the semi-structured interview guide used in an ethnographic study of Inuit concepts of mental illness by Kirmayer et al. (1997). This guide was chosen because it was designed to explore basic mental health concepts in a population where little published work had been done, and to elicit information about interviewees' knowledge of mental health and illness, prevalent explanatory models of illness, knowledge of healing practices, and the influence of mass media. The guide was adapted in English and then translated into Ga by an independent language expert. The interview prompts focused on 1) the definitions or labels used to refer to mental illness; 2) the features or descriptions of mental illness; 3) types of mental illness; 4) the perceived causes of mental illness; 5) the participants' perceptions of treatment options for mental illness; and 6) societal reactions to mental illness. Follow-up questions were asked based on participants' responses. We also collected age and gender information for each participant.

Procedure

Our interest in non-expert knowledge from particular communities led to a purposive and convenience sampling approach targeting adults recruited in three ways: (i) some participants were approached as they were walking down local streets; (ii) others were reached through door-to-door family house visits by the research assistants, with a request to speak to an adult in the household; (iii) and the final group were recruited from community-based postnatal baby "weighing centers" held in people's homes. These approaches enabled us to elicit in-depth understanding of the issues from the participants' perspectives (Seale, 2018), and in this way provided lay interpretations of mental illness experiences in these communities (Alston and Bowles, 2020; Rubin and Babbie, 2017). Interviews were conducted until the resultant data were deemed to have reached meaning saturation, at which point no new ideas and concepts were emerging. Consensus on whether meaning saturation had been achieved was discussed between the first and third authors.

All interviews were conducted by the third author, who identifies as Ghanaian and speaks Ga and English fluently. She approached prospective

participants and asked if they would be willing to participate in the study. Almost all who were approached agreed to participate. After consenting processes, interviews were conducted in participants' residences and community centers, as well as in small neighborhood shops and centers. Interviews lasted approximately 30 minutes and most were conducted in Ga. However, as is common in Ghana, there was much code-switching between Ga and English in participants' speech.

The research protocol was approved by the Virginia Commonwealth University Institutional Review Board. All participants provided either written or verbal informed consent before any interviews were conducted. The purpose of the study as well as any risks and benefits of participation were explained to the participants. They were also informed of the voluntary nature of participation and their right to withdraw from the study at any point. The participants were assured of confidentiality and privacy, and given the opportunity to ask any questions before interviews started. Participants further provided consent for audio recording of the interviews. The equivalent of $3 USD worth of mobile phone airtime was provided as reciprocity for each participant.

Methodological Integrity Considerations

In qualitative research, data quality can be compromised by factors such as the use of insufficiently sensitive methods for data collection, inadequate sampling, and unskilled interviewers (Gervais et al., 1999). Our study used the following strategies to optimize the trustworthiness of our data: a semi-structured interview format allowing for follow-up questions as needed, saturation as a means to determine the appropriate sample size, and a skilled researcher fluent in Ga to conduct the interviews. To optimize the trustworthiness of the analysis, the two coders worked on the data independently once the coding structure was finalized. Discrepancies were resolved by discussion. This minimized potential individual researcher biases.

Data Analysis

The interviews were transcribed verbatim and translated into English by the third author. They were subsequently checked for accuracy by the co-authors. The first and third authors analyzed the transcripts. Following guidelines suggested by Braun and Clarke (2006), we employed thematic analysis. Two approaches were used to analyze the data: the deductive approach was used to identify probable responses based on the findings from previous qualitative studies on mental illness in Ghana (e.g., Opare-Henaku and Utsey, 2017); and the inductive approach was also used to allow structure to emerge from the data, given that conceptualizations of mental illness have not previously been

explored among the Ga. In the first stage of coding, the coders gained familiarity with the data by repeatedly reading interview transcripts and making initial notations. Next, words and phrases related to perceptions of mental illness were used as the initial codes. Codes were then refined, developing broader themes by grouping various smaller themes based on areas of consensus, conflict, and absence. Differences were resolved by discussion, resulting in unanimous agreement. The final stage involved looking for intersections and narratives that run throughout multiple themes.

Results

The interview elicited the following information about mental illness: referent labels, descriptions, perceived types, perceived etiology, perceived treatment options, and societal reactions. We observed five main themes in response to these prompts: (1) impaired brain leading to dysfunctional behavior; (2) social disruption and social withdrawal; (3) polyphasic attributions of mental illness; (4) help-seeking and prognosis; (5) and stigma. Many of these themes cut across the interview subtopics. Table 2 presents these themes and their subthemes, as well as the number of participants who touched on them. We discuss each of them below.

Mental Illness Labels: Impaired Brain Leading to Dysfunctional Behavior

The dominant label used to describe persons living with mental illness was ‘’ which translates to “mad,” “insane,” or “lunatic.” This label was used by all 23 participants. For instance, one participant stated: “We always describe them as *sɛkɛyelɔi* [mad people] … or someone whose brain is not functioning like it should so the person does not behave the way they are supposed to” (P4). Thus, brain function was seen as the driver of inappropriate behavior that characterized mental illness. The label discourse thus provided information about perceptions of etiology.

The participants’ definitions were focused on behavior that deviated from what was considered the norm. One participant stated: “Well people usually say that the person is not ‘correct’ or his mind is not working well, or he is not normal” (P9). Another noted that mental illness is sometimes viewed as a form of intellectual impairment: “Those people are also sometimes called mad, but usually they describe them as, excuse my language, stupid or idiots” (P8).

In addition to these direct labels, 11 participants used euphemisms to describe mental illness that relate to impaired brain function or inappropriate behavior:

Table 2. Themes and sub-themes.

Themes	Sub-themes	n*
Impaired brain leading to dysfunctional behavior	Label (*sɛkɛ*)/Brain impairment	23
	Deviation from norm/dysfunctional behavior	23
	Euphemism	11
Social disruption and social withdrawal	Disruptive/dangerous physical behavior	23
	Disorganize behavior	23
	Impaired speech/hallucinations	23
	Neglect of personal hygiene and self-care	23
	Social withdrawal	18
	Self-injurious behaviors	13
Polyphasic attributions of mental illness	Spiritual causes	22
	Substance abuse	23
	Inherited/runs in families	12
	Pregnancy-related	10
	Stressful life events	14
Help-seeking and prognosis	Medical interventions	22
	Mental illness curable	16
	Residual symptoms even after treatment	5
	Biomedical cum spiritual interventions	8
Stigma	People with mental illness shunned/avoided	23
	Accept/support people with mental illness	15
	Careful monitoring/easily triggered/vulnerable	13
	Know/seen someone with mental illness	20
	Family member with mental illness	13

Notes. n represents the number of participants. The total number of participants in the study was 23.

P20: Someone who is not "all there," or "some wiring is faulty in his mind" these are polite ways of saying the person is going mad, or they have "gone off the path" (P20, male);

P23: Oh they might say, such a person is "off his bell," or "the wiring in his head has torn." These are polite ways of saying the person is mad (P23, male);

P19: Well, they might say…he has tied a bit of sand onto the end of his cloth.

The metaphor "he has tied a bit of sand onto the end of his cloth" is culturally symbolic. The ends of cloth are traditionally used by women in this part of the world to store valuable things such as money and jewelry on their person or at home. Sand, however, is the opposite of valuable—at least to Ga adults. The indication that a mentally ill person has tied some sand in the corner of the cloth suggests that the person is unable to differentiate between valuable and valueless things, and thus behaves in a manner considered unusual or dysfunctional within the cultural context.

Mental Illness Presentation: Social Disruption and Social Withdrawal

For all 23 participants, a prominent feature associated with representations of mental illness was physical behavior that was disruptive at best and dangerous at worst. People experiencing mental illness were viewed as being prone to violence, and thereby having the tendency to harm themselves or those around them. For example, one participant believed that unprovoked aggression was an indication of mental illness, and recounted her experience:

> P1: There used to be someone like that in this [neighborhood]. All of a sudden, he became very aggressive, he was always insulting people, he started breaking people's windows, and… throwing stones at children…

Thirteen participants also believed that mental illness could result in self-injury, "Some of these mad people, they hit their heads against walls and on the ground" (P1).

When asked to describe how someone with mental illness behaved, all 23 participants described disorganized behaviors as a major feature in mental illness. For example, one participant described people with mental illness as follows:

> P6: Someone who is disorganized… his dressing, the way they talk and things like that…they just start talking rapidly, and the things they say don't make any sense; or they start being aggressive towards people and sometimes you will see them hurting themselves with knives or other objects.

Other dimensions to the disorganized behavior were changes in the individual's speech and presence of hallucinations, which was also reported by all 23 participants:

> P15: The first thing you will notice is the way he talks; when everyone is talking about one thing in particular, he is usually talking about a different thing altogether without realizing that his speech is "off"; or when serious things are being spoken of, he can suddenly start laughing, when no one else is [laughing].

> P7: For instance, someone who is just walking around and talking into the air while no one is talking to them, or he can see things that no one else can see…he does things that… a normal person should not do.

A further description of mental illness was its manifestation in neglect of personal hygiene and self-care. All 23 participants described behaviors such as eating from unhygienic places like garbage bins or dumps, walking about without any clothing, or looking unkempt.

> P18: A normal human being would not walk outside his home naked. But if you have a mental illness, you can take off all your clothes and suddenly decide that the time is right for a walk outside without realizing that you are naked. So when they come back to their senses briefly—because some of them can go back and forth from normal to abnormal—then you begin to wonder why you are standing somewhere in your neighborhood stark naked.

Finally, 18 participants expressed the sentiment that suddenly withdrawing from one's social circles could be understood as a symptom or precursor to more severe mental health problems. Participants believed that such social withdrawal was a milder form of mental illness, which could increase significantly in severity if left untreated:

> P23: Some of them can also become very withdrawn and will not relate to anybody well. So if somebody suddenly becomes quiet and cannot respond to questions, or does not seem to comprehend what is going on in their surroundings, then they may also have a mental illness.

Polyphasic Attributions of Mental Illness

Twenty-two of the 23 participants said they believed that mental illness has a spiritual dimension, and the common explanation given was spiritual attacks due to envy or jealousy, as well as spiritual retribution for an offense committed against another person or a deity. Two participants noted:

> P6: Someone who is being attacked spiritually could be caused to get a mental problem; these days we need to be careful because when someone envies you or wants something you have, they can easily use the spiritual means to get you.

> P7: … one man I knew went to see a spiritualist to help him make quick money. Unfortunately, he was not able to do all the things the spiritualist told him to do. As a consequence, he became mentally ill.

Despite their strong belief in spiritual causes, all participants acknowledged that there were other factors which could result in mental illness. The most commonly cited non-spiritual factor described by all 23 participants was substance abuse. As one participant put it:

> P2: Most of the mad people you see around, when you ask, you will find that they used to smoke "weed" or sometimes they are still smoking [it]… So those people who smoke… and the cocaine addicts, they are the cause of madness around.

The participants also cited a variety of other factors that they believed could cause mental illness. These included the view that mental problems run in families, expressed by 12 participants. For example, one participant stated: "Some people believe that such madness runs in families, so that if you are from that family, then it is likely that it is in your blood and you could also have it" (P23). They also included the notion that mental disorders could be caused through the actions or inactions of expectant mothers, triggering or inducing malformation in the fetus's development. This view was expressed by 10 participants. For instance, one of the mothers in our sample said:

> P4: Those who drink too much especially when they are pregnant and sometimes when they do not want the baby, they try to abort by using various concoctions and these can affect the child

Stressful life events were also considered to contribute to changes in people's personality or social behavior. Fourteen participants suggested events like the loss of a job or a loved one, marital infidelity, or betrayal as a trigger for developing mental illness.

> P1: If someone has done something to you, and you're always thinking of it, it can also lead to you becoming too quiet and withdrawn from society and before you know it you can get some of these illnesses. Or if you lose someone close to you suddenly, you can also start behaving like that because you will always be thinking about them.

> P11: You see sometimes it is from marital problems, for instance if she happens to find her husband with her best friend in bed together, she will be very hurt, or think about it so much and then before you know it she starts to behave strangely

Another potential trigger cited for mental disorders cited by 17 participants was seizures. The consensus among participants was that seizures or convulsions by themselves were not indicative of mental illness; however, they could be precursors of mental illness.

> P17: Seizures can cause mental illness especially if the head is not supported properly…usually those children who get seizures—if they are not careful with them—the children become odd and sometimes behave strangely.

Finally, for situations where an individual was socially withdrawn, participants generally attributed the cause to a personality factor. One participant described it to us, "There are some people who are like that by nature… they do not want to offend anybody by what they say so they would rather isolate themselves and not mix with others." (P13).

Help-Seeking and Prognosis for Mental Illness

Understandings of presentation and causes of mental illness inform views on treatment. Twenty-two participants advocated for medical interventions and cited psychiatric hospitals as a resource for individuals exhibiting symptoms or unusual behaviors. Failure to seek early intervention was believed to result in dire consequences, even death. One participant advocated, "Once there is a mental hospital, then it means they have ways of making them better. And they have their specific ways of helping the people…" (P22). Further, 16 of the participants believed that mental disorders could be cured once the individual followed the prescribed treatment and refrained from doing the things which had caused the illness in the first place:

> P9: If they continue to do the things which led to their situation…then of course they will get worse, but if they stop the smoking and drinking and stuff, and get help from the hospital then they will get better.

However, five participants were of the view that even with proper treatment, the individual would continue to experience mental illness:

> P1: Well, they can get better but there is usually still some trace of the illness in them… I think that is how it usually goes, there is still some little bit of the sickness in them even though they are managing it.

Finally, eight participants recommended a combination of both biomedical and spiritual interventions to achieve full wellness: "With the right treatment, being supported by prayers and proper counseling, they can be as normal as you and I." (P15). One exception to the biomedical approach is that when stressful life events were seen as the cause for the unusual behavior, participants held the general perception that the symptoms would resolve once the problems were solved: "...If they get a solution to their problems, they will become sound once again" (P7).

Societal Reactions to Mental Illness: Stigma

In general, most of the participants recognized the fact that people living with mental disorders tend to be avoided. All 23 participants held this view, one of whom explained this to us:

> P18: You can often see that such people are shunned. And people talk a certain way to them and about them, and they may feel very bad about it. And when there are things going on that everybody is involved in, such as eating together, the person with a mental illness will be separated from that group. He will not be allowed to eat with everybody else, and he will be spoken to rudely.

However, the participants were also aware that such attitudes were problematic. Fifteen of them spoke about how such negative reactions could exacerbate the condition or result in a relapse. They therefore suggested acceptance and support from both their families and their communities and proposed that communities could help to facilitate full recovery by removing triggers from their environment.

> P23: When they come back from the hospital, the society should treat them normally and be vigilant so that whatever caused him to behave that way is removed from his environment. As much as possible, they should try to prevent whatever triggers their behavior.

Consistent with this view that stigma can exacerbate mental health conditions, our participants' accounts indicated a belief that people living with mental illness required constant care and attention. Thirteen participants spoke of the careful monitoring and care that was needed to ensure that there was no relapse. One participant noted, "Such people need to have your constant attention, you need to talk with the person and ask them how they are feeling and what worries them and stuff." (P19). This sense that individuals with mental illness are fragile and easily triggered served to deepen the stigma against that population.

Finally, although 20 participants indicated that they knew or had seen people with mental illness before, those who knew close family or friends who had sought mental health care (i.e., 13 of the 20 participants) were quick to emphasize how different their situation was.

> P2: When my father died… my mother became like that… But only for a short time… if it lasts for long then it can become a mental problem because they become different… it wasn't a mental illness because we immediately got her some help from the pastor…

Thus, participants sought to distance themselves and their loved ones from the stigma surrounding mental illness by recasting their mental health symptoms as something other than what they stigmatized.

Discussion

This study explored lay concepts about and attributions of mental illness in a Ga community in southern Ghana. Even though mental illness representation has been studied in some Ghanaian samples, limited focus has been paid to the Ga.

Social Representations of Mental Illness

The collective narrative about the physical presentation of people with mental illness observed in this study mirrors one observed by Salifu Yendork et al. (2017). In that study, interviewees (an urban adult Christian sample in Ghana) cited descriptions of overtly psychotic symptoms, nudity, and poor hygiene as distinct markers of mental illness. Poor hygiene also constitutes an important factor in negative attitudes about individuals with mental illness in North America (Day et al., 2007). Perceptions of people with mental illness walking around disheveled or naked are common in many parts of Africa (e.g., Labys et al., 2016; Teferra and Shibre, 2012; Ventevogel et al., 2013). It is unclear whether participants use these descriptors to represent severe mental illness or instances where symptoms are not being actively treated as has been observed in other studies (e.g., Opare-Henaku and Utsey, 2017). Nevertheless, the physical presentation, due to its marked visual deviation from the way everyday people are expected to present themselves in public, forms an important part of how mental illness is seen and understood.

With regard to labels of mental illness such as *sɛkɛ*, the major representation of mental illness in these Ga communities appears to be that of socially disruptive behavior stemming from cognitive injury/dysfunction. Typical descriptors of mental illness presentation included aggressive behavior, deficits in grooming and self-care, and in general an inability to successfully interact with members of society in a manner that is considered socially acceptable and productive. Similar to previous research, representations of mental illness were synonymous with "madness" (Opare-Henaku and Utsey, 2017; Salifu Yendork et al., 2017). It was connoted by many participants as the state of a faulty mind, highlighting the salience of cognitive disruption. Such representations of mental illness have been noted elsewhere in Ghana (Salifu Yendork et al., 2017).

Our study found that withdrawal from one's social circles was described by some participants as a sign of mental illness, or a precursor to more severe mental health problems. In many African settings similar to our research site,

there appears to be a recognition of social withdrawal as a feature of mental illness (Dako-Gyeke and Asumang, 2013; Labys et al., 2016; Ventevogel et al., 2013). In folk narratives of mental illness, these representations generally do not appear to be linked to specific difficulties that an individual might be facing. While social withdrawal is commonly associated with specific disorders such as schizophrenia and major depressive disorders, cultural differences in its interpretation have been noted. For instance, Nieuwsma et al. (2011) observed that, compared to a US sample, an Indian sample was significantly less likely to rate depressed persons as unsocial, likely to lose friends, or to make others depressed or uneasy.

Informing Appropriate Treatment Interventions

In this community, causal explanations for mental illness are multi-layered, fluid, complex and constantly evolving processes. They are influenced by cultural beliefs and expectations of illness and wellbeing. Thus, understanding these polyphasic attributions of mental illness etiology is important because without an appreciation for illness explanatory models, treatment interventions may be culturally inappropriate. Kirmayer (2004) emphasized the importance of recognizing the multiple systems of illness meanings within specific communities and the consequent power that such meanings hold for individuals. Without an appreciation for illness explanatory models, treatment interventions may be culturally inappropriate.

Studies on conceptualization of mental illness in different cultures—particularly polyphasic conceptualizations—have highlighted this point and its impact on treatment interventions. For instance, in a study on causal explanations of mental illness in Jamaica, Arthur and Whitley (2015) emphasized that acknowledging supernatural, biological and/or environmental beliefs (sometimes held simultaneously) could enhance outcomes. Similarly, Ikwuka et al. (2014) reported that in their sample of Nigerian participants, causal explanations influenced how symptoms manifested, stigmatizing views, and help-seeking behavior among people of Igbo descent.

Our findings revealed two approaches for help-seeking: formalized psychiatric care from a hospital, and spiritual interventions. These pluralistic approaches to treatment are consistent with participants' polyphasic attributions of mental illness. The endorsement of spiritual interventions to achieve healing instead of—or as a complement to—formal biomedical treatment options is consistent with literature on the treatment of chronic disease (Aikins, 2018), and previous mental health research in Ghana (Kpobi and Swartz, 2018; Ofori-Atta et al., 2018; Read et al., 2009). These multiple approaches to mental health care provision have also been seen in other African contexts (Aghukwa, 2012; Labys et al., 2016). Spiritual support is also highly valued in African American communities (Alang, 2016). Among

African Americans, a barrier to help-seeking from formalized mental health care facilities is institutional mistrust (Whaley, 2001).

The attribution of mental illness to brain dysfunction, via the Ga labels for mental illness, suggests a perceived link between brain function on the one hand and culturally appropriate goal-oriented behavior on the other. It also speaks to an assumption that a fully and properly functioning brain is crucial for complete personhood/selfhood, such that an aspect of the self is lost when brain function is impaired. Scientific/somato-medical explanations of mental illness (such as biochemical factors, biological factors, brain disease, and genetics) form part of multiple social representations of many communities around the world (Arthi, 2012; Furnham and Chan, 2004; Monteiro and Balogun, 2014; Stefanovics et al., 2016aStefanovics, He, et al., 2016; Wong and Li, 2014).

Despite strong beliefs in the influence of spiritual factors on the development of mental illness, findings also showed belief in the possibility of lifestyle choices, stressful life events and teratogenic factors being potential causes for mental disorders. In our interviews there was a sharp contrast between the rather unitary representations of mental illness on the one hand, and the polyphasic causal explanations on the other. In the context of this study, we see evidence of cognitive polyphasia (the adoption of multiple, and sometimes seemingly contradictory, sets of knowledge or ideas by an individual or a group, Moscovici, 2005) as participants adopt meanings of mental illness from both biomedical and supernatural explanatory models. Ghanaian settings have been found to be associated with polyphasic ways of thinking when it comes to health-related meaning making (Aikins, 2003, 2018; Aikins, 2018), and our sample was no exception to this.

Reducing the Stigma of Mental Illness

Collectively, the participants acknowledged the negative reactions that society held towards people with mental disorders. Our respondents expressed an appreciation for how these reactions could affect the individual and advocated for more positive and accepting attitudes. Stigmatization of the mentally ill refers to the direction of negative attitudes, beliefs, and rejecting behaviors towards people with diagnoses of mental illness (Parcesepe and Cabassa, 2013) and sometimes, their social network. It is a long-standing global phenomenon (Pescosolido et al., 2013). Stigma against people with mental illness diagnoses predicts discrimination (especially in work and housing); motivates social distance due to often false or exaggerated beliefs and stereotypes; and negatively impacts attitudes towards help-seeking behavior for mental illness (Parcesepe and Cabassa, 2013; Wainberg et al., 2017). While stigma is associated with mental illness across the African diaspora, there are some noticeable contextual differences. For example, for our Ga sample, the

stigma appears to be associated with the behavioral indicators of mental illness. In contrast, for some African Americans, the stigma appears to be associated with the meaning of impaired functioning. Mental illness may be sometimes perceived as a weakness and a threat to expectations of being "strong black men" and "strong black women"—deemed vital for a population that has resisted and survived centuries of racial oppression and discrimination (Alang, 2016).

Our participants also noted the negative impact of mental illness stigma and advocated for an attitude reversal. They suggested two bottom-up rather than top-down strategies for community involvement to reduce mental illness stigma. The first suggestion—acceptance and support from community members—would require cessation of discriminatory and avoidant behavior towards the mentally ill by community members on the one hand, and active efforts to provide support on the other. The second suggestion—removal of perceived triggers of mental illness—might require behavioral modifications. Some operationalizations of this goal, if not based on science, may prove to be futile or even dangerous. For example, since witchcraft is perceived by many as a cause of mental illness, removing triggers would ostensibly involve concerted efforts to remove all witches (whose identities are largely unknown) from society. The dangers of a mass witch hunt evoke memories of The Salem Witch Trials, and more recently, Northern Ghanaian settlements (called witch camps) that house ostracized women accused of witchcraft (Mutaru, 2018) and often violent witch hunts in India (Chaudhuri, 2012; Overdorf, 2017). Essentially, attempts to eliminate perceived spiritual causes of mental illness would result in a victimization shift away from the mentally ill to create another disenfranchised group—typically poor, older women, and in a few cases, young children (Adinkrah, 2011).

Changing Views of Mental Illness

We found that Ga beliefs about mental illness are similar to those found in other Ghanaian subgroups. The Akan studied by Opare-Henaku and Utsey (2017) believed that mental illness is caused by spirits, genetic defects, substance abuse, stress, and trauma. It is unclear whether these are simply shared beliefs amongst a diversity of Ghanaian ethnic groups on the one hand, or whether such shared beliefs are a result of idea transmission. There has been a lot of migration of Ghana's ethnic groups to traditionally Ga territory as a result of the colonial government's decision to locate the national capital in Accra in 1877. Since then, there has been subsequent metropolitan growth and dramatic urban sprawl.

Beliefs about mental illness observed in this current study, however, differ from beliefs reported by Ga people five decades ago. In 1960, British anthropologist Margaret Field conducted an ethno-psychiatric study of Ga

mental health beliefs. She found a strong dominance of spiritual beliefs in causes and treatment preferences, although she acknowledged some endorsement of biomedical perspectives. However, our participants reported much more diversity of thought. In Margaret Field's time the spiritual explanations were more tied to traditional religious beliefs. In contrast, contemporary studies such as Salifu Yendork et al. (2017) and the present study found that religious attributions are more consistent with Christian beliefs. Christianity has had a multi-century history in Ghana. Yet, it appears that in the period within which earlier forms of adopted Christianity ("Traditional Western Mission Churches" (TWMCs) such as Methodism, Presbyterian, Catholicism, and Anglicanism) were popular, representations of mental illness did not generally include Christian religious themes. There has been a shift in Ghana towards charismatic and more recently neo-prophetic forms of Christianity which differ in theological doctrine from the TWMCs. Similar to African traditional beliefs, these churches emphasize faith and spirit directly and actively influencing the human condition—something that TWMCs discouraged earlier on. Studies on mental health attributions in Ghana in recent years are increasingly showing attributions consistent with charismatic and neo-prophetic Christian beliefs. For instance, the idea of "spiritual attacks" as a cause of mental illness is consistent with neo-prophetic theology, and parallel to African traditional beliefs in witches causing harm to others.

Our participants' perspectives on recovery and the expectation of a cure are reflective of cultural and religious ideas about healing and a return to previous levels of functioning. The idea of managing a chronic illness as indicative of recovery was not endorsed by some of our participants. Instead, relapses were seen by some participants as indicative of failure on the part of the individual or a failure of the treatment approach. While belief systems are an important factor in such expectations, the pluralistic help-seeking behavior of the participants may also be a reflection of the limitations of psychiatric care options in Ghana (Read et al., 2009). Due to resource constraints such as limited mental health facilities and mental health professionals, psychiatric interventions are limited in scope including in the availability and affordability of more modern psychotropic medication which have minimal side effects and in the availability of social interventions. These limitations can contribute to making the spiritual interventions, which are promising a cure, appear more desirable than the biomedical option. The need to take medication for the rest of one's life was certainly less desirable than the notion of the possibility of obtaining a spiritual cure per the doctrine of religious healing.

Limitations

Our findings are constrained by weaknesses inherent in short-term qualitative research methodology. Notable among them is the fact that the findings cannot

be generalized to all Ga people. While this is not an objective in qualitative work, it does present limitations in the extent to which implications can be drawn from our data. Secondly, we did not explore the composition of the participants in terms of their lived experience. It is possible that people with lived experience may use labels for mental illness which are considered more socially appropriate from a biomedical perspective. They may frame mental illness differently given their lived experience. Likewise, it is possible that people who have relatives with mental illness as well as caregivers may conceptualize mental illness differently from those with limited to no contact with someone with lived experience. Thirdly, because we did not collect socio-demographic information related to educational, professional, or occupational background, we are unable to examine how such socio-demographic backgrounds might have influenced mental illness representation in the current study. It is possible that people who have been exposed to mental health literature or whose work may involve care for people with mental illness may adopt different framings of mental illness. Lastly, even though the respondents include participants with different age groups, the small sample size does not permit us to analyze how age affects mental illness representation.

Implications

The findings of this study have potential implications for understanding help-seeking behavior and development of mental health interventions. Unlike what is typically reported for African communities, perceptions about mental illness were not dominated by animistic beliefs. Our study shows that much nuance exists in how mental illness is perceived and understood. The cultural notions of mental illness resulting in social disruption and disharmony were strongly held within this community. Within such cultural perceptions of mental illness, people experiencing mental health difficulties may manifest more social indicators of mental illness. This is important to recognize given that such illness beliefs influence help-seeking pathways and can determine the extent to which interventions are accessed or accepted. Treatment and recovery may therefore be constructed around social dimensions. The emphasis on social disruptions rather than internal distress is also an important consideration for training mental health professionals. An appreciation for the role of social dynamics in the presentation, attribution, and treatment of mental health problems is important for the development of appropriate culturally-accepted interventions.

Our results show that there is an underlying thread that cuts across different Ghanaian communities (discussed in this paper and elsewhere) regarding how mental illness is understood and represented. One wonders whether the consistency of content may be in part due to the predominance of interviews

and ethnographic approaches to enquiry. Thus, future research in this area could benefit from the incorporation of a larger breadth of research methods (perhaps including photovoice, art-based inquiries, and biophysiological measures, for example) in future investigations. Additionally, it is possible that studying other ethnic groups not yet represented in research could bring to light new cultural factors that may be important to consider. Finally, it might be time to move research in this area beyond the exploratory questions about mental illness representation and the role of religion and biomedical approaches. An important research gap exists in the area of psychiatric epidemiology. Work in the area of the social context of mental illness has outpaced epidemiological information about mental illnesses in the region. Future research could focus on closing this gap.

Conclusions

Our findings provide insight into folk perceptions of mental illness in a Ga community. We observed many similarities between social representations and attributions of mental illness by people of African descent. This suggests that mental health interventions developed in other parts of the country, continent, and diaspora may be useful for Ga communities. At the same time, our findings suggest that education focusing on non-psychotic mental disorders, especially when characterized by private suffering rather than social disruption, may benefit this and similar populations.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

Ethical Approval

The research protocol was approved by the Virginia Commonwealth University Institutional Review Board.

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Note

1. Ga fantasy coffins, or *okadi adekai*, are elaborately decorated to represent the deceased's profession, vices, or dreams, since the Ga believe that the deceased will continue working in the afterlife. They can be made in the shape of animals, vehicles, and everyday items. They also serve as a status symbol and a way to curry favor with ancestors. Coffins can cost up to £10,000 for international clients and art collectors.

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