2013

Notions of Spirits as Agents of Mental Illness among the Akan of Ghana: A Cultural-psychological Exploration

Annabella Opare-Henaku
Virginia Commonwealth University

Notions of spirits as agents of mental illness among the Akan of Ghana: A cultural-psychological exploration

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Psychology at Virginia Commonwealth University.

by

Annabella Opare-Henaku
M. Phil. in Health Promotion, University of Bergen, Norway, November, 2006
B. A. Psychology, University of Ghana, May, 2003

Director: Shawn O. Utsey
Professor of Psychology & Chair of African-American Studies

Virginia Commonwealth University
Richmond, Virginia
May, 2013

Acknowledgment

The author wishes to express gratitude to the following people for their contributions toward the successful completion of this program. I owe a depth of gratitude to my husband, Robert Osei-Tutu, for the sacrifices he made in order for me to complete this program. I would like to thank my family for not allowing geographical distance to prevent them from being emotionally present with me over the course of these five years.

I would like to thank Dr. Ustey for his direction and guidance during the course of my study. I am thankful to my dissertation committee members, Dr. Faye Belgrave, Dr. Vivian Dzokoto, Dr. Kathy Ingram, and Dr. Micah McCreary for their interest and valuable feedback which enriched the work.

I would also like to thank Lionel Sakyi for his timely assistance with the data collection. Many thanks go to Jemimah Opare-Henaku and Zumreta Dudic for their assistance with the project.

My thanks go to my cohort, Chelsea Greer, Brad Antonides, David Guion, and Stephen Trapp for their support throughout these years. I would also like to thank Dr. Suzanne Tete for her moral support.

Last but not the least, I am thankful for the support I received from the University of Ghana, Legon, to complete this program.

Dedication

To my daughter Nana Akyaa Osei-Tutu

Table of Contents

List of Figures

List of Tables

Abstract

NOTIONS OF SPIRITS AS AGENTS OF MENTAL ILLNESS AMONG THE AKAN OF GHANA: A CULTURAL-PSYCHOLOGICAL EXPLORATION

Annabella Opare-Henaku, Ph.D.

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Psychology at Virginia Commonwealth University.

Virginia Commonwealth University, 2014.

Dissertation Director: Shawn O. Utsey, Professor of Psychology & Chair of African-American Studies

The study explores lay conceptualizations of mental illness among the Akans of Ghana as influenced by their cultural worldview. Akan, the largest ethnic group in Ghana, is noted for the use of supernatural attributions for various health-related issues. The supernatural attributions are based on Akan ontological belief that the universe is unitary such that there is no clear distinction between physical and spiritual occurrences. This worldview guides Akans in how they deal with a wide range of issues including their mental health. Clinicians and other mental health professionals who rely solely on biomedical approaches to mental health fail to meet the demands of Akan mental health help-seekers because such approaches do not recognize the cultural factors that inform lay understandings on mental illness. Limited studies have been conducted on how Akan supernatural attributions influence conceptualizations of mental illness. Using a grounded theory method of research, 14 individual interviews and 7 focus group

discussions were conducted to explore beliefs and knowledge about mental illness in two indigenous Akan communities in Ghana. Participants were of diverse age, sex, education, and occupational background. Analysis revealed that cultural factors influence lay conceptions, diagnosis, and treatment of mental illness. Local labels for mental illness as well as beliefs about etiology, development, and cure of mental illness were identified. It was found that the Akan unitary worldview aids in the endorsement of heterogeneous multi-tier causal attributions of mental illness that embrace supernatural and non-supernatural causal explanations. Although supernatural causality theories of mental illness existed, participants related a complex causal explanation that involved other non-supernatural causal attributions. Results further revealed that Akan cultural beliefs influence community response to mental illness, encouraging pluralistic help-seeking behaviors that satisfy the Akan cultural value for holistic treatment and care. The implications of the findings for clinical training, culturally-sensitive mental health practice, and mental health education and advocacy have been discussed.

Notions of Spirits as Agents of Mental Illness among the Akan of Ghana: A Cultural-psychological Exploration

Belief in spirits' role in health and illness is pervasive in Ghana. Among the Akan, an ethnic group in Ghana, this belief readily comes to the fore when people are asked about their health. When inquired about their health, an Akan response *"Nyame adom, me ho ye"* in Twi (an Akan language) translates "by God's grace, I am fine." This response reflects Akan worldview which is assumed to be unitary such that nothing, including one's health, happens by chance. The response "by God's grace" places agency for health first in the supernatural domain. It reminds individuals that their health status is primarily a matter of divine providence, not by personal abilities, skills, or behavior.

Varied definitions and explanations of mental illness abound in the Akan culture. While some define mental illness in terms of spirit agency, others have noted that the Akans also equate mental illness to a loss of social status. In the later sense, mental illness is said to imply a loss of a person's essential humanity and carries a moral charge (Read, Adiibokah & Nyame 2009; Wiredu, 2005). Like all people, Akans go through the heuristics of asking *what* caused their mental illness, and *how* it might have happened. Unlike others however, Akans believe that how one becomes mentally ill is not as important as *why*. This is because it is thought that the "how" can easily be ascertained through common sense. In asking "why," Akans seek to understand the irregularities and abnormalities that characterize an illness occurrence, which often go beyond naturalistic explanations (Appiah-Kubi, 1981; Gyekye, 1995).

The varying conceptions of mental illness among the Akans, among other groups in Ghana, promote a complex pluralistic help-seeking behavior. It is common knowledge that people seek mental health treatment from a complex mixture of psychiatrists, traditional healers –who are trained to use herbs for treating different ailments-, and spiritualists who base their treatment on invocation of God or gods in their healing procedures (Roberts, 2001; Ae-Ngibise, et al., 2010). This is primarily because the "why" of mental illness can be very complex, requiring more than one explanation and mode of treatment. Furthermore, biomedical approaches have not been able to match the beliefs and the demands of mental health seekers. This is because clinicians using the western model to treat mental illness fail to "speak the language" of the people. As such, majority of the people (Ae-Ngibise, et al., 2010) consult traditional practitioners who understand them and their worldview. As far back as 1989, the point was made that traditional healers and spiritualists recognize the broad group of mental illnesses (Odejide, Oyewunmi, & Ohari, 1989). However, practitioners using the biomedical model continue to grapple with coming to a full grasp of the lay Akan conceptions of mental illness.

The cultural grounding that creates the Akan reality of mental illness no doubt plays a role in their conceptualization of mental illness. The first place to understanding the complex conceptualization of mental illness begins not with what causes it, but rather why. The fact that there could be many answers to the "why" of mental illness occurrence in and among the Akans of Ghana is an important question that needs to be studied in its own right. The current study uses a qualitative research design to explore the "why(s)" of mental illness among the Akans of Ghana.

The Akan People of Ghana

Historical geographers and cultural anthropologists classify the indigenous people of Ghana into five major groups, namely the Akan, Ewe, Mole Dagbane, the Guan, and the Ga-Adangbe. The Akans constitute the largest ethnic group in Ghana, and they occupy 6 of the ten administrative regions in Ghana.

Historically, the Akans of Ghana are believed to have migrated from the ancient Ghana Empire to the north of modern Ghana before moving to their present settlements in the south. The Akan migratory movement to the south occurred in small groups resulting in the establishment of Akan kingdoms and states (Gocking, 2005). The Akans of Ghana are therefore made up of the Asante, Akyem, Akwapem, Akwamu, Aowin Ahanta, Nzima, Assin, Brong, Kwahu, Wassa, Denkyira, Sefwi, Fante, Effutu, Anum Boso, and Larteh Kyerepong. The commonest language among the Akans is Akan, which is made up of the dialects of Fante, Akuapem Twi, Asante Twi, Akyem, and Kwahu. Akan is generally spoken in Southern Ghana by both natives and non-Akans. The traditional occupation of the Akans living in inland Ghana is farming, and fishing for those living along the coast. They also engage in trading (Awuah-Nyamekye, 2009). The Akan political organization is based on matrilineal lineage. This implies that inheritance and successions are traced through a female ancestress. Several lineages come together to form a political unit which is headed by a chief and elders (Owusu-Frempong, 2005; Gocking, 2005; Geest, 1998).

Through the arbitrary establishment of geographical boundaries by European colonial masters, the Akan people were separated into different West African countries or states (Gyekye, 1996). Thus, besides those in Ghana, there are Akans in Togo, Ivory Coast, and other West African states.

Although the Akans in Ghana are not necessarily homogenous, the shared cultural worldview and common cultural experiences allow for generalizations to be made around their conceptions of mental illness.

Background to the Study

Ghana is a sub-Saharan country in West Africa. Ghana's population is estimated at 24.7million, with females constituting 51.2 percent (Ghana Statistical Service, 2012). Majority of people living in Ghana live in the southern half of the country. It is estimated that about 3 percent of the adult population are likely living with a severe mental disorder, and 10 percent of others in the adult population suffer from a moderate to mild mental disorder. Only 1.17 percent of the people living with mental disorders reportedly received treatment (WHO, 2007). Although mental health services are available at most levels of care — primary, secondary, and tertiary — majority of mental health treatment and care are reportedly provided through the three public psychiatric hospitals in the country. These hospitals are located in the southern part of the country.

When it comes to healthcare in general, the Ghana Ministry of Health estimates that 70–80% of Ghanaians use traditional medicine as their first-line treatment (WHO, 2007), and there are an estimated 45, 000 traditional healers (Roberts, 2001). Several reasons have been cited for the widespread use of traditional and faith healers in the provision of mental health care in Ghana, including affordability, availability, accessibility, and the fact that traditional and faith healers provide psychosocial support (Tsey, 1997; Roberts 2001; Ae-Ngibise et al., 2010). Ae-Ngibise and others (2010) have however indicated that the key reason why Ghanaians continue to use traditional and faith healers as their first line of treatment is because of the shared

understanding of mental illness. Other studies in sub-Saharan Africa (Adewuya & Makanjuola, 2008) report a similar trend for the treatment of mental illness.

Statement of the Problem

Cultural beliefs and culturally constructed reality have been identified as key factors in conceptions of health (Adams and Salter, 2007). Within the Akan society, supernatural etiology plays a fundamental role in the conceptualization of health. Prevailing Akan beliefs about spirit agency is conveyed in popular music, folklore, and everyday discourses (Adinkrah, 2008). When an Akan is ill, she or he goes through the heuristics of asking what caused this, *how* did it happen, and *why* this illness at this time? To the Akan, *how* one becomes ill is not as important as *why*. This is because it is thought that the "how" can easily be ascertained through common sense. In asking "why" the Akan seeks to understand the irregularities and abnormalities that characterize an illness occurrence, which often goes beyond naturalistic explanations (Appiah-Kubi, 1981; Gyekye, 1995). Research on beliefs and health is important in understanding the socio-cultural factors that influence health attitudes and health behavior.

Supernatural explanations have been established for most diseases encountered in the Akan society (Ahorlu, Koram, Ahorlu, Savigny, and Weiss, 2005; de-Graft Aikins, 2006; 2007; Crentsil, 2007). The dominant health and illness constructed belief is further applied to mental illness. Mental illness is often seen as a "spiritual illness" attributable to supernatural powers or evil spirits (Ae-Ngibise, et al., 2010; Gray, 2001; Danquah 1982). Beliefs in spirits are deeply rooted in people's understanding of the world around them and their culture or their worldview. The way people understand their socio-culturally constructed worldview and relate to it influences their beliefs, values, thoughts and actions (Asante & Mazama, 2009), including their

health, whether these beliefs are valid or not. Since supernatural explanations or spirits notions enter in almost all diseases explanations, it is essential to understand the underlying explanatory model that becomes a lens for all illness experiences within the Akan context. Clinicians need to work within the framework of Akan's traditional and spiritual beliefs if they are to serve their mental health needs well.

Literature Review

Theoretical Framework

Cultural beliefs provide a fundamental basis for how people construct their reality about mental illness (Dzokoto and Adams, 2005; Adams & Salter, 2007; Koltko-Revera, 2004; Kagee & Dixon, 2000; Muller, 2008). Through the process of socialization, culturally constructed realities on illness are transmitted from one generation to another. Koltko-Revera (2004) notes that this constructed reality— worldview—becomes an integral part of an individual's psychological makeup, such that the individual is often not aware of its impact on his/her perceptions, choices, and behavior. Construction and notions of the reality of spirits' role in mental illness is grounded in the Akan cultural worldview (Gyekye, 1996). It is however noted that people understand their worldview differently. Thus the current study employs two culturally relevant worldview theories: Stace's mystical worldview theory (1960), and the value orientations theory by Kluckhohn (1950) as lenses to explain how different ontological beliefs among the Akans may inform notions of spirits as agents of mental illness.

Worldview as a psychological construct. The term worldview refers to a way of thinking that organizes one's life and provides guidelines for living and affects one's perceptions, thoughts, feelings, inferences and behaviors as well as how one experiences the external world or 'reality.' Koltko-Revera (2004: p. 4) defines worldview as:

"a way of describing the universe and life within it, both in terms of what is and what ought to be. A given worldview is a set of beliefs that includes limiting statements and assumptions regarding what exists and what does not (either in actuality, or principle), what objects or experiences are good or bad, what objectives, behaviors, and relationships are desirable or undesirable. A worldview defines what can be known or done. In addition to defining what goals can be sought in life, a worldview defines what goals can be pursued. Worldviews include assumptions that may be unproven, and even unprovable, but these assumptions are superordinate, in that they provide the epistemic and ontological foundations for other beliefs within a belief system."

This definition is relevant to this study in the way that it emphasizes agency, epistemology, and ontology. In regard to epistemology, it is noted that one's cultural worldview defines what can be known or done. With regard to ontology, the definition indicates that one's worldview greatly influences one's construction of reality. It also emphasizes that one's worldview shapes one's assumptions of what goals one can pursue and what can be done — agency. In terms of the current study, one's ontological beliefs could be beliefs in a plethora of spirits, which can provide one with defining health notions, health attitudes, and health behaviors. The Akan worldview may prescribe a different personal agency for health. The definition also highlights the fact that such assumptions are powerful in providing a frame of reference not only for health, but other beliefs.

Terminological caveat.

Worldview as a psychological construct is distinguished from other related constructs such as schema, beliefs, and values. Koltko-Revera (2004) suggests that a schema is

conceptually different from a worldview in four principal ways. The constructs differ in terms of: the entities both constructs address; the mechanism through which each construct is formed; structure, ease with which people deal with disconfirmation of either constructs and consequences of such disconfirmation. For instance, schema is noted to be concrete and focused on everyday objects and actions whilst worldview is made up of abstract concepts and hypothetical objects. In relation to their formation, schemas are formed through generalization from direct, personal face-to-face experience. Worldview, on the other hand, are said to be culturally transmitted and therefore have broader collective constructions of reality (Koltko-Revera, 2004; Adams & Salter, 2007). The structures of schema and worldview are also noted to be different in that the former exist on a single dimension, which makes it easier to disconfirm whilst the later exist on a multiple dimensional level and therefore difficult to disconfirm.

Worldview is distinguished from values, and beliefs. Koltko-Revera (2004) uses Rokeach's (1973) typology of beliefs in an illustrative way to explain these concepts. It is noted that although all worldview statements are beliefs, not all beliefs are worldview beliefs. Thus, worldview beliefs are limited to beliefs that underlie constructions of reality, social relations, guidelines for living, or the existence or nonexistence of important entities. Further, although worldviews and values are forms of beliefs, values include prescriptive and proscriptive beliefs whilst worldview contains these value beliefs as well as existential beliefs and evaluative beliefs. Thus, values are embodied in worldview beliefs.

Stace's mystical worldview theory (1960). Stace defined several characteristics of the mystical cognition that resonate with the ontological view of Akans in relation to spirits' reality. Hood (1975) has operationally categorized Stace's mystical conceptualization into three

categories of the mystical experience namely, the unifying quality; the inner subjective quality; and the ego quality. The unifying quality of the mystical view relates to the ontological view that the universe is a single interconnected entity. The mystical worldview on the inner subjective quality relates that the universe is a living being such that nothing can be 'dead.' The categorization on the ego quality reveals that an individual is not concerned about his/her own attainment but that of all.

Stace's (1960) conceptualization of a unifying mystical ontology is very useful in terms of the Akan conceptualization of the universe, which posits that the universe is unitary (Gyekye, 1995; Mbiti, 1991). According to Mbiti (1991), the African view holds that there is mystical orderliness and mystical power in the universe as seen in witchcraft and sorcery and other supernatural operations. Gyekye (1995) relates that the universe is essentially spiritual such that there is a constant interaction between the supernatural beings and human beings. Attempts to differentiate between the physical and the spiritual in the Akan, and by extension the African context is likely to be met with disappointment because the awareness of the supernatural enters in all thought and actions. Gyekye (1995: pp.: 69) alludes to this when he emphasized that *"what is primarily real is spiritual."* Mbiti (1970), as related by Gyekye (1995: pp.: 197) observes that within the African ontology, of which Akan ontology is inclusive, the *"physical and spiritual are but two dimensions of the one and the same universe.*"

It is noted that the Akan conceptualization of a unifying, orderly and interconnected universe and the belief that every human experience has an ultimate cause does not leave room for chance. Mbiti (1970), as cited in Gyekye (1995: pp.: 197), indicates that *"African peoples ...feel and believe that all the various ills, misfortunes, accidents, tragedies...which they*

encounter or experience, are caused by the use of mystical power....” Thus, the reality of spirits enters in discourses on both health and illness. That is, “I am healthy or fine, by God’s grace” [*Nyame adom, me ho yɛ*] or ill because of the influence of some evil spirit. Such an interconnection makes it necessary for synchronizing occurrences in the visible world with that in the supernatural or invisible realms. Thus, one fundamental reason why people attribute mystical meaning to certain occurrences is the quest to fit these instances into their understanding of the world around them (Mbiti, 1991).

Stace’s (1960) mystical conceptualization has been operationalized into three categories (Hood, 1975). First, the unifying quality of the mystical view relates to the ontological view that the universe is a single interconnected entity. This conceptualization of a unifying mystical ontology is very useful in terms of Akan conceptualization of the universe, which posits that the universe is unitary (Gyekye, 1995; Mbiti, 1991). Second, the mystical worldview on the inner subjective quality indicates that the universe is a living being, such that nothing can be ‘dead.’ There is a constant interaction between the supernatural beings and human beings which makes it necessary for synchronizing occurrences in the visible world with those in the supernatural or invisible realms. Thus, the quest for uniformity and understanding is one fundamental reason why people attribute mystical meaning to occurrences and instances around them (Mbiti, 1991). The third categorization, ego quality, reveals that an individual is not concerned about his/her own attainment but that of all, and is related to social connectedness (Kambon, 1992).

The Kluckhohn (1950) value orientations theory. The concept of value is important in discussions on health. Kluckhohn (1951:395) defined value as “a conception, explicit or implicit,

distinctive of an individual or characteristic of a group, of the desirable which influences selection from available modes, means, and ends of action."

The value orientation theory posits that all cultures have peculiar ways of conceptualizing their worldview, which may be inferred from the way the cultures answer five common human problems: what are the innate predisposition of human beings? What is the appropriate relationship between humans and nature? What is proper time dimension? What type of personality is most valued? And what is the proper way of relating to one another? Answers to each of these questions can vary on a three-point range and although these questions may elicit different responses from different individuals within the same culture, there is a dominant response which identifies any given culture. These questions are used as a theoretical lens to illustrate how people within a common cultural worldview may hold different conceptualization of spirits' role in health.

The human orientation.

Kluckhohn's (1950) question on human nature elicits three varied responses: good, evil, and good-and-evil. The Akans concept of human nature is that it is fundamentally spiritual and good. However, the human nature can become evil through neglect of his/her spirit. And since the spirit aspect of man is more important than the fleshly or physical aspect, any such neglect can mean trouble for the individual and other humans (Parrinder, 2002). Contrary to Parrinder's views, Gyekye (1995) notes in relation to the Akans of Ghana that the original human nature is neither virtuous nor vicious but neutral. However, whether one will be described as evil or good will depend on what one does whilst on earth. This conceptualization, coupled with the ontology of the Akan culture makes possible the human belief that another human can be evil and will

want to cause ill-health to a fellow human being. Whether one person will subscribe to any one of Kluckhohn's human orientations (1950) would depend on what kind of human relations he or she has experienced in life. Such a value orientation will also inform behavior within the Akan context. For instance, one who thinks humans are inherently evil will be likely to guard against human caused illnesses by paying attention to other humans, striving not to unduly offend others, and avoiding conspicuous consumption. It is to be expected that persons who envision that human nature is extremely evil will be more likely to endorse the human causation beliefs than those who do not.

Nature orientation.

The orientation on proper relationship with nature receives three main responses: subjugation-to-nature; harmony-with-nature; and mastery-over nature. Klockhohn (1950) recognizes that there are alternative orientations within any culture. When applied to health and notions of spirit, one who is subjugation-to-nature oriented will be more likely to believe that humans cannot change nature and that health is determined by forces beyond one's control. The Akans' conceptualization of the universe permits humans, to control entities that are below them in the hierarchy of spirits and in relation to their position in the universe. However, human potency is limited in relation to other spirits in the hierarchy in the universe (Gyekye, 1995). Mbiti (1991) observes that the human is not master of the universe but rather a user who is expected to live in harmony with it. Humans will therefore have to subject to some forms of nature and dominate over others. The subjugation principle here does not necessarily indicate helplessness as Klockhohn (1950) suggests, at least not in the Akan context. Rather, humans, in this sense, are partly subject to some forces of nature whilst at the same time master-over other

aspects that are beneath them in the hierarchy. Thus, although humans have power, their power is limited relative to other forces of nature.

When translated into the social construction of illness and health, studies show that there is overlapping etiologies which demonstrate this subjugation-and-mastery profile among the Akans. In subjugating some aspects of nature, Akans have used naturalistic means such as local herbal treatments. Thus, the consideration of spirits' role is done in cognizance of the fact that both naturalists and supernatural explanations coexist in the country. Abraham (1969) noted that although the world is metaphysical among the Akans of Ghana [and other ethnic groups as well] not all problems require metaphysical solutions.

Time orientation.

The question on temporal dimension of life has these answer classifications: live in the past; the present; and the future. According to Gyekye (1995), the Akans of Ghana (and most Akan ethnic groups and Africa) hold a three-dimensional three temporal profiles as that described by Kluckhohn (1950). A person who predominantly focuses on the past will be likely to reflect on the etiological explanations that were used when a similar ailment afflicted someone in the past or what past generations attributed to be the causes of similar ailments. On the other hand, those who have alternative profiles of the present and future temporal orientations may relate differently to past metaphysical views and have different understanding of the cultural worldview. Differences in temporal orientations within the Akan context will therefore have implications for agency in health.

Personality orientation.

This orientation relates to how individuals orientation influence one's preferred way of self-expression. According to Kluckhohn (1950), the question on personality orientation elicits three answers: being; being-in-becoming and doing personality profiles. A being personality profile relates to immediate gratification and such a person will focus on the here and now. A being-in-becoming personality profile is described as one "self-contained" (Kluckhohn, 1950); A doing personality profile is one who has an "achieving" orientation (Kluckhohn, 1950). The Ghana concept of human personality, observes Gyekye (1995), is both physical and spiritual or soul (*Okra*) indicating the *"okra is the individual's life."* In line with the ontology of human nature, health implies well-being of mind, body, and spirit. What one does in the physical affects the spirit and vice versa.

Relational orientation.

Klockhohn's (1950) relational orientation elicits three response profiles: hierarchical or lineal forms of relationship; collateral relationship; or individualism. Social relation is an interesting piece in the Akan worldview. Although some literature posits that the Akan society is predominantly hierarchical or lineal, Gyekye (1996) indicates that the Akan culture permits the coexistence of communal and individualistic values. However, the individual is required to integrate his/her desires and societal values to the welfare of both. Hence, even though one may rely on the spirits for one's health, one will have to exercise a measure of control to get a desired health-related outcome. One therefore has to strike a balance between what one can do and what one has to leave to the supernatural. Adams (2005) notes that the relational ontology, such as the one found among the Akans, provides a fertile ground for nurturing enemyship. This relational

context along with the lay beliefs about illness provides a foundation for constructing spirit agency about health in general, and mental illness in particular (Mather, 2005; Mill 2001).

Conceptual Framework: The Akan Worldview

The cultural worldview of Akans posits that the universe is composed of a hierarchy of spirits. At the apex of this hierarchy is the Supreme Being (*Twi: Nyame*), who is the ultimate source of life, hence, health. Other lesser spirit beings or gods occupy the next level on the hierarchy of spirits. These lesser spirits are further grouped into two major types namely, nature spirits and human spirits. Nature spirits (*Twi: abosom*) are associated with natural objects and forces like mountains, rivers, lightning and thunder. The human spirits (*Twi: nsamanfo*) consist of spirits of the dead. The lesser spirits are vested with power and thus can have influence on human health (Gyekye, 1995; Akyeampong, 1995). The Akan worldview also holds that human beings are likewise spiritual beings encased in flesh (Abraham, 1962). Hence, human beings form part of the hierarchy of spirits.

Human beings are believed to have other aspects beyond the physical body. Among the Akans, for instance, the human being apart from being flesh (*honam*) and physical, is thought to have a soul (*okra*) and a spirit (*honhom or sunsum*), which are both spirits. The okra has been described as the guiding spirit of man which acts automatically by giving advice on what is good or bad and is responsible for human life. The *sunsum,* on the other hand, is not automatic but a spiritual substance that is educable and a moral agent in a human being. It is noted that it is one's *sunsum* that can be attacked by a sorcerer or witch, hence some ailments are said to be "spiritual illness" *["sunsum mu yare*"] (Abraham, 1969). Although a spirit, the human being is recognized

to have limitations and is thus dependent on *Nyame* and the other spirits (Gyekye, 1996; Akyeampong, 1995).

This framework of spirits provides the basis for notions of spirits as agents for health and illness in Ghana. Gyekye (1995; pp.: 197) observes that the structure of spirits has been identified as the fundamental framework for explaining the notion of causality and further notes that:

> *"Implicit in the hierarchical character of the structure [of spirits] is that a higher entity has the power to control a lower entity. Since man and the physical world are the lower entities of that hierarchy, occurrences in the physical world are causally explained by reference to supernatural powers, which are held to be the real or ultimate sources of action and change in the world."*

Thus, the Supreme Being or Great Spirit is thought to be the ultimate source of health. However, Busia (1962) as cited in Gyekye (1995) explains that evil does not originate with the Supreme Being but with the lesser spirits and other supernatural forces. In this regard, Mbiti (1991) observes that it is on seldom occasions that the Supreme Being is thought of as the direct source of disease or illness. The lesser spirits play a fundamental role in human health, both for the good and the bad. Mbiti, (1991), notes that the lesser spirits, in and of themselves, may not be evil. However, some spirits are noted to be consistently evil and it is these that some human beings, such as a sorcerer, may invoke in order to bring diseases upon another human. Based on the ontology of spirits, therefore, it is believed that some humans, such as a sorcerer, may have knowledge and skills that allow him/her to tap into powers of the lesser spirits and use them in a

malevolent way to bring about ill-health, diseases or even death (Fosu, 1981; 1992; de-Graft Aikins, 2003).

This Akan ontology therefore prescribes three supernatural models of illness causality: human causality; nonhuman (lesser spirit causes) causality; and the Supreme Being causality. The human causation belief holds that some humans such as a sorcerer can have extraordinary power which they can use either to protect one's life or bring ailments. The nonhuman causation belief posits that spiritual agents such as an ancestor or an evil spirit can be the cause of ill-health. Third, the Supreme Being explanation holds that *Nyame* is the ultimate source of health and on some occasions may strike someone with certain diseases.

More often than not, illness causality beliefs may include multiple and overlapping causative beliefs. For instance, if one offends *Nyame* or an ancestor, one may not receive the necessary protection which will make one vulnerable to attacks from an evil spirit or a sorcerer. It is envisaged that the extent to which individual Akans ascribe to and use or ignore this ontology will depend on their understanding of this worldview of spirits as well as their individual cultural orientation values.

Related Studies

Worldview Studies. Various studies lend support to the significant role of worldview in definitions of health. Poppe (1995) investigated the manner in which worldview predicted the endorsement of a particular view of health and illness. The study found a moderately strong relationship between endorsement of organicism and an endorsement of a definition of health and illness described as organismic. Similarly, endorsement of mechanism as a preferred worldview was also found to correlate with a preference for a definition of health and illness

derived from a mechanistic description. The results of this study suggest that worldview may influence the way in which individuals develop a definition of health and illness.

In a related study, Kagee & Dixon (2000) assessed how Pepper's (1942) worldview theory relates to health promoting behavior. 259 undergraduate students ranging from 18 to 24 years were recruited through course instructors at a university in the Midwestern USA. Forty-two percent of the participants were males, and 56.7 were females. Hispanic or Latino constituted 1.2% of the participants, 7.4% African American, and 89% were White. Participants completed inventories measuring worldview; health promoting behavior (HPB); social class; and sex. The results showed organismic thinkers were more likely than mechanistic thinkers to engage in health promoting behaviors. There was a relationship between sex, worldview and HPB, with women more likely to endorse an organismic worldview and therefore more likely to engage in HPB than men. No relationship was found between socioeconomic status and HPB; class, and sex. However, research conducted among Akans reveal that several factors such as age, gender, geographical location and socio-economic status have implications on notions of spirit. A major limitation is that the study used a student sample.

In another study that used a student sample, Thomas and Chambers (2000) examined the connection between African worldview and health. Participants included 80 students with ages ranging from 18 to 25 years randomly selected from historically African American university located in the southeastern United States. Participants completed the African Self-Consciousness (ASC) Scale, developed by Baldwin and Bell (1985). The ASC assesses four central dimensions of worldview namely awareness and recognition of one's identity and heritage; general ideological and activity priorities placed on Black survival, liberation, and proactive and/or

affirmative development; specific activity priorities placed on self-knowledge and self-affirmation; and a posture of resistance toward anti-Black forces and threats to Black survival. Result shows that ASC contributed uniquely to health promoting behavior. The finding is consistent with Kambon's (1992) theoretical proposition that health, for people of African descent, is contingent on the "closeness to or the continuity that . . . [they] maintain to [their] cultural origins" (p.156). Another study conducted among American Indians shows that an understanding of the sense of connectedness within their cultural worldview positively impacted their mental health (Hill, 2006).

Coming closer home to Ghana, Olugbile, Zachariah, Kuyinu, Coker, Ojo and Isichel (2009) conducted a study among the Yorubas of Nigeria, West Africa. The study assessed the relevance of Yoruba worldview on the perception and treatment of psychotic illness. Participants included 500 Yorubas living in Lagos, who completed a questionnaire. Half of the questionnaires were in English and the other half in the Yoruba language. The authors also analyzed 100 'home video' (Nigerian-made movies). The analysis identified elements of the Yoruba worldview purported to be linked to illness in general and psychotic illness in particular. Results indicated that the Yoruba worldview had a significant influence on how they perceived psychotic illnesses. Specifically, they identified seven thematic areas associated with perceptions of mental illness. (1).The metaphysical supernatural domain. (2). Natural, physical or organic domain. (3). Psychological, intra-psychic or behavioral domain. (4). Social, interpersonal domain. (5). Stress factor. (6). Yoruba traditional domain (7). Combinations of the factors listed above. The film analysis revealed that there is a preoccupation with the theme of "madness" which seems greater (39%) than what one sees with Hollywood films. Most of the patients in the films were male

adults, and the causation of the condition were reported to be 'supernatural,' stress, or relationship difficulties. Treatments were usually by spiritual or traditional intervention. Olugbile and others' study is of peculiar importance to the present one because their sample shares similar worldviews to that held by the Akans. In fact, Patel (1995) has noted that spiritual causes are frequent explanations for mental illness in sub-Saharan Africa, and that people in this area share similar beliefs around religion and health.

Ghana and Akan studies. Studies have established some form of supernatural explanation for most, if not all, diseases encountered in the Akan society. Supernatural etiology has been documented for common but persistent and life threatening tropical diseases such as malaria and malaria-related illnesses (Ahorlu, et al., 2005); chronic and debilitating diseases such as diabetes (de-Graft Aikins, 2006); as well as, deadly epidemics like HIV/AIDS (Crentsil, 2007).

In a study in two communities in southern Ghana, Ahurlo, Koram, Ahorlu, Savigny, and Weiss (2005) interviewed 101 participants aged 20 years and above on their perceptions of the causes of malaria-related illness. The participants responded to one of two locally-based illness representations of malaria vignettes, one with convulsion and the other without, among children below five years old. The results revealed that over 84 percent of the participants perceived that malaria-related convulsion was caused by spirits and sorcery. Seventy-nine percent (79%) of the respondents thought malaria without convulsion is caused by supernatural forces. Overall, supernatural explanation was the second most important cause of malaria-related convulsion, coming after causes attributed to "infection." It is also important to note that even when

respondents cited infection as the cause of malaria, some suggested that supernatural forces were accountable for the infection.

Research by Crentsil (2007) illustrates the belief in human-agents such as a sorcerer in agency for health. The study assessed death, ancestors and HIV/AIDS among the Akans of Ghana and found that some lay persons as well as some diviners attributed the cause of HIV/AIDS infections to the works of sorcery. Similar findings of sorcery and witchcraft causal theories have been documented in studies among diabetics. For instance, de-Graft Aikins (2006) found that people made witchcraft attributions for people with uncontrollable diabetes, which physiological representations looked as that of HIV/AIDS. In this particular study, one respondent asserted that the disease had been implanted in the victim's family. This use of such spiritual attributions of HIV is counterproductive to preventive health HIV/AIDS education (Liddell, Barrett, & Bydawell, 2005).

A similar study by Mill (2001) explored the experiences and illness beliefs of HIV-positive women in Ghana. It was found that although some of the respondents associated the disease with improper conduct such as prostitution, extramarital relationship and sexual promiscuity, 13 of the 26 women suggested that their HIV illness had been spiritually caused. For example, some of the women thought that the virus might have been transferred to them spiritually through *juju,* evil spirits, the devil, or God (Mill, 2001). Mill's (2001) as well as other studies (Mather, 2005) indicates that poor social relations predict the use of supernatural explanations.

With reference to mental illness, Fosu (1981) examined disease classification and health behavior in a rural community in Ghana and found that mental illness, or so-called "insanity,"

was thought to have supernatural causes. It is known that the cultural worldview that supports supernatural attributions of mental illness influences help-seeking behavior. Fosu (1995) assessed orientation towards help-seeking for psychiatric problems, among 1000 women in three selected areas in the capital of Ghana. The participants of the study were currently married women between ages 25 and 39 years, of diverse educational and ethnic backgrounds. Contrary to other studies (WHO, 2007; Tsey, 1997; Roberts 2001; Ae-Ngibise et al., 2010), results showed that majority of the participants (87.7 percent) preferred seeking help from modern mental health care professionals than from traditional healers or other sources. It was found that among other factors, ethnic background and one's level of education influenced help-seeking orientation.

In a related study, Quinn (2007) used a semi-structured interview method to study common beliefs and community responses to mental illness in Ghana. Participants included 80 family caregivers and 10 service providers in four study sites in Ghana. The study sites covered the Greater Accra and Ashanti region in the South, and the Northern region of Ghana. The study found that respondents who lived in rural areas where traditional beliefs on mental illness remained relatively intact were more likely to assign supernatural explanations than those in big cities where there is an admixture of beliefs and western biomedical influence. This finding does not, however, indicate a complete abandonment of indigenous beliefs by those who live in the cities. Studies conducted among Akans living abroad shows that although higher education and exposure to foreign cultures tend to effect some changes in cultural beliefs, the cardinal cultural beliefs remain intact (Barimah and Teiljlingen, 2008; Yebei 2000).

Yebei (2000) studied migrant Akan women in the Netherlands and found that beliefs and treatment-seeking for infertility was strongly grounded in the Akan conceptualization of health and cultural beliefs. The study observed that, irrespective of education and awareness of biomedicine, the women regarded infertility more as a spiritual problem mainly caused by witchcraft and violation of taboos or misconduct towards one's parents. This finding resonates with Quinn's (2007) study which revealed that respondents in big cities in Ghana hold some sorts of spiritual beliefs of mental illness.

Quinn's study also documented that a significant number of participants said that they did not know the cause of the mental illness. Possible explanations offered for this pattern include the idea that people may not understand the symptoms or that they did not want to speak openly about mental illness for fear of social reprisal. Quinn's study provides important information on how to negotiate discussions around mental illness. Methodological issues around the reviewed studies include the use of student sample, use of questionnaire, and a tendency to mere count the frequency at which people indicate spirit causation without providing in-depth enquiry.

Recent studies and review on mental health in Ghana (Ofori-Atta et al., 2010; Read & Doku, 2012) show that supernatural etiology for mental illness is still prevalent. In their study of causes of mental illness in women, Ofori-Atta and collogues (2012) explored common understandings of mental illness among policy makers, health professionals, users of psychiatric services, teachers, police officers, and traditional healers in five regions of Ghana and found that one the three most predominant reasons cited for mental illness was witchcraft accusations. Although the participants did not claim to hold these beliefs themselves, they indicated that perceptions that the cause of mental illness is through witchcraft activity is common in the

general population. The other causes of mental illness cited by the participants included women's vulnerability, and gender disadvantages.

Aims of the Study

- To examine Akan constructions of mental illness.
- To assess Akan understandings as to why people become mentally ill.
- To examine how the Akan worldview orientations influence their conceptions of mental illness.
- To develop an explanatory theory about mental illness among the Akans.

Methods

Grounded Theory

The grounded theory method of inquiry (Glaser & Strauss, 1967) is most relevant and best suited for exploring the current study questions because it will assist in generating conceptual hypotheses around constructions on mental illness within the Akan context.

Grounded theory is a form of qualitative data collection that aims to describe or explain social phenomenon. The basic canon of this approach to qualitative research is its emphasis of deriving explanations or theories that are grounded in the data. The difference between grounded theory and other qualitative research method is that grounded theory requires specific procedures. This includes the fact that data collection and analysis are interrelated such that analysis begins with the first interview and continues throughout the rest of the process. The purpose of this canon of grounded theory is to allow the researcher capture the full breath of the topic through the generation of hypothesis as the data analysis continues. Relatedly, the interrelated nature of data collection and analysis helps in determining which specific groups of people need to be interviewed. As such, sampling in grounded theory is said to be theory driven. That is, the hypothesis as well as the emerging theory guides subsequent sampling (Corbin & Strauss, 1990).

Data analysis in grounded theory is similar to other qualitative methods in the sense that concepts that pertain to the same phenomenon may be grouped together. A key difference with grounded theory, however, is that the analysis goes further to ascertain the common underlying

mechanism, a process called abstraction. Through abstraction, one is able to generate theories respecting the data. Abstraction can be enhanced when emerging theories are compared with similar or different emergent theories from the data (Corbin & Strauss, 1990; Charmaz, 2006). At the end of the day, the researcher using grounded theory aims to find the relationships between concepts and core categories.

Rationale for the Study

The idea of spirit agency has been explored by different academic disciplines such as philosophy (Gyekye, 1995; Wiredu, 2005), sociology and anthropology (Fosu, 1995; Adiibokah & Nyame, 2009). Few studies (Danquah, 1982) have taken the psychological perspective. As far back as 1982, Danquah hinted that the etiology of mental illness or psychological disorders among Ghanaians in general was profoundly rooted in ubiquitous socio-cultural factors. He recommended that clinicians use a multifaceted research to understand the etiology of psychological disorders in Ghana. As is often the case, Western-trained as well as Ghana-trained mental health practitioners have a tendency to rely heavily on Western models in understanding the mental health presentations in Ghana. There is no doubt that cultural frameworks influence the presentation, manifestation, and understandings of mental illness among the Akans. The way individual Akans use different dimensions of the Akan worldview can have implications for their notions of spirits and mental illness. The literature on cultural beliefs and cultural constructions show that even scholars in this area of study hold different views as to what the reality of spirits entails (Muller, 2008).

This current study uses a grounded theory design to explore cultural beliefs in spirits as agents of mental illness among the Akans. It is anticipated that exploring the issue from a

psychological perspective will put more weight on the relevance of the topic to practice. Other studies have tended to explore cultural constructions of mental illness as part of major studies and as such have failed to provide in-depth understanding in this area. Mbiti (1991) observes that belief in the existence of spirits provides a lens for explaining many mysteries in the universe.

Within the Akan context, belief in spirits role in health provided a lens for understanding an outbreak of panic in relation to so-called "genital-shrinking" (Dzokoto and Adams, 2005), also called "genital theft" (Mather, 2005) phenomenon, a mysterious occurrence that swept through Akan communities in 1997. Victims of this phenomenon complained that their genitals vanished or retracted when another person shook hands with them or touched them. As typical of cultural construction of health and the significance of spirits' role in health, this occurrence was received with different kinds of supernatural explanations. The same cultural worldview was fundamental in furnishing explanation for the outbreak of HIV/AIDS epidemic (Mill, 2001). By means of this study, we seek to explore as well as advance a cultural-psychological explanation of mental illness. The study seeks to lay a foundation for understanding the socio-cultural grounding of mental illness among the Akans of Ghana, and thereby contribute to theory and practice in this research area.

The Study Setting

The current study was conducted in two indigenous Akan communities in Aburi, the capital of Akuapem South Municipality in the Eastern Region of Ghana. The communities' main occupations are farming and petty trading. The petty trading is mainly by women. Majority of the people in the study communities are Akan but few people from other ethnic groups can be found here. The choice of a rural settlement was to help locate a place where most of the

dwellers are Akans. It was envisaged that the use of urban settlement would present a challenge as most of the people of the target population for this study would be dispersed in a cosmopolitan area making it difficult to use the house to house method of data collection adopted for the study.

Participants

Thirty-one (31) participants living in rural settlements in the Akuapem range were interviewed. The first interview was however removed because the respondent indicated that he was not an Akan. The remainder 30 participants were all Akans, and the result is based on their responses (See Appendix 1 for demographic characteristics of participants).

Fourteen (14) participants were interviewed individually, and the rest interviewed in a group. There were seven focused groups consisting of 2 to 3 people. Four of the focused groups were only females, two were only males, and one consisted of one male and one female. There were 12 males and 18 females, aged between 31 and 80. Four participants were between 30-39 years, five were between 40-49 years, and another five were 50-59 years. Seven (7) participants were between 60 – 69 years, eight were between 70-79 years old, and one participant was 80 years old. Participants' level of education varied from no level of education to university level. Three participants had no education, seventeen (17) had basic to Form 4 education; four had up to secondary education, one post-secondary education, and two had up to university education. Two did not indicate their education level. Participants were engaged in a wide range of occupations: four farmers, and nine petty traders. The others were an accountant, a clerk, an ex-military officer, a personal assistant, a seamstress, a hairdresser, and a *susu* collector (s*usu* is a form of a small scale saving scheme). Four of the participants were retired and include a retired assistant director of education, a retired headmaster, a retired medical laboratory technologist,

and a retired teacher. One participant was a housewife, and another unemployed. Four participants did not disclose their occupation.

Table 1: Participants Characteristics

Demographic Features	No. of Participants
Gender:	
Females	18
Males	12
Age:	
30-39	4
40-49	5
50-59	5
60-69	7
70-79	8
80-89	1
Education:	
None	3
Basic	2
JSS	3
Middle school	11
Secondary/ O & A-level	6
Post-secondary	1
University	2

Role of the Researcher

The researcher developed the interview guide, and provided training for the research assistant who conducted the interviews. The researcher had two meetings via phone with the research assistant prior to the data collection. During these meetings, the researcher provided the research assistant with the overview of the study and also discussed methodological issues pertaining to the study. Other correspondence via electronic-mail between the researcher and the research assistant were used in preparing the research assistant for the data collection.

During the data collection, the researcher monitored and provided feedback on a daily basis as and when the research assistant returned from the field. This was possible because the

research assistant uploaded the audio files of the interview on the same day and the researcher listened and provided feedback. The researcher and the research assistant reviewed the interviews for quality and depth, and also used the time during the feedback session to clarify issues of ambiguity and other methodological challenges faced in the field. The opportunity was also used to discuss the research assistant's use of questions and need for follow-up. The researcher also generated questions from the interview files which the research assistant explored in subsequent interviews.

The researcher was responsible for transcribing the interviews. The interview files were first translated from the Twi language into English, and then were transcribed. Subsequently, the researcher joined two other independent assistants to form a coding team. The researcher had the final responsibility of completing the analysis, results, and discussion. The researcher kept a reflective journal in which she noted her observations from the interactions with the research assistant regarding the fieldwork, transcription, and the analyses. All these were taken into consideration in writing the results and the discussion of the study.

Bracketing. Bracketing refers to a number of techniques and process adopted in qualitative research to prevent the researcher from contaminating a current study with preconceptions or prior information about the topic (Meadows & Morse, 2001; Gearing, 2004). It also involves being aware of ones biases and taking steps to prevent them from unduly influencing the interpretations in a current inquiry (Tufford & Newman, 2012). In the current study, the researcher employed bracketing to address her biases and develop a different perspective free from preconceptions.

The interviews were conducted with a preset theoretical and conceptual framework which was known to the researcher but not the research assistant. In conducting the interview, bracketing involved the use of a research assistant to conduct the interviews. The researcher, having preconceptions of the study, was removed from the interviewing context. By using a researcher assistant who did not have full knowledge of the research aims to conduct the interviews, the researcher was prevented from influencing the interviewing process. This was against the background that the researcher did not want her prior knowledge of the conceptual and the theoretical framework as well as her cultural background, religious leanings, and professional training from unduly influencing the interview process. During the coding, the researcher employed bracketing by allowing the two independent coders to suggest the themes that were dictated by the data. In this way, the researcher was limited in imposing preconceived ideas from influencing the coding. As a person of Akan descent, the researcher had fair knowledge of the Akan worldview, but she made a conscious effort to allow the views expressed by the participants of the study and the views in the scholarly literature to take precedents over personal views. Although the researcher's religious and cultural beliefs share some similarities on beliefs about spirits, the researcher was keenly aware that there are irreconcilable differences. For example, the Akan belief of hierarchy of spirits runs counter to the researcher's belief in monotheistic God. When confronted with such differences in beliefs, the researcher employed bracketing by allowing the participants' views as well as the literature to elucidate the issues point.

Although the researcher employed bracketing throughout the study which allowed her to have a different perspective on the study, she is also ware that the impact of preconceptions

could only be reduced but not be removed entirely. For instance, the researcher's background in counseling psychology may have influenced the study in the way the researcher arrived at her interpretations. Having been trained in a strength-based field of study, the researcher tended to focus on presenting results in a way that showed respect for the people interviewed and their beliefs. As an example, the researcher opted to use the theme "spiritual causes" rather than "superstition" which had been suggested by the other two independent coders. The researcher deemed it disrespectful to label the beliefs a "superstition" just because they seemed different from a supposed "norm." The researcher also realized that her training in counseling psychology may have influenced her to focus on how Akans function in their socio-cultural context rather than focus on symptoms.

Role of the Research Assistant

Research assistant is a graduate student from the University of Ghana. Following advertisement of the position for research assistant through informal solicitation, the research assistant was selected because of his credentials and experience in conducting qualitative interviews. Once selected, the research assistant was made to take the National Institute of Health (NIH) certification on working with human subjects. The research assistant then conducted two pilot interviews and received feedback from the researcher. To ascertain his conceptions of mental illness, the research assistant interviewed himself using the interview guide. The research assistant had the primary responsibility of conducting the interviews. He had the auxiliary role of coming up with follow-up question that emerged from the interviews. The research assistant and the researcher had weekly discussions about the progress made, and emerging questions were addressed.

Throughout the fieldwork, the research assistant kept a methodological journal in which he noted his observations. He discussed some of these observations during his meetings with the researcher, and submitted a field report at the end of the fieldwork. The researcher incorporated the report in the write up of the procedure and other sections of the study.

Procedure

Approval for the study was obtained from the Virginia Commonwealth University Institutional Review Board. At the study sites, a facilitator who is an indigene was recruited to provide assistance. With the help of the facilitator, the research assistant visited the study sites weeks earlier to identify areas of exploration which could help in gaining access to the community. Participants for interviews were selected using the house-to-house method that guaranteed social inclusiveness. Thus, attention was given to respondents of different demographic characteristics namely age and gender, with their ages ranging from 31 to 80 years. Informed consent was read out to each participant with permission sought and granted to record all interviews. All males and females aged 30 years and above who were mentally fit were eligible for the research. The duration of the interview ranged from 15 to 60 minutes and participants were informed of a remuneration of GHC 5 (equivalent to $2) after the interview. All the interviews were conducted by the research assistant. Both individual and focus group interviews were conducted. The focus group interviews consisted of two or three individuals from the same household. There was only one exception where the group included two members from the same house and one neighbor.

In the selection of respondents, the interviewer made sure that not more than two interviews were conducted in one house or household. After each interview, the research

assistant and the facilitator moved not less than five blocks before recruiting other respondents. This was to ensure that the participants were spread around. The reason for the research assistant's frequent movement with the facilitator was to ensure total cooperation from the respondents due to his conversance with the town. This became necessary after the research assistant went to the field alone, and found it difficult to get respondents who were willing to be interviewed because he was a stranger. All the people who were approached said they were not ready to talk to strangers. However, it is to be noted that under no circumstance were any of the respondents selected by the facilitator, all the structures and households were selected by the research assistant. All that the facilitator had to do was to take the research assistant around the town.

Participants who met the selection criteria for the study, that is, of Akan descent and above thirty years old, were given a brief introduction to the study. They were informed of their right to withdraw from the study. After building rapport and exchanging pleasantries as custom demanded, the interviewer conducted either a one-on-one interview with individual participants or focus group discussions with the participants. Semi-structured interviews were conducted in Twi (See Appendices 2 and 3 for interview questions). The biographical and demographic data of the respondents were obtained, and knowledge and beliefs on mental illness were explored. The interviews were digitally recorded.

The research assistant uploaded the interview files on a secured server shared with the researcher. The researcher, who is a bilingual speaker, translated the files from Twi to English, and then transcribed them. Every effort was made to ensure that the translations were close to the meanings conveyed in Twi. Concepts that did not neatly translate into English or those that lost

their meaning when translated were maintained whilst a closer English translation was also provided. The transcriptions therefore contain *invivo* codes that seek to maintain the nuances of what participants said. Five transcripts were randomly selected for backward translation by an independent translator who is of Akan descent and has knowledge of Twi language.

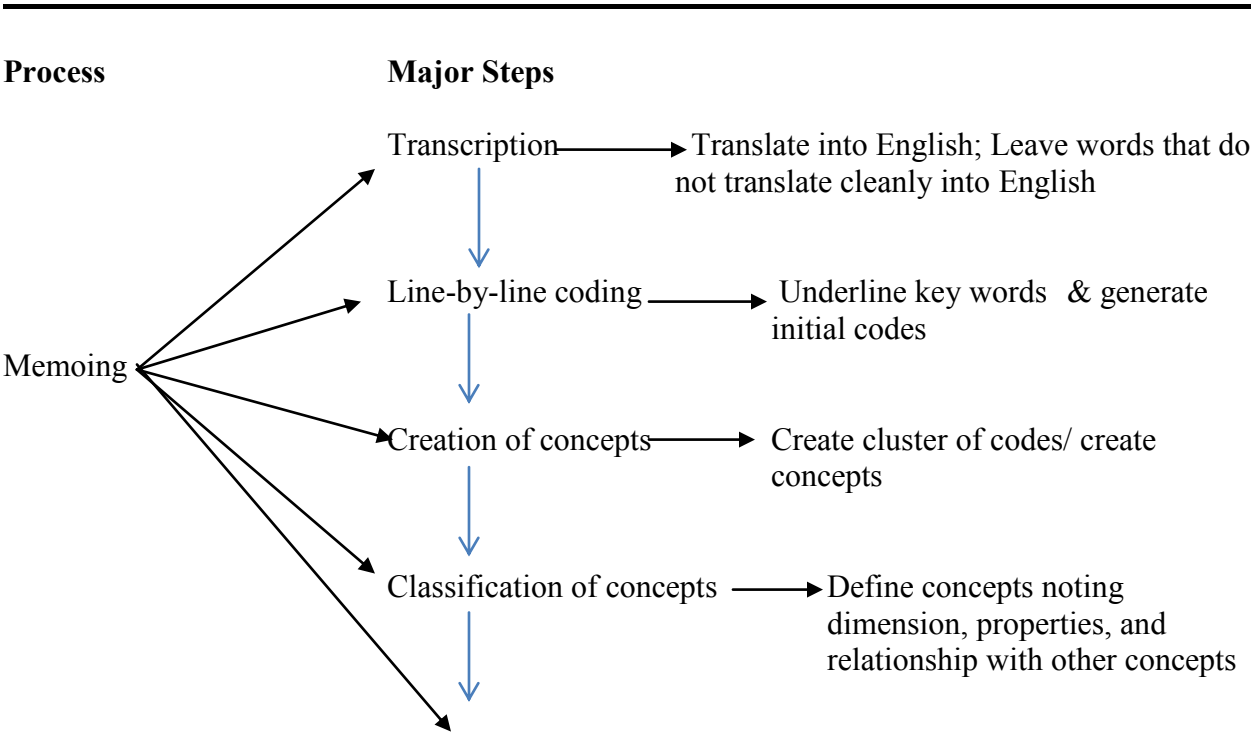
Because the study used the theory-driven methodology, data collection continued until theoretical saturation was reached. That is, when interviewers' responses no longer revealed newer explanations. The researcher and the research assistant made the decision after the last interviewers provided similar responses to that of previous respondents.

Data Analyses

This study used a grounded theory data analysis strategies put forth by Charmaz (1983), and Strauss and Corbin (1990). The reason for a synthesis is to combine the central features of grounded theory as may be relevant to this particular study. The underlying assumption of grounded theory is that data analysis is a recursive process, a process that begins with the first interview and continues throughout the data collection and analysis phase. Data collection and analyses were done simultaneously. For the purposes of structure, the process outlined in *Figure* (*1)* was assumed. It is however noted that the process was recursive instead of linear. That is, all the processes in the methodology and analysis were done synchronously. The analysis involved multiple steps of data analysis techniques.

To begin with, the researcher translated the first batch of interviews from Twi into the English language, and then transcribed them. Data analyses began with microanalysis consisting of line-by-line analysis of the interview data to generate initial categories and their theoretical dimensions. Axial coding aimed at discovering conceptual relationships between subcategories

and primary categories of the study construct was done (Henwood &Pidgeon, 1995; Hernandez, 2009). This culminated in the creation of theoretical codes. Attention was given to identification of patterns and variations in the emerging categories. This was helpful in defining the emerging concepts and their relationships to each other. Coding and classification was done along with additional data collection to gather more information that extended the scope and theoretical richness of the categories. This analytic process helped in the generation of hypotheses which was evaluated in subsequent interviews.



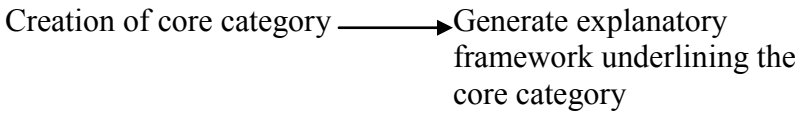


Figure 1. The Analytic Process
Adapted from Eves (2001): Combines grounded theory analysis strategies from Charmaz (1983), and Strauss and Corbin (1990).

The researcher translated the interviews from Twi into in English, and then transcribed them. At the beginning, the researcher transcribed the tapes as and when the research assistant sent in the interview files from the field. This allowed for generation of additional questions that were further explored in subsequent interviews. However, because the rate of transcription was slower than the rate of interviews conducted in the field, only few transcriptions were completed at the time of the interview. The researcher therefore decided to listen to the audio files to ascertain whether any clarifications or questions needed further exploration. Any such need for clarification was communicated to the research assistant who then explored them in subsequent interviews. Both the researcher and research assistant came to a consensus after the last interview that no further interviews were needed as the questions generated similar responses such that no new ideas were emerging from the field, a process called theoretical saturation.

After all transcriptions were done, two independent coders, a European and a Ghanaian, were selected to join the researcher in coding. The choice of two independent coders was to reduce the bias that the researcher brings on the coding due to her familiarity with the literature in the area, and also to allow for other opinions other than her own. Since one of the hall marks of grounded theory is to avoid allowing preconceptions to influence coding of the data (Charmaz, 2006), the inclusion of a non-Akan or Ghanaian in the coding team helped to reduce the incidence of preconceptions influenced coding that emanate from a culture of the two other

Ghanaian coders. The other Ghanaian coder helped with the *invivo* coding as well when the nuances of the interviews were maintained by keeping the words in the Twi language.

The three coders worked together as a team in coding the data. The only instruction the researcher gave to the team was that the study seeks to know what mental illness is. The group's task was to transform the data into codes that are grounded in the transcription. The group proceeded by doing a line-by-line coding, isolating key words that stood out to them. The initial codes were subsequently consolidated into cluster. In coming up with the cluster codes, the researcher asked the group for a term that could capture as all the initial codes that seemed to be related. Example, symptoms or physical signs of mental illness came under the cluster "*Behavioral Markers*." At the end of the team's work in forming the cluster codes from the data, the researcher analyze how the codes were linked to each other as they relate to Akan conceptualization of mental illness. This process called theoretical coding (Charmaz, 2006) allowed the researcher to conceptualize mental illness from the Akan perspective.

Validity and Reliability

Validity, as used in qualitative research, relates to the accuracy of the findings from the perspective of the researcher, the participant, or the readers of an account (Creswell, 2003). Reliability in this study is not in reference to obtaining same results on different occasions but relates to the transferability of the understanding gained to the social setting of the study. Thus, reliability can be achieved through the transparent documentation of the process that influences the findings. This involves taking note of how interpretations are reached (Evans, 2007). Williams and Morrow (2009) suggest that there are three major categories of trustworthiness to be met in all qualitative research. They include integrity of the data, balance between reflexivity,

and clear communication of findings. The current study used the following strategies to ensure integrity of data.

The researcher documented the systematic processes used in the data collection and data analysis (Patton, 2002). The research assistant and researcher used an open process where methodological issues were discussed. Both the researcher and the research assistant kept journals, and the information from the journals have been incorporated in the write-up of the study. In order to increase the sample representativeness, both men and women from diverse age, education, and occupational backgrounds were interviewed. This study addressed the issue of sample size using theoretical saturation where both the researcher and the assistant agreed that no new ideas were emerging from the interviews. Strauss and Corbin (1998) define theoretical saturation as the point in data collection at which no new properties, dimension, or relationship emerge. The researcher conducted preliminary analysis through initial coding with each interview file that was received. This allowed for assessing whether the interview questions were adequately covered or new ideas were fully explained. Subsequent interviews covered areas with adequate data and gathered additional information on emergent themes (Williams & Levitt, 2007; Patton, 1990; Bowen, 2008).

A number of steps were taken to attend to integrity of the interpretation of the data. First, the researcher and the research assistant documented their biases and expectations in advance of the study. For instance, although both the researcher and the research assistant are both Akans, they also acknowledged the possible influence of their Western education as well as their perceptions of the biomedical model in explaining mental illness. The researcher in particular accepts the bias she brings on the study because of her training as a counseling psychology

student, her experience with working with mentally ill patients, and her knowledge of the literature around mental health in general.

In the coding process, the researcher informed the other codes of her bias because of having knowledge of the research questions, as well as her experience with conducting the preliminary initial coding. For instance, the researcher had through the initial coding generated key concepts prior to meeting with the two independent coders and as such refrained from being the first to suggest a concept for the related themes of ideas highlighted during the group coding. These decisions were in harmony with the canons and procedures of grounded theory which discourages the researcher from contaminating the study with the information from other researches (Meadows & Morse, 2001). The purpose was to put prior information about the topic temporarily on hold, and use it as a comparative template to test the emerging interpretations in the current study. Most of the concepts generated by the team were similar to those initially generated by the researcher. The only difference was when local concepts of mental illness relating to the supernatural domain were labeled "superstition," but the researcher had a different opinion which was reconciled. The researcher kept a reflective journal in which she kept a diary of personal reactions throughout the study transcriptions and analyses which have been incorporated in the discussion.

To assess for language equivalence, five files which were randomly selected were sent to an independent translator for backward translation. In choosing the translator, attention was given to the language proficiency level as well as the cultural knowledge of the translator (Larkin, Dierckx de Casterlé, & Schotsmans, 2007). Hence, the translator chosen for this study is of Akan descent, and has taken a course specifically to study the Twi dialect that the participants

in this study used. After the first English transcript was sent, every fifth interview file translated into English and transcribed was sent to the same independent translator. The researcher compared the backward Twi translation with the Twi responses of the participants. There were minor variations in the two documents but they did not alter the meanings. The Twi translation varied from the original file in terms of use of synonymous words but the semantics remained unchanged (See Appendix 4). In addition, the researcher makes extensive use of Twi words from respondents to illustrate interpretations and emergent explanations. These notwithstanding, the researcher is aware that personal values, beliefs, and experiences of all those involved in the study may influence how interpretations and descriptions are made, but every effort has been made to attain a balance between participants' meanings and researcher interpretations. in the final analysis, this work is the outcome of several drafts, and rewriting that sort to ensure that the interpretations are grounded in the data. The research made several references to the different memos that were written through data collection and analysis (Charmaz, 2006). The research findings were re-examined against the data, the reflections of the researcher and the research assistant as noted in the methodological and the reflective journals.

Results

Several themes emerged from the narratives and were coded as definition, local labels, and development, forms, and behavioral markers of mental illness. The others are causes, care and treatment of mental illness and generational differences in conceptions of mental illness.

Definition of Mental Illness

In order to ascertain what participants referred to as mental illness, they were asked about what comes to mind when they hear the word mental illness. This resulted in some giving what was coded as definition of mental illness. The definition highlighted the fact that mental illness is impairment in the mind or thought.

"*What normally comes to my mind when I hear the phrase mental illness is a person whose mind does not function; a person who is not of sound mind." (Male, 71 years old)*

"Mental illness refers to someone whose thinking is impaired." (Male, 68 years old)

Local Labels for Mental Illness

Participants provided a number of local labels used in referring to mental illness. They include *"abɔdam" "adambɔ" "ogyefo" "woaɔbɔgye" "gyimigyimi" "adwenne ho ato*," *"adwennmuká"* and "*bɔdam ani te.*" The labels revealed the course of the illness as well as the level of severity. In explaining the various labels, participants often contrasted a label with what was thought to be the severest form of mental illness.

Abɔdam/Adambɔ. *Abɔdam* and *adambɔ* were used synonymously to refer to the most severe form of mental illness. The data showed that it is characterized by marked changes in behavior such that the person is often described as violent. *Abɔdam* was often said to be permanent. Three participants explain:

> "*…"adambɔ"… is a sickness that affects the mind. It damages the brain so that the mind is affected. Though the person is human, he is not with humans. Man's behavior changes to that of, excuse me to say, a wild animal or a domestic animal. That is, he is out of his mind… As for the "ɔbɔdamfo", his condition is permanent." (Male, 68 years old)*

> *"The "ɔbɔdamfo" may carry heavy load and walk long distance. He may eat anything from anywhere even picking up food from the garbage or from the ground – such a person is really mentally ill."(Female, 40 years old)*

> *"…as for the ɔbɔdam… he is so violent… Their behavior is unpredictable." (Female, 39 years old)*

Ogyefo/w'bɔgye. Participants described *ogyefo* as disturbance in thought marked by less obvious behavioral symptoms. It is either the onset of mental illness or a mild form of mental illness that fluctuates overtime.

> *"… [The ogyefo] may act in some unusual or strange way. As for the "abɔdam," as soon as you come across him, it is very obvious that he is mentally ill… As for the ogyefo, all that I know is that he may be unkempt. The ogyefo is not mentally ill, except that he is not 'normal.'…The illness fluctuates. You may sometimes see them in very good situation,*

well-kept and normal then with the passage of time the condition deteriorates again…" (Female, 63 years old)

"The one who is now becoming mentally ill we also say he is becoming or 'wabɔ gye'" whereas the one who is actually mentally ill we say "wabɔdam." ... [The ogyefo] may not really be mentally ill but the thinking is not normal. Though the person may not be mentally ill, you notice that things are not going on well for him. ... You can see from his everyday activities that there is something wrong in his thinking. " (Female, 40 years old)

Adwennemuka. This label is specific in indicating that the illness affected a part of the person's mind. A related label is "*N'dwenne ho atò.*" The label was also noted for its social appropriateness.

"When we use the phrase "n'adwenne mu ká no," it means the mental illness is not so serious to the point of being severely mentally ill, but one's actions indicates that the person is not in a sound frame of mind. Though one is not mentally ill, his actions reveal that he is becoming mental illness."(Male, 68 years old)

***"**As for the term "wabɔdam", it is not appropriate to use it for a mentally ill person if the victim's relative happens to be around. That is when we then say that "n'adwenne mu ká no." (Male, 63 years old)*

Bɔdam ani ate. This label was used to indicate that the person has some level of awareness. It also reveals the fluctuating nature of some mental illness presentations. The term

was often used to describe someone who has recovered from mental illness, but who exhibits residual symptoms post-treatment. A 68 year male participant explains the etymology of the label as well as the nature of this type of mental illness:

> *"We refer to such illness as "abɔdam." The person behaves like a dog ...Bɔdam ani ate… means…'a recovered mentally ill person.' The person looks normal yet he is not normal. … On some occasions, he would act so nicely and normal but on other days he gets out of hand. His actions reveal that he is not a person of sound mind. There are days that the person communicates very well uttering very sensible speech. But at times, he behaves like, excuse me to say, a dumb. The "bɔdam ani ate" is not really mentally ill. It is like partial mental illness. … He is aware of his behavior. At times, he would be very quiet and withdrawn. At other times also, he can be very hysterical as if he is about to become "abɔdam" proper. But it reverts after some time. And he may interact with others like all other normal persons."*

Gyimigyimi. The label which literally translates "stupid, stupid" was used in reference to children with cognitive impairment. The illness is marked by social isolation, speech impairment, and inappropriate affect. The developmental trend from *gyimigyimi* to *abɔdam* was further explained.

> "*The gyimigyimi may not walk about naked. He often remains at one place and saliva may be drooling out of his mouth uncontrollably and he may have difficulty in speaking. As you converse with him you just find him laughing all the time. He simply affirms whatever you say … He doesn't comprehend what is happening around him." (Female, 31 years old)*

"For some, during their early childhood development they might have suffered from diseases like malaria, but no proper care was provided for them. For such ones, the disease can have so severe effect on them that it leads to seizure / epilepsy. And this can affect the person to an extent that one's neck turns over. If care is not taken then the child becomes "gyimigyimi". The "gyimigyimi", when not taken care of affects his mind resulting in mental illness. His actions and behavior is simply out of the norm. For others, the mental illness prevents them from being active. They keep to themselves and choose to remain at one place. You may see saliva drooling from his mouth most of the time." (Female, 56 years old)

Development, Forms, and Behavioral Markers

Mental illness in children. Primarily, mental illness is conceived of as an adult illness. Participants noted that though children may have mental illness, they do not normally see them nor hear about them.

"I have heard that children can have mental illness but I have not personally come across any child who is actually mentally ill or suffering from any mental illness." (Female, 40 years old)

"There are children with mental illness but it is not so common."(Female, 54 years old)

The causes of childhood mental illness is varied such as through a curse, genetic, prenatal factors, and other untreated health problems.

"Concerning children with mental illness, an example is like …if a man leaves his wife for another woman who then becomes pregnant for him. The former wife may choose to retaliate by not killing the child to be born but cursing so that when the child is born he/she would be mentally ill and not be able to contribute meaningfully to society..." (Female, 39 years old)

"It could be possible that a child's mother may be mentally ill. And this could affect the child as well, just as a deaf person may transmit the deaf to her child. It is in the blood. For others, they may not be affected, because there are mentally ill mothers who give birth to normal children."(Female, 71 years old)

Mental illnesses that have onset in childhood may become severe as the person grows. The majority however were noted to remain the same. Some of the behavioral markers of mental illness in childhood include speech impairment, developmental delays, unintelligible speech, inappropriate affect and social isolation. Participants used the label g*yimigyimi* when referring to children with mental illness.

"The gyimigyimi's actions and behavior are simply out of the norm...the mental illness prevents them from being active. They keep to themselves and choose to remain at one place. You may see saliva drooling from his mouth most of the time. …he may have difficulty in speaking. As you converse with him you just find him laughing all the time. He doesn't comprehend what is happening around him." (Female, 56 years old)

"At the time of delivery, liquid discharge from the mother may enter the baby's head and that can make him dull. You may see saliva dripping from the person's mouth. One's eyesight may also be affected due to the damage to the brain. The child is negatively affected, though it is not so common. For others, it may be from one's own family." (Female, 54 years old)

Mental Illness in Adults. In adult, the different forms of mental illness were differentiated by the level of noticeability of behavioral markers; the more obvious the symptoms, the more severe and permanent the illness. Non-noticeable mental illness is less severe; has no obvious features, and may mark the onset of severe forms.

"For some people you may not notice that they have mental illness. Unlike the ones declared mentally ill who are at the asylum though, you may not see so obvious features of mental illness. With insight you can see that some people or an individual walking may have worries. That is one aspect. The other aspect is the very obvious one that you notice that the individual is sick and needs care. For others, there may not be any sign of sickness but they are not able to mingle with their peers." (Female, 40 years old)

"Mental illness has variations. ... The person no longer washes his clothes. Another may also bath, groom decently and keep his clothing clean, yet he may be mentally ill, as his speech indicates that "he is not of sound mind". Some of his actions may also reveal that such a person is mentally sick though one may be well groomed and clean. ... Some mental illness begins right from infancy while others set off later.... As for children born with mental illness, they grow with it. So, as the child grows his misbehavior continues

with him. The mental illness does not lessen but rather advances with the person as he also grows in age."(Male, 71 years old)

"…Someone with mental illness may be calm and stay at home. Another may undress and go to the public places. Another may wear tattered and dirty clothes and carry a bag into which he picks up all kinds of things from the ground. Some mentally ill people take their bath, others do not bath at all; they are dirty and reeking but they do not smell it." (Female, 54 years old)

Less severe mental illness tends to have temporary course. It goes away after the triggers are no more; or waxes and wanes allowing the affected individuals to lead some form of "normal" life. Participants noted that temporary mental illness with fluctuating course may be triggered by pregnancy, menopause, illicit drug use, the season (weather), or unknown triggers.

"A woman may be normal but once pregnant, she begins to behave abnormally and this ends right after delivery. She may be taking very good care of her child, but as soon as she becomes pregnant again, she no longer takes care of her baby and neglects her. … If you happen to communicate with her, she makes no sense of her utterances." (Female, 40 years old)

"[Some mental illness occurs] seasonally. For instance, the [name] I mentioned earlier normally suffered that situation during the rainy season… It comes and goes…when it happens it affects her dressing and every aspect of her life... Some fluctuates. It may come for some time and they would be better at other times. For example, among those

who smoke "wee", one may be sent to the mental hospital for treatment and would return home well treated and normal. But as soon as the person begins to smoke "wee" again, it recurs. There are others too that is continuously forever and ever till death departs us."(Male, 70 years old)

The most severe form of mental illness has obvious behavioral features. It is acknowledged to have either a gradual or a sudden onset, and has a consistent course over time. Some of the behavioral markers include poor grooming, self-talk, leaving home, violent and unpredictable behavior, and thought confusion as demonstrated in speech and behavior.

"A mentally ill person can be identified by one's behavior and action. For example, as we are all having this conversation right now, such a person may laugh so hysterically that you may wonder what is wrong with her. The person may also act in different manner compared to all of us. … A person may not take his bath at all. The hair may be unkempt and as soon as you see him, you would notice that such a person is not normal."(Female, 80 years old)

"[a mentally ill] person may also be very aggressive and would even try to hit or knock anyone that he comes into contact with – if he happens to hold a metal or a knife, he can harm you with it. For others, …they may be talking to themselves even when walking alone. Another may be hoarding things and carrying around a whole lot of trash meant for the dump. Even, when it comes to communication, it is very difficult for them to understand basic things; they are easily irritated, and their reaction can be very violent." (Male, 65 years old)

Causes of Mental illness

The causes of mental illness, as derived from the data, can be grouped as: problems of living; substance abuse; biological/environmental; spiritual; and unknown causes.

Problems of living. This category consisted of causes that were attributed to anxiety or worry, marital problems, and pain.

> *"... Stress due to anxiety about one's worries. When one becomes too anxious about problems it affects your head. ... too much thinking can lead to mental illness." (Female, 40 years old)*

> *"I strongly believe that anxiety can lead to mental illness. For example, take a respectable elderly man who is unable to pay his children's school fees or provide for his wife and children. He is unemployed. But he needs to pay for his rent and utilities. He needs to get a job so as to be able to meet all these obligations yet he has no employment. Anxiety over such necessities can be so overwhelming that so much thinking about it can affect one's mind to the point of becoming mentally ill. As for this, it affects a lot of the youth who are having mental problems due to anxiety."(Male, 69 years old)*

According to the data, marital problems such as unfaithfulness and relationship failures may also cause mental illness. In addition, pain from relational failures was also implicated in mental illness.

> *"...marital problems may be a factor. For example, a woman may have so much love for the husband and think that he also loves her in return. But when the husband becomes*

unfaithful and goes for another woman, the pain and agony it causes her may be so much that it can affect her mental state and make her mentally ill." (*Female, 39 years old)*

"A very painful act by one person against another. For example, one travels outside the country and sends money to another to construct a house for him. He returns only to find out that no house has been constructed and the money too has been squandered. Such a thing can affect the person's mind and his mental condition. The second factor is marriage. One's husband may be snatched or a boyfriend may be snatched by another lady to an extent that it affects the victim's mind and she becomes miserable. For others, they may just encounter the mental illness "just like that" for no reason. Such a person may be seen running about and restless. These are the three factors that I know to cause mental illness." (Female, 71 years old)

Biological/environmental factors. These include head injury, accident, childhood illnesses, genetic factors, trauma, menopause, and prenatal and pregnancy-related causes. Head injury, accident, and trauma leading to mental illness were traced by some participants.

"Another scenario is when one is involved in an accident. The accident may result in serious head injury. When the head injury is not diagnosed early by doctors then the head becomes infected with illness. This can lead to "abɔdam" where the person would be seen talking to himself." (Male, 75 years old)

"I know one lady whose family was attacked by armed robbers who then raped her and she is now having mental problems. After the ordeal with the armed robbers she thought

of it so much that it affects her mind to the point that she is now scared of men. Now when she is walking and she sees a man she runs to hide."(Female, 31 years old)

According to some participants, childhood illnesses such as high fever, seizure, epilepsy, meningitis, convulsion, and malaria could also lead to mental problems. For genetic causes, participants related that mental illness runs in some families.

"When the child was attacked by convulsion, the medicine given was not so effective. Such situations leave some of the children either becoming sickling or mentally ill." (Female, 80 years old)

"I know of some examples in which mental illness run through the family. By the age of 30 years the mental illness manifests itself among members of that family. For some, you may hear that the mother was mentally ill, and he is also mentally ill. Such a thing runs through the family – It is genetically/biologically transmitted." (Female, 56 years old)

Participants gave different opinions about whether menopause is a mental illness. Some acknowledged the symptoms as being similar to the changes that is seen in people with mental problems but thought that it is not a mental illness. Others thought that it is a form of mental illness. It is noted that the mention of menopause was only by female respondents.

"One with menopause may be walking and talking to herself alone but that does not make the person "abɔdam". As for the one suffering from menopause she is not mentally ill but it has affected her mind." (Female, 36 years old)

"Also, with advancement in age, "menopause" may lead to forgetfulness. For instance, I may enter the room with the intention of going for a particular object. But as soon as I get into the room, I forget what I wanted to pick despite the fact that the object may be right in front of me – thus menopause is also a kind of mental illness." (Female, 63 years old)

Prenatal and pregnancy-related elements were often cited as factors in mental illness in children.

"…unsuccessful abortion may end up causing brain damage to the unborn child. Some even results in deafness, blindness, dumbness (inability to speak) and mental problem." (Male, 75 years old)

Spiritual causes. Spiritual influences in the development of mental illness were highly emphasized when explaining the causes of mental illness. The code included spiritual causes resulting from having spiritual indulgences, coming under the influence of a curse, punishment from the Supreme Being, oracle, and other spiritual forces such as an evil spirit, Satan, demons, and witches.

Spiritual indulgences.

The concept was assigned when the cause of mental illness involved an individual's deliberate engagement with spirits. An act of omission or commission while engaging with the spirits could lead to the development of mental illness. Engagement in *sakawa*, a get rich quick scheme which is believed to involve indulgences with the supernatural; calling on saints or "*maame water*," a so-called sea goddess, were all noted to have a potential to lead to mental illness. The person who engages in sakawa is said to be made mental illness for a short time

during which the person is made to engage in irrational and odd behaviors after which the person would get the riches.

"Most of the mentally ill people we see may be as a result of "sakawa". For some of the "sakawa", the benefactor is specifically given mental illness as a condition for getting rich. One may have to eat from the garbage dump before getting the desired riches." (Female, 31 years old)

"A person may go and consult a Saint. But as the Saint appears, the caller takes to fright. And it was said that such running away from the saints can cause mental illness. So, at times we do hear that such and such a person engaged in such and such activity which has resulted in his mental illness." (Female, 52 years old)

Curses.

Participants identified different types of curses which may lead to mental illness.

"There are about 2 or 3 different variations of curses. One may choose to kill you. A curse may destroy you so that though one is human, ones' behavior is not that of human."(Male, 65 years old)

"For instance, in this town if you use the river to do such things [curses] it would come true. Others may use external powers. For example, if my mother should call me a prostitute when I am not, I can choose to break eggs at midnight asking that should any man sleep with her, such and such a thing should happen to her, and it would be. There are others also who may take schnapps and other requirements to the oracle to seek that

a particular person not be killed but be mentally ill. So there are many options."(Female, 54 years old)

Several forms of curses were identified as the causes of mental illness. While some curses were placed on a person in retaliation for wrong doing, others may have been cast in an attempt to destroy another person out of envy or spite.

Curse as a result of wrong doing or social retribution. A curse may be cast to punish someone for a past wrongdoing or as a form or retribution.

"A curse may result in mental illness…If you steal someone's belongings he can invoke the spirits to curse you by saying that whoever stole from him should become mentally ill before he dies." (Female, 56 years old)

"Because of someone's act, another may like to destroy the other. He may take him to the oracle and ask the oracle not to kill the fellow but agonize him mentally." (Female, 40 years old)

Generational curse. A curse was coded as being *generational w*hen it affects future generations in one's family.

"If one parent has mental illness in the family – probably it was transmitted from a great-grandfather due to a curse. … Such a curse would be transmitted from generation to generation even to grandchildren and great grandchildren. That is how mental illness is transmitted by birth." (Male, 75 years old)

"It is possible that as a result of a curse and other spiritual indulgence, the first to have suffered from mental illness was a great grandparent. Thus, if it is implanted in the family, then it is possible that later generations would suffer from such mental illness…" (Female, 56 years old)

Curse out of spite or envy. People may out of envy or jealousy use a curse to inflict mental illness on another. The purpose of such a curse is to prevent the person from progressing socially or to destroy the person.

"Depending on one's position in secular employment, others may be envious of that position. Thus to prevent you from being at that position, one's opponents may take the person to an oracle and destroy him." (Male, 63 years old)

"… it may have started from one's work. Due to the fact that he was progressing others may have been envious of his success. A fellow worker may see his progress and become envious." (Female, 36 years old)

"In the family, there are some who can foresee a child's future. Thus, knowing that a child would grow up to be a successful person, they seek to destroy him in order that the child may not attain such success. Such a child may not be mentally ill to the point of undressing and walking about naked; nonetheless, the child may not be normal." (Female, 54 years old)

Punishment from Supreme Being.

The Supreme Being *(Nyame) i*s found to play different roles in mental illness. Although *Nyame* does not create people to be mentally ill, it is noted he sometimes punishes people with mental illness.

"Nyame did not create anyone to be mentally ill. Should anyone give birth to a child with mental illness, then it might have been spiritual attack by enemies to make the child mentally ill right from birth. It is on the earth that all such calamities befall man." (Female, 36 years old)

"There are some people who are so wicked that they would like to destroy others. But God, being so good, turns back onto such ones their own wicked deeds and they rather end up becoming mentally ill." (Female, 46 years old)

Punishment from oracle.

It was often stated that oracles punish people who violate fail to fully comply with all the requirements or promises.

"If an oracle is used to get rich and one fails to abide by one of the conditions the result can be mental illness. Some may promise to fulfill certain conditions upon receiving the money, but they may not. … If one commits to the oracle, and forgets or refuses to fulfill such promise, that very oracle would not leave you unpunished for disappointing the gods."(Male, 63 years old)

In some instances, spirits may intervene and bring about mental illness without an individual actively requesting for such to happen to another.

"…Someone's property was stolen. He did not say a word, but rather went to a stream …to complain bitterly. He always goes to the stream and adjoining woods to complain about his missing property. The trees and the streams do hear the man's complaints. They are all God's creation. So as the man complaints and laments to the stream and the woods, it had an effect on the person who stole the property. The person became abnormal until she died. He did not make any curse, but the fact that he was lamenting to the streams and trees – there are spirits, spirits of god around which execute his plea. He was not even aware of the effect of his plea… But God does not respond at once. But wherever you stand to lament, the lamentation would come from the trees and streams around."(Male, 75 years old)

Wicked spirits.

Some spirits were noted to be inherently wicked and would inflict mental illness on humans. These include witches, Satan, demons, and other unnamed evil spirits.

"Mental illness for some may be due to one's own kin – if your home is not good; or there may be someone who is a witch. If the witch engages in unsuccessful witchcraft it can end him up with mental illness. (Female, 80 years old)

"For others, when Satan wants to disgrace you, he can bring mental illness on the child that you are bringing into the world. To destroy the child; he can use witchcraft to destroy the child. He would not kill the child, but destroy the child." (Male, 76 years old)

Substance abuse. There were several instances where the cause of mental illness was attributed to illicit drug use such as alcohol and marijuana.

"One's own use of his body may be a contributing factor to the mental illness. For instance, a person using illicit drugs such as "wee" (marijuana) and cocaine can end up abnormal." (Female, 39 years old)

"If one is not of age for drinking alcohol or smoking cigarette, it can lead to mental illness."(Male, 63years old)

Multiple causes. It was noted that participants always cited more than one cause for mental illness. Sometimes two or more causes were involved in a given case such that no one factor could be said to be the cause. Typically, causes due to substance abuse were easily singled out, but there were a few cases where participants cited that even the substance abuse was prompted by other causative factors. An example is where the trauma from rape and the likely sanctioning by the gods was implied in the mental illness of a person. Another example illustrates the case where substance abuse was thought to have a spiritual cause.

"The story around [name] mental illness was that her father's nephew raped her on a certain mound. You know, we blacks have a belief that nothing exists for nothing. It could be possible that the mound was "ɔbosom" [a god] or it could even happened that the bush where she was raped was a god…Its consequences can be disastrous. (Male, 71years)

"There are some who choose to destroy others through alcoholism. They may use alcoholism to destroy a fellow. One may choose to make his victim become mentally ill;

another may choose to destroy the victim but not through mental illness but through alcohol just to disgrace the victim." (Female, 63 years old)

Care and Treatment

Care of the mentally ill was placed on the individual, family, and the society as a whole. At the individual level, people with mental illness resulting from substance abuse were expected to take personal action in quitting if they are to get well.

"For the others caused through the use of illicit drugs, one needs to stop the abuse of such drugs then the hospital medication can also help in curing it."(Female, 63 years old)

"…if the mental illness was caused by abuse of alcohol, then abstaining from alcohol would help in providing relief." (Male, 65 years old)

The role of the family was highly emphasized. The family plays a financial role, as well as a vital role in deciding where to seek treatment. They also provided social support.

"If the cause is ordinary and your parents are strong, they can help you to go to the hospital for the appropriate "drugs" to be administered. …Parents also have to take responsibility." (Male, 75 years old)

"Even if such a person is cured but the family does not draw him nearer to them, then the mental illness, if caused by worries, would emerge again… The mental illness would resurface if the family does not draw the treated person to themselves, because such a person may feel isolated analyzing the family's reaction to imply that he is still

considered a mentally sick person so he is not part of the family. Such worries can send him thinking so much that his health can even deteriorate into a worse condition than previously." (Female, 50 years old)

A key issue in family care related to stigma, especially, of having a mental illness history in the family. Having a mentally ill person in one's family could have a lot of negative consequences. For instance, it can limit the marriage prospects of the family members. The issue of societal neglect was also mentioned by some participants.

"… When a person becomes mentally ill, he is normally abandoned and left alone. … The problem is that most families tend to neglect people with mental illness. No one cares for the person and so no treatment is received by the victim…Some people are ashamed to have a person with mental illness at home. Others however, provide for those of their own. …" (Male, 65 years old)

"Some people deliberately send their sick relatives to the mental hospital only to abandon them thinking that care would be provided free of charge."(Female, 80 years old)

"…sometimes if one wants to marry and he consults an elderly one who may be aware, the one may be advised against marrying from such a family known with mental illness history. It runs through the family thus once, you marry, at least one of the children is bound to suffer same. That is why our elders sometimes advise against marrying from certain families." (Female, 56 years old)

Choice of treatment. The choice of treatment for mental illness is based on cause of the mental illness as well as the level severity of the illness.

Hospital treatment.

With the exception of a few who opted for prayers as their first line of treatment, majority of participants indicated help seeking for mental illness starts with the hospital. This is followed by going for some form of spiritual assistance. The hospital served the function of confirming diagnosis, giving temporary treatment for symptom reduction, and in some instances providing guidance on the next line of care.

"I would first take the victim to the hospital. It is at the hospital that recommendation would be given as to whether we he should be given medication or otherwise. (Male, 65 years old)

"I would first take the fellow to the hospital for them to examine his mind and then I follow up with prayer…Prayers are necessary but the hospital is essential for the person to be put on medication then you follow up with prayers. But if you just send the fellow to prayers there would not be any solution to his violent behavior…Prayer is better but even if prayer heals the person, you still need to take him to the hospital for them to examine his mind to confirm his health status."(Female, 40 years old)

Participants cited specific instances when trained medical personnel would suggest that they seek alternative, often spiritual help for mental illness. In this way, the hospitals serve a vital role in determining the cause of the mental illness as well as provide guidance for care.

"Even, while visiting the hospital, some of the doctors and nurses who are spiritually inclined can advise you that the sickness is spiritual so you must seek spiritual intervention from the church."(Female, 54 years old)

"Doctors have medicine for curing diseases but not eyes for seeing things…When [some] doctors perceive the cause of an illness to be spiritual, they also provide spiritual medicine for curing and not ordinary mental brain problems such as anger, worry, etc." (Male, 74 years old)

Spiritual help.

The need for spiritual help was emphasized with participants suggesting that some form of prayer be included in the treatment of mental illness. Different types of prayers were suggested, through the oracle, the Christian church and prayer center, or a combination of these. This was important especially if the mental illness is deemed to have a spiritual cause.

"People have different ways of praying. Whereas some may go to the church to pray, others may choose to go to the oracle "ɔbosom." Some believe in "ɔbosom", others believe in Nyame. So depending on one's faith, one may choose the house of prayer in the church or at the oracle. Some may consult the oracle for so long without any improvement then resort to the man of God for prayers. Probably, one may be cured in the house of God through prayers."(Female, 54 years old)

"If it is spiritual, then the person must be taken to a very powerful prayer center. There are prayers of prayers. It is a case in which God manifests his power to heal such ones. But if it is ordinary mental illness, then medication at the hospital can cure it, but as for the ones that are spiritual, unless spiritual intervention that can cure it."(Female, 53 years old)

Some participants indicated that it is important to take the mentally ill, first to the prayer center or the oracle. Prayers help determine the cause of illness as well as provide directions for treatment.

"Prayers at a church [would be my first point of call] since it may not be a hospital sickness. As prayer is said for the victim, the cause of the mental illness may be revealed then cure effected… I would first send her to Pantang hospital. But, if no improvement is seen after some time, I will resort to prayers to find out why and how to cure the fellow." (Female, 45 years old)

"Some are taken for prayers. And if the pastor is really a representative of God, then he can eliminate the illness from its root cause. Some men of God see in vision what might be the cause of the mental illness in the victim, so they can easily heal it. Prayer is very effective." (Female, 63 years old)

Just as it was said that the doctor in a hospital could make referrals for spiritual care, it was noted that some oracles or herbalists would refer mentally ill persons to the hospitals.

"Even in the church, some pastors can inform you that such a condition is beyond prayers, thus seek alternative remedy. A person may have consulted ɔbosom. All such

indulgence can result in mental illness. Thus, when certain pastors realize this as the cause, they acknowledge their inability to cure and would advise that you seek African traditional medicine." (Female, 46 years old)

"Foremost, you have to go to the oracle for him to tell you what it is afterward he can tell you to go to the doctor and it would stop… [The mentally ill] would go to the oracle and then he would tell you that it is a spiritual illness and so I would help you to clear the spirit and subsequently you can go to the doctor for the illness to stop."(Male, 76 years old)

A few participants were not in favor of the idea of seeking hospital care, or spiritual help in treating mental illness.

"Unless the person goes to the hospital. Others may suggest various kinds of alternative medicines but none would be successful. The ultimate is to send the person to the psychiatric hospital. ...I think the hospital is the only place where cure can be found for someone suffering from mental illness." (Female, 36 years old)

Whether they visited an oracle, the Christian church, prayer center, or hospital, participants recognized the role of *Nyame,* the Supreme Being, in the healing process. *Nyame* is the recipient of the various forms of prayers said on behalf of the mentally ill. He plays a protective role by preventing one from being inflicted with mental illness by another. In addition, *Nyame* can help someone to be healed from mental illness.

"As to whether it is at the hospital, prayer camp, or the traditional healer, healing is from Nyame." (Female, 56 years old)

"Nyame would not allow that [mental illness to be passed on to children through birth]. (Female, 63 years old)

"If God loves the person, he may reveal the cause of the mental illness to the one offering the prayers and may also make healing possible."(Male, 68 years old)

"Since God is the creator and has control over all parts of man's body, I strongly believe that he also has the means to heal any part of the body that may be undergoing sickness – He may not even allow it to happen." (Male, 65 years old)

Pluralistic help-seeking behaviors.

It was noted that for most participants, no one single treatment choice was deemed adequate enough to treat a mentally ill. In most instances, a combination of treatments was suggested. This was primarily because mental illness was due to be caused by multiple factors.

"If the illness is caused by the use of illicit drugs, the hospitals can diagnose and prescribe appropriate medicine to cure it. Some may be cured forever, others may not. Those that are not cured may be spiritual and need to be referred to the house of prayer for the priest to pray over it. Once the priest identifies the cause, he can pray for healing."(Female, 63 years old)

"…a very mentally ill person can be bathed and properly groomed then taken to the hospital. There, they may give him injection that would provide some temporary relief first so he can be taken care of. Then follow up with prayers, because there may be some spiritual sickness which may be underlying the mental illness. But prayers can help counteract the spiritual forces then the medication at the hospital would take care of the mental illness." (Female, 40 years old)

"Doctors with expertise in mental health can provide medication and training for the person with mental illness to be able to recover and get back into the society. For others, it may require prayers. For those whose mental illness was caused by the illicit use of drugs, the first step is for them to withdraw from the use of such drugs. Then medication at the hospital would be able to help such a person. Not all mental illness is curable at the hospital. Some require prayers; others require herbalist practicing African traditional medicine. African traditional medicine can be used to cure mental illness. One may visit the hospital for several times, but when no improvement is seen, the family may opt for the traditional medicine where cure is found for the mental illness." (Female, 56 years old)

Another reason for the pluralistic help-seeking was the fact that participants felt that there were the limitations in seeking help from each of the treatment choices. The hospital was seen as being limited in the extent to which it can treat mental illness, and some thought that some of the mental illness with spiritual causes may be beyond the abilities of the doctors at the hospital. The

prayers, offered at whatever place, were also noted to have limitations. Thus, by seeking help from multiple sources, the deficits in one area are compensated for at the other alternate sources.

"...hospital healing process is quite long. But the traditional healer normally takes a maximum of seven (7) days to heal, but the person may have to stay with the healer for some time - sometimes about six months before being discharged finally."(Female, 56 years old)

"As for the one with spiritual connotation, doctors cannot do anything about that." (Male, 74 years old)

"Before prayer can be effective, the cause must be spiritual. Prayer is very effective for the spiritual causes. However, if it is a disease, then prayer is not necessary. The hospital is the place for such treatment. This is because those who offer the prayers are dealing with the spiritual realm... Thus, when the mental illness has spiritual connotation, prayer can be effective, but when the mental illness is a disease, then no matter how much prayer is said, unless the person is sent to the hospital for treatment, no cure can be obtained. For instance, if one's mental illness is due to a curse, then prayer may be effective in reversing it. Noteworthy is the fact if the situation is due to a curse, then no matter what medication or treatment is provided at the hospital, no cure would be obtained unless through prayers."(Female, 72 years old)

Some participants indicated that mental illness can be cured completely, but others said that mental illness may be difficult to cure completely.

"Yes, it is possible for a person with mental illness to be cured completely without any trace at all...both doctors and the traditional medicine practitioners are all able to cure mental illness completely."(Male, 76 years old)

"Some may become very well while others may not be cured completely but they can be treated to live well with others." (Female, 52 years old)

"As for mentally ill one, it is most often very difficult for them to be cured." (Female, 40 years old)

"What I personally believe is that right at the onset of the mental illness, or when the person becomes "bɔdam ani ate" and he begins showing signs of abnormality, then when cure is sought at that moment, it may be possible for the mental illness to be cured. But when the mental illness become serious, cure is difficult. ...even when the mentally ill person is cured of his mental illness, there is a little left that can be used to scare the kids. It would be very difficult to cure a really mentally ill person."(Male, 68 years old)

Generational Differences

Some generational changes were noted in how mental illness was conceptualized. It was noted that mental illness was not as common in the olden days as it is now. The explanation offered was that people back then were more "obedient" and led a "virtuous" life style. Participants noted that their parents warned them to desist from social vices in order not to develop mental illness.

Prevalence.

"Frankly speaking, mental illness was not a common thing by then. But what our parents used to say was a form of warning for us to desist from certain acts and behavior that may lead us into mental illness. Another may be due to a curse. That is what my parents used to say, and we also listened."(Female, 80 years old)

"There weren't many people with mental illness…those days, we were obedient."(Male, 76 years old)

Mental illness caused by social vices.

"My parents…believed that it is when one engages in vices that a person gets into the grips of Satan who would then manipulate the person which can sometimes end up in mental illness." (Male, 65 years old)

"It is said that if you insult an older one (disrespected) it can result in mental illness for the offender." (Female, 40 years old)

"Our older generations always advised that if we happen to owe someone, we should patiently and humbly plead with the person. But if we scornfully refuse to pay back the person's debt, the lender can make the debtor mentally ill." (Female, 45 years old)

Change over time. Some of the notable changes cited include the idea that curses are no more as effective as in the old days; and people are becoming Westernized and therefore prefer hospital treatments.

"In the olden days such curses were very effective. Such a curse would be transmitted from generation to generation even to grandchildren and great grandchildren. That is how mental illness is transmitted by birth." (Male, 75 years old)

"Currently we have all become westernized so when you are sick instead of going to get some herbs from the bush for enema, they say no take him to the doctor. It may not be an illness to be treated by a doctor, but they take you to the doctor. You would just die for nothing. The doctor may not have the cure, if it is someone causing your illness the doctor cannot know and tell you but the oracle can tell you that about your mental illness." (Male, 76 years old)

Another change over time relates to changes in understanding on causes and attributions illness.

"In their time, when the women get into menopause, it was attributed to witchcraft or "dambɔ." (Female, 31 years old)

A 68 year old male participant also noted how technology may impact the presentation of mental illness as follows. A person may be perceived as engaging in self-talk, which have been identified as a behavioral maker for mental illness, whilst she or he may actually be speaking on the phone via a cordless ear device.

"The youths of today put earpiece/earphones in their ears even when walking in public. They are therefore seen talking with the earpieces in their ears. Continuous use of such devices can affect some to the extent that though they may not be mentally ill their actions may show them as otherwise."

Discussion

Akan Conceptions of Mental Illness

The study shows that Akans recognize that mental disorders are characterized by impairment in behavioral, psychological, and social functioning. This socially contrasted conception of mental illness reflects the socio-cultural context in which the Akans live as well as their experience with mental illness.

The cluster of behavioral symptoms that participants reported showed what the Akans value as normal human functioning. Within the Akan context, it is expected that a socially responsible person would be capable of taking care of his/her physical hygiene, among other things. As such, most participants cited that a change in a person's grooming would be a key marker that a person, if not already mentally ill, is at the onset of mental illness. Further, Akan cultural values enjoin the individual to contribute to communal relationships through social mutuality (Gyekye, 1995; 1996). As such, one who is not able to engage with others in socially appropriate ways is also deemed to be mentally ill. This is because the cultural expectation is that all would be able to contribute to social harmony by engaging with others. It is therefore not surprising that social dysfunction was identified as a cardinal feature of all the forms of mental illness identified by the respondents of this study. The social dysfunction, which was seen as distressing to the one who is mentally ill, was also distressing to onlookers. Disordered thought

pattern, another cardinal feature of mental illness, also makes engagement with others practically difficult or even impossible.

The Akan conceptualization of mental illness is, in part, similar to that used in the Diagnostic and Statistical Manual of mental disorders (DSM: American Psychiatric Association, 2000). Like the DSM, the Akan construction of mental illness highlights deficits in social functioning and disordered thought as cardinal features of mental disorders. Akan construction of mental illness also makes a qualitative distinction between what can be considered mental illness and what is not. For many years, clinicians and researchers have been discussing what meets the criteria for a mental illness or a psychological disorder (Meehl, 1986; Cooper, 2005; Kindler, Zachar, and Carver, 2011). Kindler, Zachar, and Carver (2011), for instance, note that the question of what constitutes a psychiatric disorder continues to be a key issue of consideration within researchers' and clinicians' circles. It is interesting therefore to note that the question of what constitutes mental illness is not only left in the domain of clinicians and researchers, but that lay Akan people also engage with the issue.

Although there seemed to be a consensus on what constitutes mental illness among the Akan, it appeared that some presentations defied the Akan definition of mental illness. The basic definition underlying Akan categorization of what is mental illness is surmised to be, 'a cluster of behavioral symptoms (such as aggression, irrelevant or disordered speech and behavior) accompanied by impairment in thought, leading to social dysfunction.' Using this framework, participants made attempts to distinguish between what changes in behavior is considered to be "normal" and what can be classified as a mental illness. For instance, the discourse on whether the behavioral symptoms associated with menopause made it a mental illness shows that a

careful attempt is made in reaching a consensus on what meets the local criteria for mental illness. Likewise, some participants indicated that certain behavioral markers need to accompany use of alcohol to be considered a mental illness. Such on-going discourses seem to suggest that Akan conception of mental illness is not static.

The Akan local labels for mental illness also show that Akans recognize a broad range of mental disorders. Different forms of mental illness were identified by the respondents, and so were different levels of severity in mental illness addressed. Although participants did not label specific categories of mental illness like depression or schizophrenia, the descriptions they provided show that lay Akan people appreciate the fact that there are different forms of mental illness. A close examination of the symptoms described for *abɔdam* — disruptive behavior, disordered thought pattern and impairment in social functioning — resembles DSM diagnostic label for psychosis (Read, Adiibokah, and Nyame, 2009). The finding is similar to others found in east Africa where lay descriptions of psychosis is similar to Western symptomatology of psychosis (Edgerton, 1966). Like Edgerton's findings, the respondents in this study did not make mention of hallucination as part of the presentation for *abɔdam,* neither was this implied in their descriptions. Notwithstanding, the presentations of severe mental illness shared a lot of resemblance with western presentations of psychosis. Likewise, *gyimigyimi* is akin to western presentations of Down syndrome and autism which are marked in part by cognitive deficits, developmental delays, and impairment in social functioning.

The Akan conception of mental illness finds support in Leventhal and colleagues' (1984) common sense model (CSM) of illness perception, giving an idea about how individuals respond to mental illness. According to the CSM, people take five dimensions into account when

organizing lay beliefs about an illness, namely: the identity of the disease; the etiology; consequences; timeline; and control. In terms of identity, it was realized that the Akans not only have labels or names for mental illness, but they also note the symptoms as well as the levels of seriousness of the various forms. With regards to the etiology, the Akans interviewed in this study cited several causes for mental illness. The dimensions on consequences as well as duration of the illness were equally covered when participants talked about the seriousness of mental illness and how it impacted the daily lives of the affected individuals as far as their physical, social, and psychological functioning were concerned. Finally, the discussions around whether mental illness is curable or not, and beliefs about treatments satisfied the fifth dimension of the CSM, control. The level of control of mental illness is contingent upon the cause. If individual actions led to it, and there were no spiritual influences, the affected person could take remedial actions. However, curses could require different actions at cure. Ultimately, the issue of control rests on the individuals, family, and involved spiritual sources.

Despite the similarities found between the Akan conceptions of mental illness and the DSM and the CSM of illness representation, important cultural differences exist. These include the fact that Akan conceptions emphasize that mental illness has multiple causes, make limited references to the role of disturbance in emotion in mental illness, and emphasizes that holistic help-seeking behavior is the best way to treat mental illness.

Akan heterogeneous, multi-tier etiology of mental illness. The causal explanations for mental illness identified in this study were a direct consequence of the Akan ontology. Akans have varied causal explanations for mental illness. These factors are often multi-tiered in such a way that knowing just one cause may not be enough in explaining any one's mental illness. In

establishing the etiology for mental illness, one needs to give room for multiple tiers of causes, namely primary and secondary causes, and, in some cases, tertiary causes. To illustrate, the primary cause of one's mental illness could be that he offended his or her fellow, a socio-cultural attribution of personal responsibility. The second tier of etiology is that the offended person invokes a curse which leads to mental illness. In most instances, however, the tiers of causes are often difficult to take apart, and the intersections of spirit influence as well as personal responsibility are assumed or implied.

According to Gyekye (1995), Akans use a dual causality theory in explaining occurrences in the physical world. These two causal explanations, the supernatural causality and non-supernatural causality, came to the fore when participants explained that various factors cause mental illness. There seemed to be a consensual knowledge among the Akans that explanations that are not readily available in the physical world could be found in the spiritual.

In explaining the causes of mental illness, participants showed that the dual causality worldview is much more complex than duality may suggest. The cause of one's mental illness may not simply be a supernatural explanation or a non-supernatural explanation. Participants indicated that even when a supernatural causality attribution is made, there could be more than one supernatural factor involved in a given case. Thus, mental illness is indeed multiply-caused. In this regard, Wiredu (2009) notes that scholars risk making a mistake when they attempt to apply categorical thoughts to the Akan ontology. That is, attempts to explain causes in a dichotomous way, supernatural versus non-supernatural distinctions, run the risk cause of missing the full idea behind African thinking. Thus, the cause of mental illness is not either supernatural or non-supernatural. Rather, a combination of supernatural and non-supernatural

factors may be involved in one person's mental illness. When supernatural causal attribution is made, it is expected that some non-supernatural factors may also be at play. Likewise, when a non-supernatural casual attribution is made, it should not be surprising that some supernatural factors could be cited, if not now, later. This is because the Akan worldview is unitary such that both the physical and the spiritual are often intertwined. What is physical may as well be spiritual.

In the current study, participants indicated supernatural causality, said to be vertical such that a more powerful spirit can control a less powerful spirit (Gyekye, 1995), mainly after non-supernatural explanations have been exhausted. This shows that the conclusion that Akans reach when they make a supernatural causality attribution is not one reached through a hurried process. Just as a trained clinician may use a heuristic to rule out one diagnosis from another, the Akan may use a worldview-based heuristic in reaching a conclusion about the cause of one's mental illness. An Akan may do this on his/her own, or consult a more qualified person. Consultations could be with an oracle, a herbalist, medical doctor, priest at a prayer camp or church, or other medical professionals. This process is important because the results often dictate the next line of treatment and care.

The Akan worldview allows for understanding mental illnesses that seem to defy one basic causal explanation. The acknowledgement of non-supernatural causality allows the Akan to accept that genetic factors, individual roles, and accidents could lead to mental illness. A key part of the Akan worldview is the recognition that individuals have free will and moral responsibility. Even when supernatural causality was made, personal responsibility attributions were also isolated. This socio-cultural attribution was particularly the case in issues of curses that were the

result of wrong doing, offending the gods, or offending another human being. It was emphasized that spirits do not, in most instances, bring a curse of mental illness unless individuals do something wrong or offend the other. Moral failures are therefore punishable with mental illness. The Akan owes it to himself and to posterity to engage in behaviors that are deemed socially appropriate so that he/she can prevent mental illness. It appears then that the key to preventing mental illness is to lead a morally upright life, according to Akan conceptualization. It is noted that no one is created to be mentally ill and that people are in most part accountable for their behavior and its consequences.

The issue with personal enemies is also reflective of the Akan ontology (Adams, 2000). Although the Akan believes in and values social harmony and collective well-being, the nature of their interdependent values makes them develop a measure of relational friction (Adams & Dzokoto, 2003). It is easy to offend and be offended in an interdependent setting, some of them resulting in jealousy and envy. Reisman (1986) made a similar observation noting that the interdependent values of the African peoples foster relational frictions, making one prone to the risks and dangers associated with interdependent relational life. In harmony with this thought, the Akan is inherently aware of the presence of other people who may want to do harm to him or her. The personal enemies could be blood relations, neighbors, or workmates to whom one had relational conflicts. There are other personal enemies who are as such because of being simply envious or jealous of others' progress. The accusation of personal enemies as the cause of mental illness resonates with the Akan worldview of human nature.

Human nature, according to the Akans is neutral. Although not created evil, humans by their actions and inactions can be good or bad. There are countless Akan maxims on hatred,

jealousy, envy, and other negative traits that are a reality of every human society. These invariably warn that another person can do harm through physical and spiritual means. With the exception of few instances when non-supernatural attributions were made when the mental illness was deemed to have come about as a result of marital distress, mental illness from personal enemies always had supernatural attributions. The reason is that non-supernatural causality is limited in power, and it is only with the backing of spirits that one can control the other in the spirit.

Pluralistic help-seeking behavior. The multiple causality explanation of mental illness among the Akans encourages them to engage in pluralistic help-seeking behaviors. The purpose is to gain a holistic treatment that takes into account the individual's physical as well as the spiritual wellbeing. The study recognizes the fact that other factors such as cost, severity of ailment, and availability of mental health services influence pluralistic help-seeking behavior (de-Graft Aikins, 2005), but it also surmises that the compelling reason for pluralistic help-seeking among the Akans is their heterogeneous, multi-tier causality explanations for the causes of mental illness. The suggestions around the line of treatment for mental illness show a clear case of the mind-body-spirit "mutualism" that what happens in the body could actually have a spiritual underpinning and vice versa. Mental illness could be an indication that there is something wrong in the spiritual realm. With the different sources of help, traditional herbal medicine, spiritual, and biomedical, available in Ghana, it is possible or easier to have treatments that are tailored to suit one's needs. The pluralistic help-seeking behavior found in Akans, as well as other Ghanaians, has led to an interesting mental health referral system.

Mental illness referral.

An interesting finding from this study is the referral system that has emerged in the mist of multiple health resources. Akans in particular, and Ghanaians in general, have the privilege of having a buffet of health care treatments from which to choose. The available sources allow one to choose help that is in consonance with what one perceives to be the best and effective treatment as per his or her worldview. Previous studies conducted in Ghana (Tsey, 1997; Roberts 2001; Ae-Ngibise et al., 2010), and other parts of Africa (Adewuya & Makanjuola, 2008), indicated that people in sub-Saharan Africa have a preference for traditional and spiritual healers as their first line of treatment of mental illness. Contrary to these findings, the current study revealed what could be a change in the line or sequence of help-seeking when it comes to mental illness treatment.

The results showed that most of the respondents had a preference for hospital care as their first line of treatment. It appears that Akans have come to the point where they can appropriate the use of the hospital. Formally, the task of finding out what the cause of a mental illness is rested on the individual and family members. Now, people seem to gain similar help in deciding on the cause of the illness when they send a mentally ill person to the hospital. Here, they get a temporary symptom check and medication for temporary symptom reduction. This affords them the opportunity to make a final decision on long-term treatment. In some instances, they are able to receive both hospital and alternative treatment concurrently. While the person is at the hospital, prayer or spiritual help may be sought by family members. In this way, the sick person receives holistic treatment that takes care of the mind, body, and spirit as consistent with their worldview. By going to the traditional healer, the Akan gets to consult with one framework

of care is similar to that of the lay people and who recognizes the socio-cultural causes and consequences of mental illness and who is willing to work with him from the same perspective. The visit to the hospital takes care of the biological component of the illness (Fosu, 1995).

The emergent mental health referral system where health professional within the hospital system would suggest alternative treatment, such as the need for spiritual help, and the vice versa, is a healthy system that seems to accommodate and show respect for the Akan people and their beliefs. Although some studies have indicated that one of the dangers inherent in pluralistic help-seeking behavior is delaying referrals to the hospital, this study recognizes the strength that lies in providing holistic treatment that meets the needs of the people being served.

Mental Illness: A Mechanism of Spiritual Retribution

One major theme that emerged from this study is the fact that Akans apply a moral perspective to their construction of mental illness. This conceptualization of mental illness as a form of a punishment permeated most of the explanations on causes of mental illness. In most cases, socio-cultural attributions of personal responsibility were inferred whether someone became mentally ill because of a curse or because of abusing drugs. That is, one became mentally ill because he did something wrong and was being cursed, or the person misused drugs and therefore was deserving of the illness. The only few instance where personal responsibility was not applied was in relation to children with mental illness and cases involving excessive worrying related to problems of living.

The idea of illness being a mechanism of retribution has been found elsewhere (Ito, 1982; Abdullah & Brown, 2011), and have impacts on individual as well as collective responses to mental illness. It was realized that applying a moral perspective to the conceptualization of

mental ill attracted different kinds of responses. Mental illness which was clarified as having moral implications attracted stigma, where as those associated with problems of living attracted pity. For example, one who is mentally ill because of disappointments in marriage is often spoken of with sympathy and empathized with. However, those that were purported to have been stricken spiritually for past wrong doings were spoken of as somewhat deserving the punishment of mental illness. For such ones, the development of the illness is as a form of retribution. Through "retributive mental illness," *Nyame,* and spirits exert control over people, especially those who violate societal norms or offend others. This is consistent with the statements attributed to older generations, warning against practicing social vices that would make one susceptible to mental illness. Susceptibility to mental illness was therefore related to how one conforms to societal norms, and the potential for past wrongs to be sanctioned with mental illness was to serve as deterrence. With a few exceptions, such as being the victim of one's envy or jealousy and accidental causes, people are deemed to have contributed in some way to their development of mental illness. This socio-cultural attribution of personal responsibility influences how Akans respond to those who are mentally ill.

Response to the Mentally Ill

Akans show varied responses to the mentally ill, including pity and shame. Participant responses also revealed stigma toward the mentally ill and those with mentally ill family members. Akans attach different virtues as well as vices to the "home" one comes from with someone's identity closely related to the house she is affiliated to (Geest, 1998). People are described as good or bad depending on the house they are associated with. Thus, when someone's mental illness is said to be from home or the house, it cast a stigma on all those

associated with that house. The effect is that people tend to dissociate themselves from family members who are mentally ill, to the point of neglect. The factors that produce mental illness stigma among the Akans are varied, and include lay conceptions of the etiology of mental illness, perspectives of risk involved with engaging with mentally ill persons, and ideas about cure.

This study shows that public stigma about mental illness is tied with the local conceptualizations around the etiology of mental illness. People who were suspected to be suffering for their bad deeds or incurring the wraths of the spirits are stigmatized for being held socio-culturally accountable for their past wrong doings. The idea that one is cursed is in itself stigmatizing (Mishira et al., 2009), and no one really likes to be associated with an accursed person or one chastised by the gods, an oracle, or some other spirit. The stigma that comes with being cursed translates into how Akans respond to the mentally ill.

Perception of risks associated with mentally ill persons exacerbates mental illness stigma. There is a high level of stigma around how unpredictable and violent mentally ill persons can be. Why? The mental illness person is often thought of in animalistic terms, perceived to behave like an unpredictable and dangerous animal. This notion may explain the practice whereby people with severe mental illness are chained or tied up (Roberts, 2001).

Studies conducted in Ghana (Barke, Nyarko, and Klecha, 2011; Rosenberg, 2002; Roberts, 2001) have documented different types of stigma associated with mental illness. Barke, Nyarko, and Klecha (2011) noted in a study of a section of urban populations and a sample of mentally ill patients in three psychiatric hospitals in Southern Ghana that a high prevalence of public stigma existed in the country. The study found that both positive and negative attitudes towards the mentally ill co-existed such that some in the public felt that the mentally ill should

be treated with dignity and their rights should be respected. At the same time, there was a general concern with possible risk of living with a mentally ill person. The result is consistent with the beliefs expressed by the respondents of this study. Although the people may have sympathy for the mentally ill, they at the same time entertained a level of fear because of the perception that mentally ill persons can be violent. While the participants expressed some strong sentiments about how families and the society as a whole should care for the mentally ill, they also warned of the potential danger of being around a mentally ill person. The mentally ill is often described as dangerous, aggressive, violent, and unpredictable.

The seemingly discrepant responses, positive and negative attitudes, to the mentally ill have been documented among other people of African descent (Abdullah & Brown, 2011). It appears that the cultural values of collectivism found in Akans, and other people of African descent, endears them towards those of their kin who are ill, but at the same time the other values related to the notions on spirits' role in mental illness and associated stigma make people distant themselves to avoid being associated with the mentally ill person. While people desire that those with mental illness be treated with dignity, they are constantly confronted with the risk involved in doing so. It appears that the perception of severe mental illness has become the template or prototypic schema for adults with mental illness.

Studies conducted in other countries have shown the influence of culture in the development and experience of mental illness stigma (Abdullah & Brown, 2011). As already mentioned, local conceptions determine what behaviors constitute mental illness and determine local response to mental illness. In the case of the Akans, some of the beliefs have been influential in promoting stigmatizing beliefs about mental illness.

Another cultural belief which promotes mental illness stigma is related to cure. There were heterogeneous beliefs about cure for mental illness. When supernatural factors were cited as the primary etiology for mental illness, cure was often thought to be impossible. In addition, severe mental illness was thought to be incurable. It was believed that even those treated could be unpredictable given that they may have residual symptoms that may lead to future relapse. This idea only aggravates the experience of stigma as people may be less likely to engage with ones who were once mentally ill. Given that Akans value highly collectivism and group identity, the experience of mental illness stigma can be very isolating for the affected individuals. While this study did not interview mentally ill patients, it is anticipated that they would carry similar notions which could result in self-stigma where the internalized local beliefs about mental illness may increase the shame of being mentally ill (Abdullah & Brown, 2011).

Implications

Cultural Context and Mental Illness

Several calls have gone out appealing for more research into cultural influences on mental illness (Abdullah & Brown, 2011) within African settings (Adams & Salters, 2007) and Ghana in particular (Read & Doku, 2012). The purpose is that clinicians and researchers would develop awareness and a better understanding that enables them to provide culturally-sensitive services for those from different ethnic backgrounds. Studies in the African setting further contributes to a better understanding of the African people and adds to the field of psychology in general. Understanding lay conceptions of mental illness is very important for several reasons. Socio-cultural conceptualizations influence lay diagnosis, help-seeking, and communal response to people with mental illness. As noted by Olafsdottir and Pescosolido (2011), lay conceptions guide individuals in making meaning of what is normal and abnormal within a given social context. This further helps in guiding them to make decisions about seeking help either for themselves or for others. Since lay beliefs may often be different from that of trained professionals, there is often a knowledge gap between professionals and lay people. To be able to offer a culturally sensitive mental health service, clinicians need to understand lay people's views.

The current study answers the calls for researching the African setting as well as cultural influences on mental illness, and the findings have many implications for training, clinical practice, and mental health advocacy.

Importance for clinical practice. Mental health professionals have a moral duty to honor the lay beliefs of the people they serve so far as the beliefs do not infringe on human rights. For psychologists in particular, and for those trained under the American Psychological Association (APA), there is an ethical obligation to examine the role of culture in their conceptualizations, assessments, research, and practice. The APA Ethics Code, Principle E, mandates psychologists to be aware and respect cultural influences (APA, 2002). This implies that psychologists consider how culture influences lay beliefs on mental illness. This is important in serving diverse cultural groups of which Akans are included.

Today, Akans can be found in different parts of the world. Hence, the knowledge gained from this study could be explored with clients who show up in different clinician offices around the globe. This would go a long way in enhancing the therapeutic alliance between Akan clients and their clinicians. It would show that clinicians desire to understand their Akan clients' worldviews just as they do other ethnic groups. This knowledge can be used to inform treatment and interventions. In addition, similar studies conducted in different cultures could help in reducing the knowledge gap between clinicians and their clients. Indeed, Abdullah and Brown (2011) made a similar suggestion after their review of the literature on mental illness and stigma in the United States. Specifically, they suggested that qualitative research be conducted to determine culturally salient values that perpetuate mental illness stigma. This would be important in determining how to convey issues of mental illness diagnosis to clients. For instance,

clinicians would need to be cognizant of cultural beliefs when discussing mental illness issues with Akan clients. This is especially important given the stigma associated with severe mental illness and the potentiality associated with family neglect. Such sensitivity to cultural factor of clients would certainly make for an ethically sound clinical practice.

Implications for clinical training. Cultural competence is one of the hallmarks of effective clinical practice (Kirmayer, 2012). The first step to becoming culturally competent is to understand cultural assumptions of the culturally diverse population of mental health help-seekers, and mental health training programs play a key role in preparing trainees to be sensitive to the impact of culture on clients. The results of this study can therefore be of much importance in training clinicians who serve people of Akan descent. The number of mental health training programs based in Ghana may incorporate some of the findings about the Akans in this study into their cultural competency curriculum. The master training in clinical psychology offered at the University of Ghana, for instance, can benefit from the knowledge gained about how the Akan cultural beliefs influence their conceptualization of mental illness. The information could be incorporated into current curriculum for multicultural training.

For students training in non-Ghanaian institutions, but who intend to practice in Ghana, the information gleaned from this study could provide an overview for the beliefs of the Akans and it can serve to prepare mental health professionals on how to work with Akan clients. By and large, the training received in the United States focuses on major ethnic groups in the US. Clinicians who intend to work with ethnic minorities or ethnic groups in other countries would have to develop an awareness of the cultural beliefs and values that their clients live in. Even clinicians who do not practice in Ghana but who serve Akan clients around the world could

benefit from the awareness that this work brings to the fore. It would be important to continue engagement with cultural groups to learn about them in such a way that practice and research would be tailored to meet the needs of the people who seek mental health services.

Other health professionals whose work brings them in contact with the mentally ill such as social work and nursing can also benefit from this work as they also tend to rely on biomedical theories about mental illness, creating a gap between their perception and that of the lay people (Fosu, 1995).

Implications for mental health advocacy. Public education and advocacy on mental illness continues to be carried out in Ghana. With respect to mental illness, the study reveals how the worldview of the Akans encourages a rich system of help-seeking behavior and an emergence of a healthy mental illness referral system. These notwithstanding, it was realized that some aspects of the cultural beliefs encourage the development of mental illness stigma which needs to be addressed. It would be important to engage with Akan communities on how to fight the stigma without condemning their valued beliefs. The study advocates for a joint public education on the issue learned from this study. It has been indicated that education does not only minimize stigma, but it also leads to a more positive attitude towards mental illness (Barke, Nyarko, Klecha, 2011). The new mental health law in Ghana which aims, among other things, to combat discrimination and stigmatization against people with mental disorders and promote the human rights of people with mental disorders (WHO, 2007) would be realized if lay beliefs are taken into account.

Conclusion

The study examined Akan conceptualizations of mental illness. It was conducted against the backdrop that Akans tend to ascribe supernatural causal attributions to a wide range of illness and disease. The purpose was to examine how Akan worldview influences constructions of mental illness, assess Akan understandings as to why people become mentally ill, and ultimately develop an explanatory theory about mental illness among the Akans. The study found that the cultural-psychological factors influenced Akan conceptualization in several ways. The unitary view of hierarchy influenced the construction of a heterogeneous and a multi-tier explanation of mental illness. Thus, mental illness is not either a supernaturally caused illness or a non-supernatural illness. Rather, in most instances, a complex combination of both factors influence the development of mental illness. The etiological explanations of the Akans give rise to a pluralistic help-seeking behavior which is catered for by the buffet of mental health services that are available in the country. A downside is that the idea that mental illness is a form of social retribution gives rise to the development of mental illness stigma which inadvertently influences response to those mentally ill. This is especially the case when the primary cause of mental illness is assumed to be spiritual. In addition, the prototypical views of a mentally ill person as one who is disruptive, violent, and unpredictable also intensify the development of mental illness stigma.

The study also found similarities in the constructions of mental illness. It was found that lay Akans use criteria similar to that used by the DSM in determining what constitutes mental

illness and what it is not such as cluster of behavioral makers, impairment in social functioning, and disordered cognitions. They also recognize a wide range of mental illness, as well as levels of severity. Some of the mental illness presentations described were similar in symptomatology to Western labels for psychosis, cognitive deficits, but Akans have different local labels for mental illness. Akans also use common sense dimensions in forming mental illness perception (Leventhal et al., 1984), giving considerations to the identity of the mental illness, etiology, consequences, duration or course of illness, and level of control one has over the illness.

Limitations

A number of limitations have been identified with the study. The sample did not include people below the age of 30. It is not known whether people below 30 years old would have similar views as those shared by those who are above 30 years old. This could be an area for future research given the fact that the study documented some generational differences in the conceptualizations of mental illness. The results of the study have to be interpreted with caution since the Akans in Ghana are not necessarily homogenous. It however believed that the shared cultural worldview would allow for some generalizations to be made around Akan conceptions of mental illness.

Future Direction

This study documented local Akan conceptualizations on mental illness in only two Akan communities. It is possible that there could be slight differences in different Akan communities. Hence, future studies can expand on the scope by sampling a more diverse sample from more Akan sub-groups. More research is also needed to understand how cultural factors influence responses to psychotherapy. It would be interesting, for instance, to find out how clinicians of Akan descent negotiate their beliefs when exposed to clinical trainings that are based on Western

ideologies about mental illness. Future research can also examine how clinicians of Akan descent respond to clients of Akan descent who have similar mental illness conceptualizations as the ones reveled in this study. Other studies could examine how Akan mental health seekers respond to biomedical approaches that do not recognize the Akan worldview.

Much remains to be learned about other ethnic groups in Ghana and other African settings on how their beliefs influence their understanding of mental illness. Future studies in Ghana can focus on other ethnic groups.

References

Abdullah, T. & Brown, T. L. (2011). Mental illness stigma and ethnocultural beliefs, values, and norms: An integrative review. *Clinical Psychology Review, 31,* 934–948.

Abraham, W. E. (1962). The mind of Africa. In Gyekye, K. (1995). *An essay of African philosophical thought: The Akan conceptual scheme.* Revised ed. Philadelphia: Temple University Press.

Adams, G. & Dzokoto, V. A. (2003). Self and identity in African studies. *Self and Identity, 2,* 345–359.

Adams, G. & Salter, P. S. (2007). Health Psychology in African Settings: A Cultural-psychological Analysis. *Journal of Health Psychology,* 12, 3, 539–551

Adams, G. (2005). The collective construction of enemyship in Ghana and the USA: Implications for the study of psychology and culture. Unpublished doctoral dissertation, Stanford University, California.

Adewuya, A. O. & Makanjuola, R. O. A. (2008). Lay beliefs regarding causes of mental illness in Nigeria: pattern and correlates. *Soc Psychiatry Psychiatr Epidemiol, 43*, 336–341.

Adinkrah, M. (2008). Witchcraft themes in popular Ghanaian music. *Popular Music and Society 31,* 3, 299–311.

Ae-Ngibise, K., Cooper, S., Adiibokah, E., et al., (2010). 'Whether you like it or not people with mental problems are going to go to them": A qualitative exploration into the widespread use of traditional and faith healers in the provision of mental health care in Ghana. *International Review of Psychiatry, 22,* 558-567.

Ahorlu, C. K., et al. (2005). "Community concepts of malaria-related illness with and without convulsions in southern Ghana." *Malaria Journal,* 4, 47.

Akyeampong, E. (1995). Alcoholism in Ghana: A socio-cultural exploration: *Culture, Medicine and Psychiatry, 19,* 261-280.

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders- Text Revision* (4th ed.). Washington D. C.: American Psychiatric Association.

American Psychological Association (2002). *Ethical principles of psychologists and code of conduct.* American Psychological Association, Washington, DC.

Appiah-Kubi, K. (1981). *Man Cures, God Heals: Religion and medical practice among the Akans of Ghana.* New Jersey, Allanheld, Osman & Co. Publishers, Inc.

Asante, M. K. and Mazama, A. (2009). (eds.). *Encyclopedia of African Religion.* Thousand Oaks: Sage.

Awuah-Nyamekye, S. (2009). Salvaging nature: The Akan religio-cultural perspective. *Worldviews*, *13*, 251-282.

Baldwin, J. A., & Bell, Y. R. (1985). The African Self-Consciousness Scale: An Africentric personality questionnaire. *The Western Journal of Black Studies*, *9*(2), 61-68.

Barimah, K.B. & Teijlingen, E. R. (2008). The use of traditional medicine by Akans in Canada. *BMC Complementary and Alternative Medicine, 8*, 30.

Barke, A., Nyarko, S., and Klecha, D. (2011). The stigma of mental illness in Southern Ghana: Attitudes of the urban population and patients' views. *Soc Psychiatry Psychiatr Epidemiol, 46,* 1191–1202.

Bowen, G. A. (2008). Naturalistic inquiry and the saturation concept: a research note. *Qualitative Research, 8:* 137-152. DOI: 10.1177/1468794107085301.

Busia, K. A. (1962). The Ashanti of the Gold Coast. In Gyekye, K. (1995). *An essay of African philosophical thought: The Akan conceptual scheme.* Revised ed. Philadelphia: Temple University press.

Charmaz, K. (1983). The grounded theory method: An explication and interpretation. In Eves, Y. D. (2001). A synthesis technique for grounded data analysis. *Methodological issues in nursing research, 35,* 5, 654-663.

Charmaz, K. (2006). *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis.* Thousand Oaks, CA: Sage Publications.

Cooper, R. (2005). *Classifying madness.* Springer : Dordrecht, The Netherlands.

Corbin, J. & Strauss, A. (1990). Grounded theory research: Procedures, canons, and evaluative criteria. *Qualitative Sociology*, 13, 1, 3-23.

Crentsil, P. (2007). Death, Ancestors, and HIV/AIDS among the Akans of Ghana. *Faculty of Social Sciences*. Helsinki, University of Helsinki: 238.

Creswell, J. W. (2003). *Research Design, Qualitative, Quantitative and Mixed Methods Approaches.* (2nd Ed), London: Sage.

Danquah, S. A. (1982). The practice of behavior therapy in West Africa: The case of Ghana. *Journal of Behavior Therapy and Experimental Psychiatry, 13*, 5-13.

de-Graft Aikins, A. (2003). Living with diabetes in rural and urban Ghana: A critical a critical social psychological examination of illness action and scope for intervention. *Journal of Health Psychology, 8,* 557-72.

de-Graft Aikins, A. (2005). Healer shopping in Africa: new evidence from rural-urban qualitative study of Akan diabetes experiences. *BMJ: British Medical Journal, 331*, 7519, 737.

de-Graft Aikins, A. (2006). Reframing applied disease stigma research: A multilevel analysis of diabetes stigma in Ghana. *Journal of Community & Applied Social Psychology* 16: 426–441.

Dzokoto, V. A., & Adams, G. (2005). Understanding genital- shrinking epidemics in West Africa: *Juju*, *Koro*, or mass psychogenic illness? *Culture, Medicine, and Psychiatry*, *29*, 53–78.

Edgerton, R. B. (1966). Conceptions of psychosis in four East African societies. *American Anthropologist, New Series, 68,* 408-425.

Evans, J. (2007). *Your Psychology Project: The essential guide.* California, Sage Publications.

Eves, Y. D. (2001). A synthesis technique for grounded data analysis. *Methodological issues in nursing research, 35,* 5, 654-663.

Fosu, G. B. (1992). Perception of mental disorders in the context of social change: correlates and implications for socio medical behavior. *Curr. Issues Anthrop. X,* 103.

Fosu, G. B. (1995). Women's orientation toward help-seeking for mental disorders. *Sot'. Sci. Med,* 40, 8, 1029-1040.

Fosu, G.B. (1981). Disease classification in rural Ghana: Framework and implications for health behaviour. *Soc.Sci. Med.* 15B, 471.

Gearing, R. (2004). Bracketing in research: A typology. *Qualitative Health Research 14,* 10, 1429–52.

Geest, V. D. (1998). *Yebisa wo fie*: Growing old and building a house in the Akan culture of Ghana. *Journal of Cross-Cultural Gerontology,* 13**:** 333–359.

Ghana Statistical Service (2012). *2010 population and housing census: Summary of final results*. Accra.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research.* Hawthorne, NY: Aldine.

Gocking, R. (2005). *The history of Ghana. The Greenwood histories of the modern nations.* Westport, Conn.: Greenwood Press.

Gyekye, K. (1995). *An essay of African philosophical thought: The Akan conceptual scheme.* Revised ed. Philadelphia: Temple University Press.

Gyekye, K. (1996). *African cultural values: An introduction.* Accra: Sankofa Publishing.

Gyekye, K. (1996). The idea of African philosophy. In Asante, M. K. & Abarry, A. S. (Eds). *African intellectual heritage: A book of resources*. Philadelphia: Temple University Press.

Henwood, K. and Pidgeon, N. (1995). Grounded theory and psychological research. *The Psychologist,* 8, 3, 115-118.

Heppner, P. P., Kivlighan, D. M. Jr., and Wampold, B. E. (1999). *Research design in counseling.* Belmont: Wadsworth Publishing.

Hernandez, C. A. (2009). Theoretical coding in grounded theory methodology. *The Grounded Theory Review, 8, 3, 51-60.*

Hill, D. L. (2006). Sense of belonging as connectedness, American Indian worldview, and mental health. *Archives of Psychiatric Nursing, 20*, 5, 210-216.

Hood, R. W., Jr. (1975). The construction and preliminary validation of a measure of reported mystical experience. *Journal for the Scientific Study of Religion, 14,* 29–41.

Ito, K. L. (1982). Illness as retribution: A cultural form of self analysis among urban Hawaiian women. *Culture, Medicine and Psychiatry 6*, 385-403.

Kagee, A., & Dixon, D. N. (2000). Worldview and health promoting behavior: A causal model. *Journal of Behavioral Medicine, 23,* 163–179.

Kambon, K. K. (1992). *The African personality in America: An African-centered framework*. Tallahassee, FL: Nubian Nation.

Kindler, K. S., Zachar, P., and Carver, C. (2011). What kinds of things are psychiatric disorders? *Psychological Medicine, 41*, 1143–1150.

Kirmayer, L. J. (2012). Cultural competence and evidence-based practice in mental health: Epistemic communities and the politics of pluralism. *Social Science & Medicine 75,* 249-256.

Kluckhohn, C. (1951). Values and value orientations in the theory of action. In T. Parsons & E. A. Shields (Eds.), *Toward a general theory of action*. Cambridge, MA: Harvard University Press.

Kluckhohn, F. R. (1950). Dominant and substitute profiles of cultural orientations: Their significance for the analysis of social stratification. *Social Forces, 28,* 376–393.

Koltko-Rivera, M. E. (2004). The psychology of worldviews. *Review of General Psychology, 8,* 1, 3–58.

Larkin, P. J., Dierckx de Casterlé, B. & Schotsmans, P. (2007). Multilingual translation issues in qualitative research: Reflections on a metaphorical process. *Qual Health Res.* 17, 468-476.

Leventhal, H., Nerenz, D.R., & Steele, D.J. (1984). Illness representations and coping with health threats. In A. Baum & J. Singer (Eds.) *A handbook of psychology and health* (Vol. 4, pp. 219–252). Hillsdale, NJ: Erlbaum.

Liddell, C., Barrett, L., & Bydawell, M. (2005). Indigenous representations of illness and AIDS in Sub-Saharan Africa. *Social Science & Medicine 60*, 691–700.

Mather, C. (2005). Accusations of genital theft: A case from Northern Ghana. *Culture, Medicine, and Psychiatry*, *29*, 33–52.

Mbiti, J. S. (1970). *African religions and philosophy*. New York: Doubleday.

Mbiti, J. S. (1991). *Introduction to African Religion (2nd Ed.)*. Oxford: Heinemann Educational publishers.

Meadows, L. M., & Morse, J. M. (2001). Constructing evidence within the qualitative project. In Morse, J. M., Swanson, J. M., & Kuzel, A. J. (Eds.) (2001). *The nature of qualitative evidence*. Thousand Oaks: Sage.

Meehl, P. E. (1986). Diagnostic taxa as open concepts: metatheoretical and statistical questions about reliability and construct validity in the grand strategy of nosological revision. In T. Millon, T. and Klerman, G. (eds.) *Contemporary directions in psychopathology*. pp. 215–231. Guilford Press: New York, NY.

Mill, J. E. (2001). Shrouded in Secrecy: Breaking the News of HIV Infection to Akan Women. *J Transcult Nurs, 14*. 6, 6-16.

Mishra, S. I., Lucksted, A., Gioia, D., Barnet, B., & Baquet, C. R. (2009). Needs and preferences for receiving mental health information in an African American focus group sample. *Community Mental Health Journal, 45*, 117–126.

Muller, L. F. (2008). The reality of spirits? A historiography of the Akan concept of 'mind.' *QUEST: An African Journal of Philosophy, 22,* 163-184.

Odejide, A. O., Oyewunmi, L., K., & Ohari, J. U. (1989). Psychiatry in Africa: An overview. *American Journal of Psychiatry, 146*, 6, 708-716.

Ofori-Atta A., Cooper, S., Akpalu, B., Osei, A., Doku, V., Lund, C., et al. (2010). Common understandings of women's mental illness in Ghana: Results from a qualitative study. *International Review of Psychiatry, 22,* 589-598.

Olafsdottir, S. & B.A. Pescosolido. (2011).Constructing illness: How the public in eight western nations responds to a clinical description of "schizophrenia." *Social Science and Medicine, 73,* 929-38.

Olugbile, O., Zachariah, MP, Kuyinu, A., Coker, A., Ojo, O., and Isichel B. (2009). Yoruba world view and the nature of psychotic illness. *African Journal of Psychiatry, 12,* 149-156.

Owusu-Frempong, Y. (2005). Afrocentricity, the Adea festival of the Akan, African American festivals, and intergenerational communication. *Journal of Black Studies, 35*, 730-750.

Parrinder, E. G. S. (2002). *West African psychology: A comparative study of psychological and religious thought.* Cambridge: James Clarke & Co.

Patel, V. (1995). Explanatory models of mental illness in sub-Saharan Africa. *Soc. Sci. Med., 40*, 9, 1291-1298.

Patton, M. Q. (1990). *Qualitative research and research methods*. (2nd ed.). Thousand Oaks, CA: Sage.

Patton, M. Q. (2002). *Qualitative evaluation and research methods* (3rd ed.). Thousand Oaks, CA: Sage.

Pepper, S. C. (1970). *World hypotheses: A study in evidence.* Berkeley: University of California Press.

Poppe, L. D. (1995). Metatheoretical Constructs: Implications for Health and Illness Definition Preference and Health Related Behaviors, Unpublished doctoral dissertation, Ball State University, Muncie, IN.

Quinn, N. (2007). Beliefs and community responses to mental illness in Ghana: The experiences of family carers. *International Journal of Social Psychiatry 53*, 2, 175-188.

Read, U. M., Adiibokah, E., & Nyame, S. (2009). Local suffering and the global discourse of mental health and human rights: An ethnographic study of responses to mental illness in rural Ghana. *Globalization and Health*, *5*:13 doi:10.1186/1744-8603-5-13.

Read, U. M. & Doku, V. C. K. (2012). Mental health research in Ghana: A literature review. *Ghana Medical Journal, 46*, 29-38.

Riesman, P. (1986). The person and the life cycle in African social life and thought. *African Studies Review, 29,* 71–138.

Roberts, H. (2001). A way forward for mental health care in Ghana? *The Lancet, 357*, p.1859.

Rokeach, M. (1973). *The nature of human values.* New York: Free Press.

Rosenberg, D. (2002). It also takes a village: Developing community mental health. *International Social Work, 45*, 305-314. DOI: 10.1177/002087280204500335 7

Stace, W. T. (1960). *Mysticism and philosophy.* Los Angeles: Tarcher.

Strauss, A. L., & Corbin, J. M. (1990). *Basics of qualitative research: Grounded theory procedures and techniques.* Newbury Park, CA: Sage.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory (*2nd Ed.). Thousand Oaks, CA: Sage.

Thompson, S. N. & Chambers, J. W., Jr. (2000). African self-consciousness and health-promoting behaviors among African American college students. *Journal of Black Psychology, 26,* 3, 330-345.

Tsey, K. (1997). Traditional medicine in contemporary Ghana: A public policy analysis. *Soc. Sci. Med., 45*, 7, 1065-1074.

Tufford, L. & Newman, P. (2012). Bracketing in qualitative research. *Qualitative Social Work, 11,* 1, 80-96.

Williams, D. C. & Levitt, H. M. (2007). A qualitative investigation of eminent therapists' values within psychotherapy: Developing integrative principles for moment-to-moment psychotherapy practice. *Journal of Psychotherapy Integration, 17*, 2, 159–184.

Williams, E. N. and Morrow, S. L. (2009). Achieving trustworthiness in qualitative research: A pan-paradigmatic perspective. *Psychotherapy Research*, *19*, 576-582.

Wiredu, K. (2005). (ed.). *A Companion to African Philosophy.* Blackwell Publishing.

Wiredu, K. (2009). An oral philosophy of personhood: Comments on philosophy and orality. *Research in African literatures, 40,* 8-18.

World Health Organization (2007). Ghana: A very progressive mental health law. The country summary series. Accessed on August 28, 2012 from http://www.who.int/mental_health/policy/country/GhanaCoutrySummary_Oct2007.pdf.

Yebei, V. N. (2000). Unmet needs, beliefs and treatment-seeking for infertility among migrant Akan women in the Netherlands. *Reproductive Health Matters, 8,* 16, 134-141.

Appendices

Appendix 1: Demographic Information

Participant No.	Gender	Age, yrs	Education	Occupation
100	Female	40	Form 1	Petty trader
101	Female	45	Class 6	Trader
102	Female	39	JSS 3	Petty trader
103	Female	31	Form 3	Susu collector
104	Female	56	Form 4	Trader
105	Female	63	No education	Petty trader
106	Male	75	Form 4	Clerk
107	Male	63	O level	Teacher(retired)
108	Female	36	Form 4	Seamstress
109	Male	68	University	Personal assistant
110	Male	68	Form 4	Farmer
111	Female	71	__	__
112	Female	54	Form 4	Trader
113	Female	39	__	__
114	Female	46	Form 4	Service provider
115	Female	80	No education	Farmer
116	Male	65	Secondary	Accountant
117	Male	75	A level	Retired Assistant Director of Education
118	Male	70	University	Retired Headmaster
119	Male	71	Secondary	Retired Medical Lab Technologist
120	Male	69	Secondary	___
121	Male	65	None	Farmer
122	Female	72	Primary 6	Farmer
123	Female	50	Form 4	Unemployed
124	Male	74	Secondary	Ex-military officer
125	Female	53	Form 4	Housewife
126	Female	42	Form 4	Trader
127	Female	52	Form 4	Trader
128	Male	76	Seminary	___
129	Female	46	Form 4	Trader

(___) Information not provided

Appendix 2: Initial Interview Guide (English Version)

Introduction: I am asking people in your area about mental illness and would like to know what your views are. When I say mental illness I mean any illness that takes over a person's mind and makes him/ her not to act normally.

1. Are there any special words you use for mental illness in this area?
2. Do you have any other words or expressions for mental illness besides the one(s) you have given?

From this point, use Mental Illness Label the interviewee supplies whenever you are referring to mental illness

3. Can you tell me what you know about [**Insert Mental Illness Label]**?
4. How would you describe people who have **[Insert Mental Illness Label]**?
5. I know that we hear a lot of things from our older people, and I will like to know what you heard your grandparents and parent say about people with [**Insert Mental Illness Label**] when you were a child.
6. What have you heard about children who are born with **[Insert Mental Illness Label]**?
7. Who do you know or heard of one who had [**Insert Mental Illness Label**]?
8. What usually happens to people who have **[Insert Mental Illness Label]?**
9. Why do people become **[Insert Mental Illness Label]**?
10. What did your parents and grandparents say on why people become **[Insert Mental Illness Label]**?
11. Once a person becomes **[Insert Mental Illness Label]**, what can he/she do, if anything, to get better?

Appendix 3: Sample of Questions Generated During the Interviews

1. What is the difference between a mentally ill person and one who is not mentally ill?
2. When do you consider a mentally ill person as "ɔre yɛ abɔ gye"?
3. What do you think may be the causes of "*obi a wabɔgye"* or *"obi a wabɔdam*"?
4. I realized that you were making reference to one who is on the path of being ill mentally. What is the difference between the one on the path of getting mental illness and the one who is actually mentally ill?
5. Would the mental illness of a pregnant woman affect the child to be born?
6. Is that a spiritual cause or it is just because of the pregnancy?
7. From what you heard, do you know what may cause mental illness among children?
8. Why may worrying cause mental illness?
9. You mention that some mental illness may be caused by other people, how is that?
10. Have you come across anyone who was normal but now have mental illness due to painful act of another person?
11. How can one be cured of mental illness?
12. Apart from hospital care, is there any other way of caring for the mentally ill?
13. Where would be your first place of call for someone suffering from mental illness?
14. How do you associate mental illness with an individual's life style?
15. Do you mean seizure can cause mental illness among children?
16. Can someone suffer mental illness through spiritual means?
17. Apart from witchcraft, what other thing can cause one to become mentally ill?
18. Do you know anyone suffering from mental illness as a result of too much worries or anxiety?
19. Do you personally believe that mental illness can be cured?
20. Where can mental illness be cured?
21. If a relative of yours become mentally ill, where would you send her for treatment?
22. You mentioned earlier that the older generation advised against engaging in vices as they can lead to a curse resulting in mental illness. May I know how a curse can lead to mental illness?
23. You mentioned earlier that children become *"gyimigyimi"*. What is the difference between "*gyimigyimi"* and *"adambɔ"?*
24. Are *"gyimigyimi"* and "*abɔdam*" caused by the same factor?
25. When should mental illness be sent to the hospital, prayers, or the traditional healer?
26. You mentioned earlier that we have two types: "*ogyefo*" and "*abɔdam*." How do you differentiate between the two?
27. You mentioned earlier that some of the mental illness is transmitted through birth. Can you kindly explain what you mean by that?
28. From what you said, do you mean there may be some whose mind may be altered due to menopause but they are not mentally ill?
29. How can you identify the cause of one's mental illness as being spiritual or otherwise?
30. You mentioned two types of mental illness: *"abɔdam*" and "*bɔdam ani ate*." So what is the difference between "*bɔdam ani ate*" and *"abɔdam*"?
31. Can failure to carry out such virtuous acts result in one becoming mentally ill?
32. What would you do if treatment at the hospital seems not to be yielding any result?
33. Can a person pray for another to become mentally ill?
34. Can the mental illness with spiritual connotation as you claim be cured at the hospital?
35. When should a mentally ill person be sent to the hospital?
36. What do families normally do about those with mental illness?

Appendix 4: Sample Forward-Backward Translation

Twi Response	English Translation	Back-Twi-Translation
Wobehu de kyɛrɛ sɛ wo ne nneyeɛ ne ne nsɛm ka mu no. Ebia nipa no kasa by heart kyerɛsɛ ebia ofie a ɔwo mu no ɔnkasa nso bere tia bi mu no na woatew ne ho asi kurom tumi kɔnenam…	You can see from one's utterances and behavior that the person is mentally sick. The person may be uttering irrelevant speech. If he is one who likes talking, you will notice that the person no longer takes delight in communication, he keeps to himself alone all the time. He may leave the home and set off on a journey of nowhere…	Wohu wɔ ne kasa ne neyeɛ mu sɛ nipa no wɔ adwenmu yare. Ebia na nipa no ka nsɛm a ɛho nhia. Sɛ ɔyɛ obi a ɔpɛ kasa a, wobehu sɛ afei ɔmpɛ kasa pii. Bere biara nso na wayɛ moamoa. ɔbetumi afi fie akɔnenam baabi a obiara nnim…
Ebi wɔ ho a wee, cocaine, ne ade . Wɔ nom a, etumi haw wɔn adwene. Sɛ woahu nea mekyerɛ yi? Ena ebi nso wɔ hɔ a ɔhaw bi, ade bi, asɛm bi ato no. ɛtoo no saa no, otumi, time biara, ɔdwene ho nti ɛbɛma n'dwene ayɛ basaa.	Some abuse drugs such as 'wee', cocaine and others to the extent that it affects them mentally. I hope you get it now? For others, some may be troubled by an issue. For that reason, the person may be thinking and anxious so much that they become worried.	Ebinom fa nnuru bɔne bi te sɛ wee, koken ne nea ɛkeka ho, ma ne ka wɔn adwene. Sɛ woahu nea merekyere yi afei? Ebi nso wɔ hɔ a na asɛm bi haw wɔn. Eyi ma nipa no dwen saa ara ma no bɛyɛ wɔn dadwen.
Nnipa no nso bi wɔ hɔ a wo hu sɛ woafi ase nti nea wobɛka ne sɛ ɔrebɔdam ba.	Sometimes the person may just have started exhibiting symptoms of mental illness.	Ebi wɔ hɔ a na afei na nipa no ɛfi ase reda adwenmu yare ho neyeɛ adi.
Obi wɔ hɔ a obi ayɛ na de ma ahye no. Te sɛ obi wɔ abrɔkyiri ose si ɔdan ma me, ofi abrɔkyiri bɛba no dan ne hɔ, sika ne ho.Etumi ma n'dwene yɛ basaa saa ara.	A very painful act by one person against another. For example, one travels outside the country and sends money to another to construct a house for him. He returns only to find out that no house has been constructed and the money too has been squandered. Such a thing can affect the person's mind…	Sɛ obi yɛ ade yayaaya tia ne yɔnko a. Te sɛ ebia, obi wɔ akwantu mu na wamane obi sika sɛ ɔnsi dan mma no. ɔbɛba no na nipa no adi sika no a wansi dan no. Biribi a ɛtɛ sɛɛ tumi nya nsunsuanso wɔ nipa no adwen so.

Appendix 5: Themes & Sub-themes

Major themes/concepts	Sub-themes/concepts
Definition of Mental Illness	
Local Labels for Mental Illness:	*Abɔdam* *Adambɔ* *Ogyefo* *Woaɔbɔgye* *Gyimigyimi* *N'adwenne ho ato,* *Adwinne mu ká* *Bɔdam ani te*
Development, Forms, and Behavioral Markers:	Mental illness in Children Mental Illness in Adults
Causes of Mental Illness:	Problems of living Biological/environmental Spiritual: Spiritual indulgences Curses Punishment from the Supreme Being Punishment from oracle Wicked spirits Substance abuse Multiple causes
Care and Treatment:	Choice of treatment Hospital treatment Spiritual help Pluralistic help-seeking behaviors
Generational Differences	

Vita

Annabella Opare-Henaku was born on October 31, 1979, in Ghana, West Africa. She graduated from Wesley Girls' High school, Cape Coast, Ghana in 1997. She received her Bachelor of Arts in Psychology from the University of Ghana, Legon-Accra, Ghana in 2003, and a Master of Philosophy in Health Promotion from University of Bergen, Norway in 2006. She taught at the University of Ghana for two years, between 2007 and 2009. She has been involved in a number of researches focusing on worrying among primary school children in Ghana, race-related stress, cultural grounding of emotional expression, and Ghanaians reactions and adjustments to currency redenomination.