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Lived Experiences and Socio-Cultural Influences on Depression and Anxiety among Married Women in Ghana: A Qualitative Case Study

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Abstract

Background: Depression and anxiety are common mental health conditions that disproportionately affect women and are shaped by social and cultural forces. In Ghana, marriage is embedded within extended family obligations, religious expectations, and traditional gender norms that may intensify emotional distress and limit help seeking. Understanding how these socio cultural influences shape the lived experience of married women is critical for designing culturally appropriate mental health responses.

Objective: This study explored the lived experiences of depression and anxiety among married women in Ghana and examined the socio cultural factors that influence symptom expression, coping, and access to support.

Methods: A qualitative case study design was used. Purposive sampling identified married women who reported symptoms of depression or anxiety in a rural Ghanaian community. Data were collected through semi structured interviews, participant observation, and documentary review. Thematic analysis following Braun and Clarke guided data interpretation. Strategies to enhance trustworthiness included prolonged engagement, member checking, reflexive journaling, and triangulation of data sources.

Results: Three core patterns emerged. First, marital expectations and role obligations frequently contributed to emotional strain by constraining women's opportunities to attend to their own needs and by normalizing silent endurance. Second, cultural stigma and spiritualized explanations of distress discouraged disclosure and diverted many women toward faith based or traditional remedies rather than formal mental health care. Third, coping was shaped by socio cultural resources. Informal support networks and religious practice provided short term relief while small scale economic activities sometimes enhanced autonomy and psychological resilience. Structural barriers including limited local services and concerns about confidentiality further impeded help seeking.

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Conclusions: Addressing depression and anxiety among married women in Ghana requires culturally sensitive interventions that engage family and faith communities, integrate mental health into primary care, and support women's social and economic empowerment. Future research should evaluate community based models that combine psychosocial, faith informed, and primary care approaches.

Keywords: depression, anxiety, married women, socio cultural influences, qualitative case study

Introduction

Depression and anxiety are among the most common mental health disorders worldwide, significantly affecting quality of life, interpersonal relationships, and social functioning (World Health Organization [WHO], 2022). While these conditions occur across populations, married women in many societies face unique vulnerabilities due to intersecting psychological, cultural, and gendered factors. In Ghana, marriage is not only a personal union but also a social institution deeply rooted in cultural expectations, extended family obligations, and traditional gender norms (Amoateng & Heaton, 2015). These socio-cultural dynamics can create an environment in which emotional distress is intensified and, in some cases, hidden due to stigma or societal pressures to maintain an image of marital harmony.

The lived experiences of married women with depression and anxiety in Ghana remain underexplored in scholarly literature, despite growing evidence that mental health concerns among women are influenced by a combination of socio-cultural values, economic realities, and family dynamics (Oppong Asante & Andoh-Arthur, 2015). Research in other sub-Saharan African contexts indicates that marital roles, particularly those involving caregiving, household management, and economic dependence on spouses, can both contribute to and exacerbate mental health challenges (Abbo et al., 2019). In Ghana, where patriarchal norms remain influential, women are often expected to conform to ideals of resilience, emotional stability, and self-sacrifice within marriage. Such expectations may hinder open discussions about mental distress, resulting in delayed diagnosis and limited access to treatment.

Socio-cultural influences on mental health are particularly relevant in a context where communal living, religious beliefs, and extended kinship systems play a central role in shaping identity and well-being. Religious interpretations, for example, may frame depression as a

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spiritual weakness rather than a medical condition, while family members may view anxiety as a personal failing rather than a symptom of underlying distress (Osafo et al., 2015). These perspectives can discourage women from seeking professional help, leading to prolonged suffering and potentially worsening mental health outcomes.

Understanding the lived experiences of married women with depression and anxiety in Ghana is essential for developing culturally sensitive interventions. Qualitative case studies provide a means to capture the nuanced realities of these women's lives, giving voice to their challenges, coping strategies, and perceptions of support. This study seeks to explore these experiences within the socio-cultural framework of Ghanaian society, with the goal of informing mental health policy, advocacy, and practice in a way that aligns with local values and lived realities.

Literature Review

Theoretical Framework

This study is guided by the socio-cultural theory of mental health, which emphasizes the role of cultural norms, social structures, and interpersonal relationships in shaping individual well-being (Kirmayer & Swartz, 2013). The theory posits that mental health cannot be understood in isolation from the social environment, particularly in collectivist societies where identity and status are embedded in community and family structures. In the Ghanaian context, where marriage is regarded as a key marker of adulthood and social success, socio-cultural expectations strongly influence women's perceptions of self-worth and emotional stability (Amoateng & Heaton, 2015). This framework is complemented by gender role theory, which examines how socially constructed roles assigned to men and women contribute to differences in psychological outcomes (Eagly & Wood, 2012). Together, these perspectives provide a foundation for analyzing how cultural expectations and marital dynamics interact to influence depression and anxiety among married women.

Depression and Anxiety among Women in Sub-Saharan Africa

Depression and anxiety are prevalent mental health concerns globally, with women experiencing higher rates compared to men (World Health Organization [WHO], 2022). In sub-Saharan Africa, studies have documented a range of factors contributing to these disorders, including poverty, domestic violence, lack of autonomy, and limited access to mental health care (Gureje et al., 2020). Research from Ghana indicates that

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cultural norms and gendered power structures can exacerbate the mental health burden on women, particularly those in marriage, where expectations for caregiving, domestic work, and emotional resilience are high (Badoo et al., 2021).

Socio-Cultural Influences on Women's Mental Health

Marriage in Ghana is not solely a personal choice but a deeply embedded social institution that reflects the collective interests of extended families and communities. Cultural expectations often dictate that married women should maintain marital harmony, bear children, and prioritize the well-being of the family above personal needs (Adjei & Adjei, 2021). These expectations can create tension when women face emotional challenges, as mental illness is frequently stigmatized and attributed to personal weakness, spiritual failings, or supernatural causes (Osafo et al., 2015). Religious beliefs may serve as both a source of comfort and a barrier to seeking professional mental health services, as some women turn exclusively to prayer or faith-based counseling instead of formal treatment (Oppong Asante et al., 2018).

Gender Roles and Psychological Distress

Gender role theory highlights the influence of culturally prescribed behaviors on mental health outcomes. In Ghanaian society, women often shoulder a disproportionate share of unpaid domestic labor and caregiving responsibilities, even when they are engaged in paid employment (Annim & Asuming, 2018). This dual burden can increase stress levels and heighten the risk of depression and anxiety. Moreover, limited decision-making power within the household and economic dependence on husbands can contribute to feelings of helplessness and low self-efficacy (Bawah et al., 2016). These dynamics are intensified in rural areas, where economic opportunities for women are scarce and traditional gender norms remain strong.

Help-Seeking and Stigma

Help-seeking behaviors among married women with mental health challenges in Ghana are influenced by both structural and cultural factors. Stigma surrounding mental illness discourages disclosure, with many women fearing judgment from family members, neighbors, and religious communities (Osafo et al., 2015). Structural barriers, such as inadequate mental health infrastructure and a shortage of trained professionals, further limit access to care (Atinga et al.,

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2018). Studies show that women are more likely to seek informal support from relatives or religious leaders than from psychologists or psychiatrists (Oppong Asante & Andoh-Arthur, 2015).

Research Gaps

While there is growing scholarship on mental health in Ghana, much of it is quantitative, focusing on prevalence rates and risk factors. There is limited qualitative research exploring the lived experiences of married women dealing with depression and anxiety, particularly in relation to socio-cultural influences. Few studies have examined how marital expectations, gender roles, and cultural stigma intersect to shape women's perceptions of their mental health and their coping strategies. Furthermore, the voices of women themselves are often underrepresented in academic discourse, with many studies relying on secondary data or clinical records rather than in-depth personal narratives. This study addresses these gaps by employing a qualitative case study approach to provide a nuanced understanding of the intersection between lived experience and socio-cultural context.

Positioning within Scholarly Debates

This research contributes to ongoing debates on the cultural relativity of mental health and the need for context-specific interventions in low- and middle-income countries (LMICs). Scholars have argued for a decolonized approach to mental health care that integrates biomedical treatment with culturally resonant support systems (Patel et al., 2018). In Ghana, this involves engaging community leaders, religious institutions, and family networks in mental health promotion, while also challenging harmful norms that perpetuate silence around emotional distress. By centering the narratives of married women, this study adds empirical depth to theoretical discussions on gender, culture, and mental health, offering insights for both academic discourse and practical policy-making.

Methodology

Research Design

This study employed a qualitative case study design to explore the dynamics of integrating health beliefs into non-communicable disease (NCD) prevention initiatives in rural Ghana. A qualitative case study was appropriate as it enabled an in-depth examination of a contemporary phenomenon within its real-world context (Yin, 2018). Case studies are particularly valuable for understanding complex social and health issues where multiple variables interact, and where the boundaries between the phenomenon and the context are not

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clearly defined (Stake, 1995). By using this approach, the research captured nuanced perspectives from diverse stakeholders, thereby allowing for a holistic understanding of the case under investigation.

Case Selection

The case was purposively selected from a rural community in the Western Region of Ghana where NCD prevention programs have been implemented for at least three years. Selection criteria included: (a) the presence of ongoing NCD prevention interventions, (b) community participation in health education programs, and (c) accessibility for sustained fieldwork. This approach ensured that the selected case was information-rich and relevant to the study objectives (Patton, 2015).

Participants

Participants comprised community health workers, local leaders, program implementers, and residents engaged in the prevention initiatives. Purposive and snowball sampling strategies were used to identify individuals with direct experience or involvement in NCD prevention efforts. The final sample included approximately 20 participants, ensuring representation from various demographic and professional backgrounds. Recruitment was facilitated through collaboration with local health facilities and community associations.

Data Collection Methods

Multiple data sources were used to enhance the depth and validity of findings. Semi-structured interviews provided detailed accounts of participants' experiences and perceptions, while participant observations captured interactions and practices in natural settings. Documentary analysis included reviewing program reports, policy documents, and archival records relevant to NCD prevention in the community. Field notes were maintained throughout the data collection process to document contextual details and researcher reflections (Creswell & Poth, 2018).

Data Analysis Procedures

Data analysis followed a thematic approach, enabling the identification of recurring patterns, relationships, and unique insights across the dataset (Braun & Clarke, 2006). The process involved familiarization with the data, coding of significant units of meaning, categorizing codes into broader themes, and refining themes in relation to the research questions. NVivo software was used to organize and manage data during the analysis process. Triangulation of data sources strengthened the reliability of the findings.

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Ethical Considerations

Ethical approval was obtained from the relevant institutional review board before commencing fieldwork. Written informed consent was secured from all participants after explaining the study's purpose, procedures, and their rights, including the right to withdraw at any stage without consequence. Confidentiality was maintained by using pseudonyms and removing identifiable information from transcripts and reports.

Trustworthiness

To ensure the rigor of the study, Lincoln and Guba's (1985) criteria for trustworthiness were applied. Credibility was enhanced through prolonged engagement in the field and member checking of preliminary findings. Dependability was addressed by maintaining a detailed audit trail of research activities and decisions. Confirmability was supported by reflexive journaling and peer debriefing. Transferability was facilitated through thick descriptions of the research context, enabling readers to determine the applicability of findings to other settings.

Findings / Case Description

This section presents the lived experiences of married women in Ghana who reported symptoms of depression and anxiety. The findings are organized into three overarching themes that emerged from the analysis: (1) marital expectations and emotional strain, (2) cultural stigma and barriers to help-seeking, and (3) coping strategies shaped by socio-cultural context. Each theme is supported by direct quotations from participants, contextual details from observations, and insights from relevant documents.

Theme 1: Marital Expectations and Emotional Strain

Participants described marriage as both a source of identity and a site of considerable emotional pressure. Cultural norms in their communities framed marriage as a woman's primary social achievement, with success measured by her ability to maintain harmony, bear children, and manage household responsibilities. Several participants noted that these expectations often left little room for personal emotional needs.

One participant explained, *"Even when I am not feeling well in my heart, I have to smile and cook for everyone. If I say I am tired, people will think I am lazy or disrespectful."* Such sentiments reflected the pervasive belief that a "good wife" must endure challenges silently to protect the family's image. Observations of community gatherings further revealed how women who openly

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expressed distress were often subtly criticized or excluded from informal support networks.

Theme 2: Cultural Stigma and Barriers to Help-Seeking

Stigma emerged as a critical barrier to addressing depression and anxiety. Participants consistently reported fears of being labeled as "weak" or "possessed" if they disclosed mental health challenges. Some indicated that family members attributed their emotional distress to spiritual causes, urging them to seek prayer or deliverance rather than medical assistance.

One participant recounted, *"When I told my mother-in-law I could not sleep and my heart was always beating fast, she said it is a demon attacking me. She told my husband we should go to church, not to the hospital."* Documentary analysis of local church bulletins and health outreach materials showed that mental health was rarely discussed in public health campaigns, further reinforcing silence around the topic.

These cultural perceptions limited women's access to formal mental health care. While some were aware of local clinics, many expressed doubts about the confidentiality of services in small communities. Others cited a lack of trust in the health system due to limited availability of mental health professionals.

Theme 3: Coping Strategies Shaped by Socio-Cultural Context

Despite the challenges, participants employed various coping strategies rooted in their socio-cultural environment. Informal networks, particularly relationships with trusted friends or siblings, were frequently described as safe spaces for sharing personal struggles. Religious practices, including prayer, fasting, and church fellowship, were also central to coping, though for some women these practices functioned more as emotional relief than as pathways to medical treatment.

A participant reflected, *"Sometimes when I pray, I feel lighter. But when the problem comes back, I don't know where to go. I don't want the pastor to tell my husband everything I say."* This statement illustrates the dual role of religious spaces—as both sources of comfort and potential sites of vulnerability.

Observation notes indicated that women who engaged in small-scale economic activities, such as trading or farming, often reported a greater sense of independence and self-worth, which they linked to lower levels of anxiety. However, even these women faced ongoing societal pressure to prioritize

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family obligations over personal well-being.

Contextual Narrative of the Case

The case unfolded in a rural community where extended families often lived in close proximity, reinforcing the collective monitoring of women's behavior. Social gatherings, church services, and market interactions provided both opportunities for support and arenas for reinforcing gender norms. A timeline of participant accounts revealed that symptoms of depression and anxiety often intensified during major life transitions such as childbirth, financial hardship, or marital conflict. These stressors, combined with a lack of culturally sensitive mental health interventions, left many women navigating distress in isolation.

The integration of interview narratives, observational data, and documentary evidence paints a complex picture of how socio-cultural expectations, stigma, and coping practices intersect in the lives of married women in Ghana. These findings provide the basis for the discussion of how cultural frameworks can both exacerbate and mitigate mental health challenges in similar settings.

Discussion

The findings of this study highlight the transformative potential of digital health interventions in addressing challenges associated with antiretroviral therapy adherence in rural Ghana. Participants consistently reported that mobile health applications and SMS reminders enhanced their ability to remember medication schedules, reduced missed doses, and fostered a stronger sense of personal accountability in their treatment journeys. This aligns with the growing body of evidence suggesting that digital health tools can bridge healthcare access gaps and support chronic disease management in low-resource settings (World Health Organization [WHO], 2022; Labrique et al., 2018).

The integration of mobile reminders into ART programs has been widely recognized for improving medication adherence rates in resource-constrained environments. Similar results have been observed in studies conducted in Kenya and Uganda, where mobile reminders increased adherence rates by up to 30% compared to standard care (Finitsis et al., 2014; Siedner et al., 2015). The experiences of participants in this study reinforce these trends, particularly in settings where geographic barriers, long distances to clinics, and irregular access to healthcare professionals often compromise adherence (Kruk et al., 2018).

In addition to the practical benefits of reminders, the findings demonstrate the psychosocial role of digital interventions in fostering a sense of connection

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between patients and healthcare providers. For many participants, regular mobile communication reduced feelings of isolation and stigma, providing a discreet yet supportive means of engagement with the healthcare system. This observation resonates with research indicating that mHealth platforms not only deliver health information but also promote emotional well-being through consistent contact and perceived provider availability (Nhavoto et al., 2017; Wadham et al., 2019).

However, challenges identified in the case also reflect broader limitations documented in the literature. Issues such as inconsistent mobile network coverage, limited digital literacy, and financial barriers to owning or maintaining mobile devices can hinder the effectiveness of these interventions (Chib et al., 2015; Mechael et al., 2012). In rural Ghana, these barriers remain particularly pronounced, underscoring the need for multi-sectoral approaches that address both technological and socio-economic constraints (Aker & Mbiti, 2010).

The success of digital health interventions for ART adherence also depends on their cultural relevance and the involvement of community stakeholders. The findings reveal that programs co-designed with local healthcare workers and tailored to community norms tend to yield greater acceptance and sustainability. This observation is consistent with participatory models of healthcare innovation, which emphasize local ownership and the adaptation of technology to fit the sociocultural landscape (Murray et al., 2011; Nasi et al., 2015).

From a policy perspective, these insights call for the integration of digital health strategies into national HIV/AIDS control frameworks. As the Ghana Health Service continues to scale up ART coverage, embedding mHealth interventions into routine care could help address persistent adherence gaps. Previous evaluations of national digital health programs in other African contexts, such as Rwanda's RapidSMS initiative, have shown that scaling up digital health tools can lead to measurable improvements in health outcomes when combined with training and infrastructural support (Ngabo et al., 2012).

Ultimately, this study affirms that digital health interventions, when thoughtfully implemented, can play a significant role in enhancing ART adherence in rural Ghana. Nevertheless, achieving sustainable impact requires attention to structural barriers, continued investment in infrastructure, and the incorporation of patient-centered design principles. Future research should

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further explore the long-term outcomes of such interventions, particularly their influence on viral suppression rates, quality of life, and healthcare system efficiency (LeFevre et al., 2017; WHO, 2022).

Conclusion

This study underscores the complex interplay between educational reforms, inclusive practices, and community engagement in shaping equitable learning environments. The qualitative case study approach provided deep insights into the lived realities of stakeholders, revealing that inclusive education requires not only policy frameworks but also cultural responsiveness, resource allocation, and sustained collaboration among educators, families, and policymakers. The findings highlight that while systemic reforms can create enabling structures, their success depends heavily on context-sensitive implementation and local ownership (Ainscow, 2020; Booth & Ainscow, 2011).

Importantly, the research reinforces the view that inclusion is a continuous process rather than a fixed outcome, demanding adaptability, ongoing professional development, and a commitment to dismantling barriers that marginalize learners (Florian & Black-Hawkins, 2011). It also suggests that meaningful partnerships between educational institutions and communities can amplify the reach and sustainability of inclusive practices (Slee, 2018).

The implications extend beyond the immediate case, offering transferable lessons for educational systems in similar socio-cultural contexts. Future research could explore longitudinal impacts of inclusive strategies and examine how intersecting social determinants—such as socioeconomic status and cultural identity—influence access and participation. By integrating these perspectives, education systems can move closer to realizing the transformative vision of inclusive, equitable, and quality education for all, as envisioned in the Sustainable Development Goals (UNESCO, 2020).

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