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Socio-Cultural Beliefs and Their Influence on Mental Health Service Utilization in Ghana

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ABSTRACT

Mental health service utilization in Ghana remains significantly influenced by entrenched socio-cultural beliefs and traditional explanatory models. This study investigated how local perceptions of mental illness shape treatment preferences, stigma, and resistance to biomedical care in five districts of the Western Region. Using a mixed-methods design, quantitative surveys (N=150) revealed that over 77% of respondents believed mental illness is caused by spiritual or supernatural forces, with 67% preferring traditional or religious interventions over formal psychiatric care. Stigma was widespread, with 59% associating mental illness with family shame and 58% admitting they would feel embarrassed to seek help at a mental health facility. Qualitative interviews with 20 key informants reinforced these findings, highlighting deep-rooted beliefs in witchcraft, curses, and spiritual affliction as causes of mental illness. Respondents also expressed limited trust in hospitals and emphasized the social consequences of disclosure. The study concludes that mental health interventions must integrate cultural understandings and partner with traditional healing systems to overcome resistance, reduce stigma, and promote effective service uptake. Policy strategies should prioritize culturally grounded education, stigma reduction, and coordinated collaboration with non-biomedical practitioners.

Keywords: Mental health utilization, Ghana, Cultural beliefs, Traditional healing, Stigma, Help-seeking behavior

INTRODUCTION

Mental health service utilization in Ghana, as in many African countries, is deeply shaped by prevailing socio-cultural beliefs and traditional explanatory models of illness. Despite growing efforts to improve access to formal mental health care, utilization remains low, with many individuals and families opting for traditional or spiritual interventions rather than biomedical treatment (Read & Doku, 2012; Ae-Ngibise et al., 2010). This preference is strongly tied to the cultural understanding of mental illness as a manifestation of spiritual attack, witchcraft, ancestral punishment, or moral failure, rather than as a clinical or psychological condition (Ofori-Atta et al., 2010).

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The Western Region of Ghana presents a unique socio-cultural context where these belief systems are strongly embedded and influence not only how mental illness is perceived but also how individuals seek care. In many communities, traditional healers and spiritual leaders are viewed as the first point of recourse, particularly in rural areas where biomedical services are limited. Even when formal services are available, stigma and cultural mistrust often discourage individuals from seeking help at health facilities (Appiah-Poku et al., 2004). These beliefs are further reinforced by community narratives and informal social control mechanisms, which frame mental illness as shameful or dangerous, resulting in secrecy, delay in care-seeking, and human rights abuses such as chaining and confinement (Sorsdahl et al., 2010).

In Ghana's policy discourse, mental health is framed as a public health priority, but actual service uptake remains significantly constrained by these socio-cultural determinants. This disconnect calls for a nuanced understanding of the role cultural models play in shaping behavior toward mental illness. This study investigates how socio-cultural beliefs influence help-seeking patterns, perceptions of mental illness, and resistance to formal psychiatric treatment in selected districts of the Western Region. By exploring lived experiences and local understandings of mental illness, the study contributes to a culturally informed mental health policy and care model that takes into account indigenous epistemologies and behavioral responses.

METHODOLOGY

This study employed a qualitative-dominant mixed-methods design, combining quantitative surveys with qualitative interviews and focus group discussions. The research was conducted in five districts of the Western Region: Tarkwa Nsuaem, Nzema East, Jomoro, Wassa Amenfi East, and Sekondi-Takoradi.

Participants and Sampling

A total of 150 community members participated in the quantitative survey, while 20 individuals—comprising traditional leaders, religious figures, mental health users, and caregivers—were purposively selected for in-depth qualitative interviews. Inclusion criteria for qualitative participants included individuals with lived experience of mental illness, either personally or as caregivers, or those identified as key community informants by local leaders.

Data Collection Instruments

The survey instrument assessed beliefs about the causes of mental illness, attitudes toward mental health services, and reported treatment pathways. Items included both Likert-scale and closed-ended questions. The interview guide explored cultural interpretations of mental illness, stigma, preferred care-seeking channels, and barriers to formal treatment. Focus group discussions (FGDs) were held in three communities to deepen understanding of collective norms and shared narratives.

Data Analysis

Quantitative data were analyzed using descriptive statistics. Frequencies and percentages were calculated to identify

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prevailing beliefs and attitudes. Qualitative data were transcribed verbatim and analyzed using thematic analysis. Codes were developed both deductively (based on literature and the research questions) and inductively (emerging from the data). NVivo software was used to support data management and theme development. Thematic categories included spiritual causation, fear of labeling, trust in traditional systems, and ambivalence toward hospitals.

Ethical Considerations

Ethical approval was obtained from the University Research Ethics Committee of Atlantic International University. Informed consent was obtained from all participants. Anonymity, confidentiality, and the right to withdraw were upheld throughout the study.

RESULTS

1. Demographic Characteristics of Respondents

The study involved 150 community members who participated in the survey and 20 key informants for qualitative interviews. The demographic data reflect a broad representation of gender, age, occupation, and educational background

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Table 1: Demographic Characteristics of Survey Respondents (N = 150)

Variable	Category	Frequency (n)	Percentage (%)
Gender	Male	82	54.7
	Female	68	45.3
Age Group	18–29 years	34	22.7
	30–39 years	51	34.0
	40–49 years	39	26.0
	50 years and above	26	17.3
Occupation	Farmers/Fisherfolk	42	28.0
	Traders	33	22.0
	Artisans/Labourers	29	19.3
	Students/Unemployed	21	14.0

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	Teachers/Professionals	25	16.7
Education Level	No formal education	18	12.0
	Basic education	53	35.3
	Secondary education	47	31.3
	Tertiary education	32	21.3

Source: Field Data, 2017

2. Quantitative Findings

Survey results provided insight into cultural beliefs, stigma, and treatment preferences.

Table 2: Community Beliefs and Attitudes Toward Mental Illness (N = 150)

Item	**Yes (n)**	**%**	**No (n)**	**%**
Mental illness is caused by spiritual or supernatural forces	116	77.3	34	22.7
Mental illness is shameful to the family	89	59.3	61	40.7
Preferred treatment is through a traditional healer or spiritual leader	101	67.3	49	32.7
Formal hospitals can cure mental illness	43	28.7	107	71.3
People with mental illness are dangerous	95	63.3	55	36.7
I would feel ashamed to seek help at a psychiatric facility	87	58.0	63	42.0

Source: Field Data, 2017

The majority of respondents endorsed spiritual explanations for mental illness and preferred traditional treatment. Stigma was widespread, with many perceiving mental illness as shameful and dangerous.

3. Qualitative Findings

Interviews with community leaders, religious figures, caregivers, and persons with lived experience revealed deep-rooted socio-cultural beliefs that shape mental health behavior.

Most participants interpreted mental illness as a result of curses, witchcraft, or punishment by ancestors or deities. This spiritual framing significantly influenced help-seeking decisions,

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leading many to first consult traditional priests or pastors.

"Mental illness is not for the hospital. It is spiritual. You must go to the shrine or church to remove the curse." – Traditional Leader

Stigma was consistently mentioned as a major deterrent to seeking help. Families often kept mentally ill relatives hidden due to fear of community ridicule or social disgrace.

"We don't let outsiders know. It brings shame to the family. People will avoid you." – Female caregiver

There was a widespread belief that hospitals are ineffective in treating mental illness, especially when the perceived cause is spiritual. Medication was seen as insufficient or irrelevant to the problem.

"Doctors only give tablets, but if the spirit is not cast out, nothing will change." – Pentecostal Pastor

Some interviewees highlighted the poor communication between health workers and traditional healers, which led to fragmented and uncoordinated care.

"There is no cooperation. Everyone does their own thing. The hospital does not recognize the spiritual side." – Faith Healer

Others described how delays in seeking formal care often led to worsening conditions and, in extreme cases, physical restraint or abandonment.

"She was tied for weeks because she became violent. We only sent her to the hospital when things got out of hand." – Family Member

4. Integrated Interpretation

The findings from both quantitative and qualitative data underscore how socio-cultural beliefs play a dominant role in shaping mental health service utilization in Ghana. A significant proportion of respondents attributed mental illness to spiritual or supernatural causes, and preferred traditional or religious interventions over hospital care. These perceptions were closely linked to feelings of shame and fear of societal rejection, which in turn discouraged early help-seeking.

The qualitative accounts provided context to these patterns, revealing that community norms often prioritized spiritual healing as the appropriate first response. Families frequently delayed or avoided formal treatment until the condition became severe. The lack of trust in biomedical services was compounded by poor communication between health professionals and local belief systems, leading to gaps in care continuity and access.

Together, the results reveal that mental health in Ghana is not merely a clinical issue but a cultural one, requiring interventions that are not only accessible but also culturally congruent. Any attempt to improve service utilization must therefore address these underlying belief systems and engage traditional actors as allies in mental health promotion.

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DISCUSSION

The findings from this study clearly demonstrate that socio-cultural beliefs remain powerful determinants of mental health service utilization in the Western Region of Ghana. Despite increased awareness and expansion of psychiatric services in recent years, most respondents in this study attributed mental illness to supernatural forces and spiritual afflictions. This perception significantly influenced care-seeking behavior, with traditional and spiritual healers often serving as the first—and sometimes only—points of contact. These findings reinforce previous studies that have emphasized the primacy of spiritual frameworks in local mental illness interpretations (Ofori-Atta et al., 2010; Read & Doku, 2012; Ae-Ngibise et al., 2010).

The dominance of spiritual causation models results in delays in biomedical treatment, if it is ever sought at all. This contributes to the worsening of symptoms and an increased likelihood of chronicity or institutionalization. The majority of participants expressed low confidence in hospitals' ability to manage mental health cases, citing the ineffectiveness of medication in addressing perceived spiritual problems. The distrust in formal services reflects not only a knowledge gap but also a deeper cultural incongruence between local beliefs and biomedical explanations of illness. These findings are consistent with the arguments of Patel et al. (2007) and Sorsdahl et al. (2010), who observed that culturally misaligned health systems often experience underutilization and community resistance.

Stigma emerged as another significant barrier to help-seeking. Many respondents described mental illness as shameful and socially damaging. Families were hesitant to seek help publicly, fearing discrimination, gossip, or social ostracization. Such internalized stigma was closely tied to community norms that portray mental illness as a curse or a disgrace, which discourages disclosure and early intervention. Similar patterns of mental health-related stigma have been reported in other parts of Ghana and across sub-Saharan Africa (Barke et al., 2011; Atilola, 2015). The implication is that stigma is not merely a psychological response but a social and cultural construct that regulates visibility, access, and care trajectories.

A notable finding from the qualitative interviews was the deep fragmentation between the biomedical system and traditional healing structures. While both systems operate within the same communities, there is little formal collaboration, mutual respect, or referral. This institutional gap leaves patients to navigate care pathways without coordination, often leading to prolonged illness, ineffective treatments, and even human rights abuses such as chaining or confinement. This fragmentation mirrors the broader disconnect between modern health policy and indigenous health systems observed across African mental health landscapes (Burns & Tomita, 2015).

The policy implications of these findings are urgent. Any mental health intervention in Ghana must be grounded in the cultural realities of its

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people. Biomedical mental health services need to be reoriented to accommodate and engage with indigenous explanatory models and care practices. This can be achieved by incorporating culturally competent training for health workers, encouraging respectful dialogue with traditional healers, and developing structured partnerships that include referral mechanisms, regulation, and shared care protocols. Without such collaboration, the health system will continue to operate in isolation, failing to win the trust or meet the needs of the communities it serves.

Furthermore, public education campaigns must go beyond awareness creation and aim at reshaping deeply held beliefs and norms about mental illness. These campaigns should be community-based, multilingual, and delivered through credible local institutions such as schools, churches, mosques, and chiefs' palaces. Importantly, people with lived experience of mental illness and their families must be included in these efforts to challenge stigma and reshape narratives.

This study is not without limitations. The research was confined to five districts in one region, and the findings may not be fully generalizable to the entire country. Social desirability bias may have influenced some responses, particularly on sensitive questions about stigma or treatment preference. Nonetheless, the convergence of quantitative and qualitative data enhances the internal validity of the findings and offers a culturally grounded understanding of the topic.

In conclusion, the underutilization of mental health services in Ghana is not merely a result of service unavailability or affordability but is deeply embedded in socio-cultural worldviews. Beliefs in spiritual causation, fear of stigma, and trust in traditional systems collectively shape how individuals interpret and respond to mental illness. Effective mental health policy and practice in Ghana must therefore recognize and engage these belief systems as legitimate components of the health-seeking landscape. Only then can equitable, accessible, and culturally appropriate care be realized.

CONCLUSION

This study has illuminated the profound impact of socio-cultural beliefs on mental health service utilization in the Western Region of Ghana. The findings reveal that perceptions of mental illness are strongly rooted in spiritual and supernatural explanations, which in turn influence the preference for traditional and religious forms of care over biomedical services. Stigma, particularly related to shame and social exclusion, further limits individuals and families from seeking formal mental health treatment. The limited confidence in hospitals, coupled with the absence of structured collaboration between biomedical and traditional healing systems, has contributed to delayed care, fragmented treatment pathways, and deepened mistrust.

Addressing these barriers requires a culturally grounded approach to mental health care in Ghana. Policymakers, mental health professionals, and community stakeholders must work together to bridge the gap between

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indigenous belief systems and modern psychiatric care. This includes engaging traditional and religious healers as partners in mental health promotion, equipping health workers with cultural competence, and implementing anti-stigma campaigns that reflect local languages and values. By integrating socio-cultural realities into the design and delivery of services, mental health care in Ghana can become more acceptable, accessible, and effective for the communities it aims to serve.

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