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Jonathan Okoe*

<https://orcid.org/0000-0002-4913-6203>

Yahaya Halidu**

<https://orcid.org/0000-0002-5290-6379>

Constructing Madness: Media Narratives and Public Understandings of Mental Illness in Contemporary Ghana, c. 2000–2025

Constructing Madness: Contemporary Ghana'da Ruhsal Hastalığın Medya Anlatıları ve Kamusal Algıları, c. 2000–2025

Abstract

This article examines how Ghanaian news media reflect public understandings of mental illness during a period of growing media visibility and partial mental health reform. Drawing on Stuart Hall's constructionist theory of representation and insights from the health humanities, it argues that news media in Ghana do not simply report on mental illness but function as a stabilizing narrative space through which meanings about danger, morality, spirituality, and disorder are produced and sustained. Rather than reshaping public attitudes in line with reforms such as the Mental Health Act of 2012, media representations often absorb biomedical and rights-based language into longstanding moral and spiritual frameworks. Using qualitative interpretive analysis of selected media coverage, this article demonstrates how persistent narrative frames shape public understandings of mental illness in Ghana. It argues that despite institutional reforms, media representations continue to embed biomedical discourse within longstanding moral and spiritual interpretations, thereby limiting the transformative impact of policy change. By approaching journalism as a form of narrative mediation and as a site where both stigma and empathy are negotiated, the article shows that legal and policy reforms alone remain insufficient to reduce stigma in the absence of broader shifts in narrative representation. The study contributes to African mental health scholarship by conceptualizing stigma not only as a problem of policy implementation or public awareness but also as a narrative issue embedded within everyday processes of meaning-making.

Keywords: Ghana, media, mental illness, journalism, stigma, Mental Health Act 2012

* PhD Student, Department of History, College of Liberal Arts, The University of Texas at Austin, Austin, TX, USA, okoejonathan11@gmail.com

**Postgraduate Teaching & Research Assistant, Department of History, College of Liberal Arts, The University of Texas at Austin, Austin, TX, USA, greatsymbo@yahoo.com,

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Öz

Bu çalışma, Gana'da haber medyasının ruhsal hastalığa ilişkin kamusal algıları, medyanın görünürlüğünün arttığı ve ruh sağlığı alanında kısmi reformların gerçekleştiği bir dönemde nasıl yansıtıldığını incelemektedir. Stuart Hall'un inşacı temsil kuramı ile sağlık beşerî bilimleri literatüründen yararlanan çalışma, Gana'daki haber medyasının ruhsal hastalığı yalnızca aktaran bir araç olmadığını; aynı zamanda tehlike, ahlak, maneviyat ve toplumsal düzensizlik gibi anlamların üretildiği ve yeniden dolaşıma sokulduğu bir anlatı alanı olarak işlev gördüğünü ileri sürmektedir. 2012 Ruh Sağlığı Yasası gibi reform girişimlerine rağmen medya temsilleri, biyomedikal ve hak temelli söylemleri çoğu zaman yerleşik ahlaki ve manevi yorumların içerisine eklemektedir. Seçilmiş medya içeriklerine yönelik nitel yorumlayıcı analizden hareketle makale, süreklilik gösteren anlatı çerçevelerinin Gana'da ruhsal hastalığa dair kamusal anlamlandırmaları nasıl şekillendirdiğini ortaya koymaktadır. Çalışma, kurumsal reformlara rağmen medya söylemlerinin biyomedikal yaklaşımları uzun süredir varlığını koruyan ahlaki ve manevi yorumlarla birlikte yeniden ürettiğini, bunun da politika değişimlerinin dönüştürücü etkisini sınırladığını savunmaktadır. Gazeteciliği hem anlatsal bir dolayım bacağı hem de damgalama ile empati arasındaki ilişkilerin müzakere edildiği bir alan olarak ele alan makale, yalnızca hukuki ve kurumsal reformların damgalamayı azaltmak için yeterli olmadığını göstermektedir. Bu nedenle ruhsal hastalığa ilişkin baskın anlatı kalıplarında da dönüşüm gerekmektedir. Çalışma, damgalamayı yalnızca politika uygulamaları ya da kamuoyu farkındalığıyla açıklanabilecek bir sorun olarak değil, gündelik anlamlandırma süreçlerine yerleşmiş anlatsal bir mesele olarak kavramsallaştırarak Afrika ruh sağlığı literatürüne katkı sunmaktadır.

Anahtar Kelimeler: *Gana, medya, ruhsal hastalık, gazetecilik, damgalama, 2012 Ruh Sağlığı Yasası*

Introduction

This article situates mental illness, representation, and public perception within Ghana's contemporary information environment. News narratives have increasingly become central to public discussions surrounding health, morality, and social order. Since 2000, Ghanaian media coverage across print newspapers, radio, television, digital news platforms, and more recently social media spaces has consistently circulated public narratives concerning mental illness. The analysis approaches news journalism through Stuart Hall's constructionist framework, which emphasizes the socially produced nature of representation and meaning-making (Hall, 1997). Drawing on this theoretical perspective, the article argues that Ghanaian media discourse has reflected and reproduced socially embedded understandings of mental illness in everyday life. Earlier scholarship, including the work of Quarshie et al. (2015) on suicide reporting, examined particular cases and reporting patterns but did not fully theorize the broader cultural construction of mental illness within public discourse. Through qualitative content analysis and the application of Hall's constructionist theory to both secondary scholarship and primary online media materials, this study demonstrates how recurring representations shape public meanings associated with mental illness in Ghana and how these constructions contribute to the persistence of stigma within wider society.

Health humanities scholarship provides important interpretive frameworks for understanding why representation, interpretation, and cultural meaning remain central to experiences of mental illness. Within this field, illness is understood not solely as a biomedical condition but also as something mediated through narratives, images, institutional language, and collective social expectations. Scholars of narrative medicine and health humanities, including Charon (2006) and Frank (2013), have demonstrated that the ways societies describe, narrate, and interpret illness significantly influence social

responses to suffering and the recognition afforded to those experiencing it. Their work strengthens the present argument by illustrating that Ghanaian media coverage does not merely report on mental illness as a social issue; it also participates in constructing the moral and emotional frameworks through which psychological distress is interpreted by the public. These approaches further illuminate how stigma, empathy, fear, and responsibility become attached to mental illness through culturally situated narratives rather than through medical knowledge alone. This article therefore approaches media simultaneously as reflective and generative. News narratives draw upon pre-existing cultural assumptions regarding mental illness while also reinforcing and stabilizing these meanings through repetition, framing practices, and linguistic choices embedded within everyday reporting.

Methodology

This article employs qualitative interpretive analysis to examine how media narratives in Ghana have functioned not as neutral sites of information transmission but as active spaces through which meanings surrounding mental illness are reflected, reproduced, and negotiated. The study is grounded in Stuart Hall's constructionist theory of representation and is further informed by health humanities scholarship, particularly the work of Rita Charon (2006) and Arthur Frank (2013), both of whom conceptualize illness as an experience shaped through narrative, interpretation, and social interaction.

The primary materials consist of selected Ghanaian online media coverage published between 2000 and 2025. The study draws on the documentary *Under the Mango Tree: New Documentary on the Mentally Ill in Ghana* (Food Tank, 2014), as well as prior analyses of Ghanaian media reporting on mental health conducted by Dzokoto et al. (2018) covering the period between 2000 and 2015. It also incorporates the media analysis undertaken by Quarshie et al. (2015) concerning adolescent suicide reporting in Ghana. Additional primary materials were drawn from media outlets including *MyJoyOnline* (2014), *Graphic Online* (2015), and *Graphic Online* (2025), among others.

To identify relevant primary materials, keyword searches were conducted using terms including *mental illness*, *insanity*, and *psychiatric illness*. Similar search criteria were applied in identifying secondary scholarship examining stigma, public discourse, and culturally embedded understandings of mental illness through newspapers, oral narratives, and related media forms. Sources were selected on the basis of thematic relevance and recurrence within public discourse. The materials were then inductively organized into thematic categories, including stigma, institutional care, public morality, policy discourse, and spirituality. Through close reading of selected texts, these themes were subsequently developed into broader narrative frames that illuminate how mental illness is socially interpreted and publicly communicated. Direct quotations from media materials were incorporated where analytically necessary, while secondary scholarship was primarily used to provide contextual and interpretive

support rather than serving as the principal unit of analysis. This methodological approach enables the study to conceptualize media simultaneously as reflective of existing cultural understandings and as generative of new social meanings. In doing so, it clarifies how representation contributes to meaning-making processes surrounding mental illness within the Ghanaian context. The qualitative dataset for this study consisted of a purposive sample of six primary media texts, including online news reports, editorial commentaries, documentary materials, and multimedia sources. These materials were supplemented by the analysis of nineteen key secondary scholarly works relevant to mental health representation, stigma, and public discourse in Ghana.

Media Narratives and the Making of Mental Illness in Ghana

The Ghanaian media play a central role in shaping public understandings of mental illness. Media representations since the beginning of the twenty-first century indicate that one of the dominant themes surrounding mental illness has been public awareness and mental health education. Coverage examined by Dzokoto et al. (2018), *MyJoyOnline* (2014), and *Graphic Online* (2015, 2025) highlights the institutional challenges facing mental healthcare services while also emphasizing the significance of religion and spirituality in the interpretation of mental illness among many Ghanaians. These reports frequently demonstrate how mental illness is associated with spiritual causality within public discourse.

MyJoyOnline (2014) reports that Dr. Okwesi Osei, then Chief Psychiatrist of Ghana, directly challenged these dominant interpretations by stating that mental illness “has nothing to do with witchcraft...or juju.” The necessity of such clarification is itself analytically significant because it suggests that spiritual explanations already occupy a prominent position within public understandings of mental illness. In this context, biomedical discourse is often presented not as the dominant explanatory framework but as a corrective intervention responding to deeply rooted cultural interpretations. Consequently, media reporting does not merely describe social beliefs; it also reproduces a narrative environment in which spiritual causality remains a widely recognizable interpretive framework.

Reporting on suicide similarly demonstrates how narrative framing shapes public understanding of psychological distress. As shown by Quarshie et al. (2015), media accounts frequently emphasize method, location, and interpersonal conflict while offering comparatively limited attention to broader structural or psychological dimensions. Such framing individualizes suffering and can obscure wider social conditions, including unemployment, social isolation, economic precarity, or limited access to mental healthcare services. The emphasis on dramatic detail over contextual explanation contributes to a moralized narrative structure in which suicide is interpreted primarily through individual circumstances rather than through broader social and institutional contexts. Through this mode of

representation, media narratives not only reflect public anxieties surrounding mental illness but may also intensify perceptions of unpredictability and social instability associated with psychological distress.

Beyond online news reporting, documentary media further illuminate the lived experiences of individuals experiencing mental illness. *Under the Mango Tree: New Documentary on the Mentally Ill in Ghana* (Food Tank, 2014) highlights overcrowding within psychiatric institutions, shortages of medicine and food, and the widespread reliance on prayer camps for treatment. The documentary further illustrates how some treatment approaches are connected to supernatural interpretations of mental illness. According to the documentary, Ghana at the time had approximately one psychiatrist for every two million people, underscoring the structural limitations affecting mental healthcare provision. These institutional constraints possess a longer historical trajectory extending back to the colonial period, during which mental healthcare infrastructure remained highly limited until the end of colonial administration in 1957 (Okoe & Halidu, 2025). Persistent shortages of resources and overcrowding within psychiatric facilities continue to shape public discussions surrounding mental healthcare provision in Ghana.

At the same time, media representations can contribute to the normalization of social attitudes surrounding mental illness. Rather than consistently challenging stigmatizing assumptions, some forms of reporting may inadvertently reinforce existing perceptions by repeatedly associating mental illness with danger, instability, social disorder, or spiritual crisis. Consequently, public understandings of mental health are shaped not only by lived experience and institutional realities but also by the cumulative effects of recurring narrative patterns within the media environment.

Documentary media reinforce similar dynamics through visual and experiential framing. *Food Tank* (2014) juxtaposes overcrowded psychiatric institutions with scenes from prayer camps where healing practices are closely linked to spiritual intervention. This visual contrast constructs a narrative in which institutional psychiatric care appears insufficient, thereby increasing the social legitimacy of alternative spiritual approaches to treatment. Simultaneously, the repeated visual emphasis on restraint, confinement, overcrowding, and scarcity risks presenting these conditions as socially inevitable rather than historically and structurally produced. The documentary therefore functions both as a critique of institutional inadequacies and as a representation that may unintentionally stabilize problematic assumptions surrounding mental illness and care.

Scholars working within narrative medicine and the health humanities argue that experiences of illness are always mediated through the stories available within a given society. Such narratives shape how suffering is recognized, interpreted, legitimized, or marginalized. Charon (2006), for example,

emphasizes that narratives fundamentally structure public understandings of illness and care. Similarly, Frank (2013) demonstrates that public narratives can either create space for individuals experiencing illness to articulate their experiences or silence suffering through reductive stereotypes and social categorization. Within the Ghanaian context, media narratives frequently foreground danger, disorder, vulnerability, and spiritual disruption in ways that influence broader social understandings of mental illness.

Journalistic reporting on mental illness therefore participates in a wider narrative structure that shapes how suffering becomes socially intelligible, how empathy is distributed, and how particular forms of distress are granted legitimacy within public discourse. Viewing journalism through the lens of narrative medicine demonstrates that media reporting operates not merely as a practical mechanism for information dissemination but also as a cultural process involved in constructing social meaning surrounding illness and care (Kleinman, 1981).

Public Attitudes, Stigma, and Everyday Understanding of Mental Distress

Everyday cultural beliefs, social practices, and longstanding understandings of the relationship between body, spirit, and community continue to shape public attitudes toward mental distress in Ghana. Existing scholarship demonstrates that many Ghanaians interpret mental illness through multiple explanatory frameworks simultaneously, combining biomedical perspectives with spiritual explanations involving witchcraft, curses, or malevolent spiritual forces (Dzokoto et al., 2023). The coexistence of biomedical and spiritual interpretations strongly influences how symptoms are recognized and interpreted within communities. In many cases, distress becomes socially visible primarily when behavior is perceived to disrupt social order rather than when individuals experience internal emotional suffering. Dzokoto et al. (2023) demonstrate in their work on Ga communities that greater emphasis is often placed on observable behavioral changes such as wandering, shouting, aggression, or withdrawal than on less visible experiences such as sadness, anxiety, or psychological exhaustion. Their findings reinforce the idea that mental illness frequently becomes socially recognized when it interrupts familial or communal expectations. As the authors note, mental illness was often understood as “behavior that deviated from what was considered the norm” (Dzokoto et al., 2023).

Stigma is likewise shaped through everyday interactions occurring within homes, public spaces, religious settings, and institutional environments. Families may respond through silence, distancing, concealment, or shame because mental illness is sometimes interpreted as evidence of spiritual imbalance, moral failure, or familial misfortune (DIGNITY – Danish Institute Against Torture, 2022). Research has documented situations in which psychological distress is attributed to divine punishment, witchcraft, or supernatural attack, occasionally resulting in coercive treatment practices, forced

confinement, or abandonment within prayer camps despite the passage of Ghana's Mental Health Act in 2012 (Mfoafo-M'Carthy & Grishow, 2017). These experiences demonstrate that stigma functions simultaneously at emotional, social, and structural levels. Individuals living with mental health conditions may experience ridicule, exclusion, suspicion, or discrimination connected to their condition, while institutional neglect and limitations in access to adequate care further reinforce processes of marginalization. Public responses frequently include social distancing, fear of association, or avoidance of interaction with individuals perceived to be experiencing mental illness, contributing to the persistence of stigma in everyday life (King & Kiura, 2025).

More recent media analyses further illustrate how public attitudes circulate through narratives that simultaneously promote awareness and reproduce stigma. In their analysis of Ghanaian newspaper coverage between 2000 and 2015, Dzokoto et al. (2018) identified themes related to awareness campaigns, suicide reporting, charitable interventions, and religious discourse. At the same time, however, some forms of reporting continued to reinforce stereotypes associating mental illness with danger, unpredictability, or spiritual disturbance. Public figures and celebrities in Ghana also navigate these social pressures through strategies of concealment, selective disclosure, avoidance, or private religious practice. As King and Kiura (2025) note, "Prayer served as a means to seek healing and strength from God without drawing public attention to their struggles." Such strategies illustrate how stigma can encourage silence and self-concealment rather than open discussion of mental health experiences. Collectively, these cases demonstrate that public attitudes toward mental illness in Ghana are shaped by complex intersections of empathy and suspicion, biomedical knowledge and spiritual interpretation, as well as personal coping strategies and broader structural limitations. These overlapping dynamics continue to influence how mental distress is understood, discussed, and experienced in everyday social life.

A comparison with Stevenson's work in the Canadian Arctic further clarifies how cultural narratives shape the recognition of suffering. Stevenson (2014) argues that bureaucratic systems may preserve biological life while failing to acknowledge the emotional, relational, and social dimensions that give life meaning. This perspective helps illuminate why Ghanaian media narratives frequently emphasize visible disruption or public disorder when discussing mental illness. Such representational frames influence which forms of suffering become publicly recognizable and which remain socially marginalized or invisible. Similar to the Inuit communities discussed by Stevenson, individuals experiencing mental illness in Ghana may encounter a gap between institutional goals centered on safety or containment and the deeper emotional and social needs that render care meaningful. This

comparison highlights how public narratives contribute to determining whose suffering becomes culturally legible and whose experiences remain insufficiently acknowledged.

Concepts of empathy developed within the health humanities also help explain the emotional dynamics shaping everyday interactions surrounding mental illness. DasGupta (2008) introduces the concept of “narrative humility,” emphasizing that individuals can never fully comprehend another person’s experience and must therefore remain open to the complexity of others’ stories and suffering. This perspective helps explain why responses to mental illness may vary considerably within Ghanaian society, ranging from empathy and support to fear, distancing, or alienation depending on the interpretive narratives through which mental distress is understood. Holmes (2013) further demonstrates how structural pressures influence the capacity for empathy by constraining the time, resources, and emotional energy available to caregivers and communities. Together, these perspectives suggest that empathy should not be understood solely as an individual moral quality but also as something shaped by broader cultural narratives and structural conditions that influence how illness is interpreted within society. These narrative patterns continue to persist even as Ghana’s mental health system undergoes institutional reform, suggesting an important disjunction between changes in formal policy and continuity in public meaning-making surrounding mental illness.

Policy, Institutions, and the Changing Landscape of Mental Health Care in Ghana

Over the past two to three decades, Ghana has made sustained efforts to shift the delivery of mental healthcare services away from reliance on a small number of psychiatric hospitals toward a more integrated system involving general healthcare facilities, community mental health teams, and partnerships with non-state actors. Government policy has increasingly emphasized deinstitutionalization, integration into primary healthcare systems, and improved protection of patients’ rights. Nevertheless, media coverage of these reforms frequently frames them through narratives of crisis, scarcity, and institutional fragility. For example, a *MyJoyOnline* (2014) report warned that resource constraints could “force shutdown of mental facilities,” foregrounding institutional vulnerability and financial limitations rather than policy advancement. Such framing positions reform as uncertain and precarious, suggesting that institutional change remains incomplete rather than fully transformative.

Similarly, media representations of mental health policy often connect reform efforts to broader moral discussions concerning dignity, care, and stigma rather than focusing solely on structural transformation. *Graphic Online* (2015), in discussing the need to “provide dignity to mental health patients,” framed policy reform as a response to longstanding social neglect and marginalization. The repeated emphasis on dignity implicitly acknowledges the persistence of stigma despite legal and

institutional reforms. Another *Graphic Online* (2015) report calling for society to “treat mental patients with dignity” highlighted overcrowding and inadequate facilities, reinforcing the perception that formal policy reform had not yet translated into substantial improvements in lived experience. These media narratives therefore do more than report institutional developments; they construct reform as morally urgent while simultaneously portraying implementation as materially constrained.

At the district level, situation analyses further demonstrate how national mental health goals encounter significant practical limitations. A five-district study conducted by Weobong et al. (2023) identified weak or absent district mental health plans, minimal supervision of the limited number of specialists, persistent shortages of psychotropic medication, and very limited availability of psychological therapies because of insufficient numbers of trained clinicians. The study estimated treatment coverage for conditions such as depression, schizophrenia, and epilepsy to be below 1%. At the same time, the authors identified potential pathways for improvement, including greater use of the District Health Information Management System, expanded reliance on community volunteers, and strengthened collaboration, where appropriate and safe, with traditional and faith-based providers.

Transforming the mental healthcare system also requires attention to how care is delivered across different institutional and community settings. For decades, community psychiatric nurses in Ghana have conducted follow-up visits and community-based interventions, although their reach has often been limited by uneven investment and the long-term effects of austerity measures. Contemporary policy discussions increasingly encourage forms of collaboration with traditional healers and faith-based practitioners in order to address treatment gaps and reduce harmful practices. In practice, however, coercive practices such as chaining and forced fasting continue to occur in some healing spaces, while oversight mechanisms remain difficult to implement consistently. At the same time, coercive conditions may also emerge within formal psychiatric institutions when facilities are severely under-resourced. This complex situation demonstrates that meaningful reform requires both improvement of hospital conditions and consistent protection of patient rights across all sites of care (Read & Kpobi, 2025). Media and advocacy reports further reinforce the tension between legal reform and lived realities of care. The report produced by DIGNITY – Danish Institute Against Torture (2022) documents practices including chaining, flogging, forced fasting, and confinement within some prayer camps, framing these practices as violations of human rights and dignity. The continued public visibility of such practices highlights the limitations of policy enforcement and reinforces narratives suggesting that institutional reforms remain unable to fully regulate alternative systems of care. In this respect, media representations frequently position mental health reform not as a completed transition

but as an ongoing negotiation between legal frameworks, institutional limitations, and culturally embedded treatment practices.

The Mental Health Act of 2012 and related WHO guidance both frame collaboration with traditional and faith-based healers as a dual process involving recognition of culturally trusted forms of care while simultaneously prohibiting coercive or abusive practices. Ghana has attempted to strengthen visiting committees, inspection mechanisms, and professional training programs for psychiatrists, mental health nurses, and community mental health workers. Compared with some other African contexts, many Ghanaian communities now have at least one community mental health worker, reflecting a significant institutional shift. Nevertheless, inspection systems continue to face serious resource limitations, while many healers operate as private practitioners responsible for independently meeting regulatory standards. Without sustainable public funding, the burden of reform frequently falls upon actors operating with limited institutional support (Read & Kpobi, 2025).

Frontline healthcare providers themselves also experience the effects of stigma and institutional neglect. Interviews with psychiatric nurses at Ankaful Psychiatric Hospital conducted by Mensah (2024) describe two interconnected forms of stigma: social stigma associated with working in the field of mental health and structural stigma linked to inadequate governmental support, resource shortages, and difficult working conditions. These findings suggest that meaningful reform requires attention not only to patient care but also to provider well-being, workplace conditions, and professional recognition. Without such support, reforms risk stagnating at the level of implementation.

Recent district-level analyses additionally demonstrate persistent inequalities in access to mental healthcare within primary healthcare systems. A case study from Ga South identified stigma, weak referral pathways, high medication costs, and shortages of psychiatrists as continuing barriers to care (Weobong et al., 2023). Healthcare workers reported that even after receiving mental health training, many practitioners continued to experience difficulties managing psychiatric cases within general healthcare settings. These findings indicate the importance of sustained professional training, improved medication financing and supply systems, and clearer referral and follow-up structures capable of supporting continuity of care.

Despite these ongoing challenges, the overall direction of mental health policy in Ghana remains relatively clear. The WHO (2022) situational assessment outlines six major areas of focus: planning, contextual analysis, policy development, prevalence and treatment coverage, service delivery, cultural and non-health sectors, and information systems. Ghana's current mental health strategies broadly align with these priorities. However, movement from policy planning toward effective implementation depends on several interrelated factors, including adequate funding for medication and personnel,

sustained integration of mental health services into primary healthcare systems, consistent enforcement of patient rights protections, and initiatives aimed at strengthening the professional legitimacy and public perception of psychiatric care. Achieving these goals would make it increasingly possible for individuals to access first-contact care closer to home, receive timely referrals when necessary, and pursue recovery within conditions that preserve dignity and safety.

The ongoing challenges within Ghana's mental healthcare system also reflect what health humanities scholars describe as structural forms of suffering. Farmer (2010) argues that political and economic inequalities produce patterns of illness, exclusion, and neglect that cannot be explained through individual behavior alone. Metzl and Hansen (2014) extend this argument through the concept of "structural competency," emphasizing the importance of recognizing how poverty, institutional limitations, and policy decisions shape clinical outcomes. These perspectives are equally relevant to media narratives and public discourse surrounding mental illness. Holmes (2013) similarly demonstrates how structural pressures affect both patients and caregivers by generating exhaustion, uneven care, and emotional strain within healthcare systems. Together, these approaches deepen the argument of this article by framing understaffed hospitals, medication shortages, and unequal access to treatment not merely as administrative failures but as structural conditions that shape suffering and limit possibilities for recovery.

More recent editorial commentary continues to situate policy reform within broader cultural narratives concerning mental illness. A *Graphic Online* (2025) editorial argues that Ghana's broader social transformation depends upon addressing mental health challenges while also identifying stigma, superstition, and social neglect as continuing obstacles. By linking policy outcomes to cultural beliefs and public attitudes, such narratives shift attention away from institutional capacity alone and toward broader processes of social meaning-making. Media representations therefore do not simply track policy developments; they also shape how the success, limitations, or failures of reform are interpreted within public discourse. Taken together, these narratives demonstrate that mental health reform in Ghana is repeatedly interpreted through overlapping frameworks of crisis, morality, institutional limitation, and cultural belief. This reinforces the central argument of the article that institutional change alone cannot fundamentally transform public understandings of mental illness without corresponding shifts in narrative representation and social interpretation.

Bringing these health humanities perspectives together further demonstrates how representation, cultural belief systems, and institutional structures collectively shape experiences and understandings of mental illness in Ghana. Charon (2006) and Frank (2013) show how narratives influence the moral interpretation of suffering, while Stevenson (2014) illustrates how institutions

shape whose lives receive recognition, legitimacy, and care. Farmer (2010), Holmes (2013), and Metzl and Hansen (2014) further demonstrate how political and economic structures constrain treatment possibilities and shape everyday outcomes. DasGupta's (2008) concept of narrative humility additionally highlights why empathy varies across social contexts and why certain forms of suffering remain socially unrecognized. Considered together, these works demonstrate that mental illness in Ghana cannot be understood independently from the cultural narratives, structural inequalities, and emotional frameworks that shape public understanding and institutional response.

Conclusion

Media narratives, cultural beliefs, and institutional structures intersect in significant ways in shaping how mental illness is understood and experienced in Ghana. Throughout the period examined in this study, Ghanaian news media have functioned as important narrative spaces through which meanings surrounding mental illness are continuously reproduced, negotiated, and normalized within public discourse. Although biomedical and rights-based understandings of mental illness have become increasingly visible in public discussions, particularly following the passage of the Mental Health Act in 2012, these perspectives are often incorporated into pre-existing cultural and moral frameworks rather than replacing them entirely. As a result, representations of mental illness within media discourse frequently absorb institutional developments into already familiar narratives concerning spirituality, social disorder, morality, and vulnerability.

The findings of this article suggest that media representations do not simply lag behind institutional reforms but actively shape how such reforms are interpreted within society. Consequently, legal and institutional changes alone have had only limited effects on transforming broader public perceptions of mental illness. News media therefore operate not merely as platforms for the dissemination of information but as active sites of meaning-making through which ideas about danger, responsibility, legitimacy, care, and social belonging are continually constructed and circulated.

At the same time, Ghana has experienced important legal and institutional developments in mental healthcare policy, particularly through the implementation of the Mental Health Act of 2012 and the growing emphasis on community-based mental healthcare services. These reforms represent meaningful efforts to improve access to care, strengthen patient protections, and move beyond highly centralized psychiatric systems. Nevertheless, this article argues that institutional and rights-based reforms alone remain insufficient to substantially reduce stigma or transform public understanding if dominant media narratives continue to frame mental illness primarily through themes of fear, instability, moral failure, or spiritual crisis.

Approached through a constructionist and health humanities perspective, this study contributes to existing scholarship by demonstrating that mental healthcare reform in Ghana involves more than institutional restructuring or legislative intervention. Changes in policy and service delivery must also be accompanied by shifts in the cultural meanings attached to mental illness within public discourse and media representation. Without broader transformations in narrative framing, stigma may continue to persist even alongside significant institutional reform efforts.

Author Contributions

Jonathan Okoe and Yahaya Halidu contributed collaboratively to the conception of the study, methodological design, interpretation of the findings, drafting of the manuscript, and subsequent revisions. Both authors read and approved the final version of the manuscript prior to publication.

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