TREATMENT SEEKING BEHAVIOUR OF PEOPLE LIVING WITH MENTAL ILLNESS IN REGIONAL PSYCHIATRIC HOSPITALS IN GHANA

BY

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THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF MPHIL PSYCHOLOGY DEGREE

JUNE, 2014
DECLARATION

I hereby declare that this thesis is the result of my own research towards the award Master of Philosophy Degree in Psychology. Except for the works of other people which has been duly referenced and that this thesis has not been presented in whole or part to this or any university of a degree.

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ABSTRACT

Mental illness is widely recognized as a major contributor to the global burden of disease. Unfortunately, there is a lack of appropriate treatment seeking among the Ghanaian population. This research sought to examine the treatment seeking behaviour of people living with mental illness in regional psychiatric hospitals in Ghana and how patient’s attitude toward professional mental health treatment and illness perception influence these behaviours. One hundred and fifty (150) participants comprising hundred (100) mentally ill patients and fifty (50) sickle cell disease individuals were involved in this study. Mentally ill participants were outpatients of the Accra Psychiatric Hospital, Pantang Hospital and Ankaful Psychiatric Hospital, which are the three major psychiatric hospitals in Ghana. Sickle cell disease individuals were sampled from the Korle-Bu Teaching Hospital. Data was collected using the Pathway to Care questionnaire, the Illness Perception Questionnaire, General Health Questionnaire and the Attitude toward Mental Health Treatment scale. Results indicated that a significant number of mentally ill patients perceived their illness as genetic compared to sickle cell disease patients. However, both groups did not differ in terms of onset of treatment seeking. Mentally ill patients who have positive attitude towards professional mental health treatment sought psychiatric treatment as the first choice of treatment as compared to those who sought psychiatric treatment as the second or third choice of treatment. The most important predictor of treatment seeking among people with mental illness is attitude towards professional mental health treatment. Implications of the findings were discussed.
DEDICATION

This thesis is dedicated to my husband, Mr. Philip Kojo Tamakloe and Faith Awo Tamakloe, my daughter. Pee, thank you for your support and the great encouragement you gave me to come this far. Faith, I cannot express how much you have been a source of strength and motivation for me. You started and ended this journey with me. Thank you for understanding me through all the countless number of trips to campus we made together and the hard times that I stayed away from you. You will never know how much you mean to me, Pee and Faith. God bless you.
ACKNOWLEDGEMENT

The Lord is good; I will lift him up always! To God be the glory, great things He has done.

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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>CONTENT</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>DECLARATION</td>
<td>i</td>
</tr>
<tr>
<td>ABSTRACT</td>
<td>ii</td>
</tr>
<tr>
<td>DEDICATION</td>
<td>iii</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENT</td>
<td>iv</td>
</tr>
<tr>
<td>TABLE OF CONTENTS</td>
<td>v</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>viii</td>
</tr>
<tr>
<td>LIST OF ABBREVIATIONS</td>
<td>ix</td>
</tr>
<tr>
<td>CHAPTER ONE</td>
<td>1</td>
</tr>
<tr>
<td>INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>1.1 Background to the Study</td>
<td>1</td>
</tr>
<tr>
<td>1.2 Problem Statement</td>
<td>6</td>
</tr>
<tr>
<td>1.3 Aim and Objectives of the Study</td>
<td>8</td>
</tr>
<tr>
<td>1.4 Relevance of the Study</td>
<td>9</td>
</tr>
<tr>
<td>CHAPTER TWO</td>
<td>11</td>
</tr>
<tr>
<td>LITERATURE REVIEW</td>
<td>11</td>
</tr>
<tr>
<td>2.1 Introduction</td>
<td>11</td>
</tr>
<tr>
<td>2.2 Theoretical Framework</td>
<td>11</td>
</tr>
<tr>
<td>2.2.1 Illness Perception Model (Levantal, Nerenz &amp; Steele, 1984)</td>
<td>11</td>
</tr>
<tr>
<td>2.2.2 Health Service Utilisation Model (Andersen &amp; Newman, 1973)</td>
<td>13</td>
</tr>
<tr>
<td>2.3 Review of Related Studies</td>
<td>14</td>
</tr>
<tr>
<td>2.3.1 Mental Illness and Treatment Seeking Behaviour</td>
<td>14</td>
</tr>
<tr>
<td>2.3.2 Availability of Mental health Services and Treatment Seeking</td>
<td>18</td>
</tr>
</tbody>
</table>
2.3.3 Socio-demographic variables as related to treatment seeking behaviour of the mentally ill ........................................................................................................................................... 21

2.3.4 Mental illness perceptions and treatment seeking behaviour ............................................... 24

2.4 Summary .................................................................................................................................. 30

2.5 Rationale of the Study .............................................................................................................. 30

2.6 Statement of Hypotheses .......................................................................................................... 31

2.7 Operational Definition of Terms ............................................................................................ 33

CHAPTER THREE ......................................................................................................................... 34

METHODOLOGY .......................................................................................................................... 34

3.1 Introduction ............................................................................................................................... 34

3.2 Population ................................................................................................................................ 34

3.3 Participants/ Sampling Technique ............................................................................................ 34

3.4 Inclusion and Exclusion Criteria ............................................................................................. 37

3.5 Research design ......................................................................................................................... 37

3.6 Measures: ................................................................................................................................ 38

3.7 Data Collection Procedure ..................................................................................................... 40

CHAPTER FOUR ............................................................................................................................ 42

RESULTS .................................................................................................................................... 42

4.1 Introduction ............................................................................................................................... 42

4.2 Preliminary analysis .................................................................................................................. 42

4.2 Testing of Hypotheses............................................................................................................... 43

4.3 Summary of Findings ................................................................................................................. 51

CHAPTER FIVE ............................................................................................................................. 53

DISCUSSION ............................................................................................................................... 53
5.1 Introduction ................................................................................................................... 53
5.2 Discussion of findings ................................................................................................... 54
5.3 Limitations .................................................................................................................. 62
5.4 Recommendations ....................................................................................................... 63
5.5 Directions for future studies ....................................................................................... 64
5.6 Conclusion .................................................................................................................. 64

REFERENCES .................................................................................................................... 66

APPENDICES .................................................................................................................... 79

APPENDIX A: Demographic Questionnaire .................................................................. 79
APPENDIX B: Pathway to Care Questionnaire ............................................................. 81
APPENDIX C: Illness Perception Questionnaire (IPQ) .................................................. 84
APPENDIX D: General Health Questionnaire (GHQ – 12) ........................................... 86
APPENDIX E: Attitudes toward Mental Health Treatment Scale (ATMHT) .................. 88
APPENDIX F: Consent Form ......................................................................................... 90
APPENDIX H: Ethical Approval .................................................................................... 93
LIST OF TABLES

Table 1: Demographic Characteristics of Participants in the study………………… ……36

Table 2: Means, standard deviations, normality of the distribution of scores and Cronbach
alpha of scales……………………………………………………………………………………………42

Table 3: Independent t-test of perceived causes of Illness between Mentally Ill and SCD
Patients…………………………………………………………………………………………………………………44

Table 4: Independent t-test of Perceived Timeline, Control and Consequence of Mentally
Ill and SCD Patients…………………………………………………………………………………………………………………45

Table 5: Chi Square test results of Attitudes toward Mental Health Treatment and Choice
of First Treatment sought by Mentally Ill Patients……………………………………………………………46

Table 6: Logistic Regression Analysis of Treatment Seeking Behaviour as a Function of
Socio-Demographic Characteristics………………………………………………………………………………………………………48

Table 7: Chi square analysis of the association between type of diagnosis and onset of
treatment seeking …………………………………………………………………………………………………………………………………………49

Table 8: Chi Square Table Showing Results of First Treatment Option by Mentally Ill
Patients………………………………………………………………………………………………………………………………………………50

Table 9: Independent t-test of General Health Differences between Patients who sought
Psychiatric and other Treatments………………………………………………………………………………………………………………51
## LIST OF ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>APA</td>
<td>American Psychiatric Association</td>
</tr>
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<td>ATMHT</td>
<td>Attitudes toward Mental Health Treatment Scale</td>
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<tr>
<td>DSM-5</td>
<td>Diagnostic and Statistical Manual of Mental Disorders, 5th Edition</td>
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<td>GHQ</td>
<td>General Health Questionnaire</td>
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<td>GICG</td>
<td>Ghana Institute of Clinical Genetics</td>
</tr>
<tr>
<td>ICD</td>
<td>International Classification of Diseases</td>
</tr>
<tr>
<td>IPQ</td>
<td>Illness Perception Questionnaire</td>
</tr>
<tr>
<td>IV</td>
<td>Independent Variables</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Government Organization</td>
</tr>
<tr>
<td>SCD</td>
<td>Sickle Cell Disease</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Positive mental health is linked to a range of development outcomes and is fundamental to coping with adversity. On the other hand, poor mental health impedes an individual’s capacity to realize their potential, work productively, and contribute to their community (World Health Organization, 2012). Affective, anxiety and addictive disorders are noted among the common types of mental disorders and associated with a wide range of disabilities and functional impairments (Dahlberd, 2008).

According to the American Psychological Association (2005), Dictionary of Psychology, “mental illness, also called mental disorder or psychiatric illness is a disorder characterized by psychological symptoms, abnormal behaviours, impaired functioning or any combination of these. Such disorders may cause clinically significant distress and impairment in a variety of domains of functioning and may be due to organic, social, genetic, chemical or psychological factors” (APA, 2005). Specific classifications of mental disorders are elaborated in the APA’S Diagnostic and Statistical Manual of Mental Disorders (APA, 2000) and the World Health Organization’s International Classification of Diseases (WHO, 1997). Some of these specifications include schizophrenia, anxiety disorders, substance use disorders, personality disorders and childhood disorders among others. The World Health Organization estimates major depression as the second most burdensome disease in the world by 2030 (Maters & Loncar, 2006).
The World Health Organization (WHO) reports that there are over 2 million Ghanaians suffering from moderate to mild mental disorders, and 650,000 of which are suffering from severe illnesses (WHO, 2014). It is further estimated that Ghana’s treatment gap (defined as the number of people whose illness goes untreated) stands at 98 percent (WHO, 2014). Considering the 98% gap for treatment of mental illnesses, the majority of Ghanaians suffering from mental illness may not encounter a psychiatrist or mental institution. This suggests that patients are seeking other means of treatment.

The World Health Report (2001) stated that many individuals living with mental illness do not seek treatment, and most often, both anxiety and depression go undiagnosed. According to this report, under-recognition is generally more common in mild rather than severe cases though mild disorders are still a source of concern (World Health Report, 2001). The situation is further compounded by the derailing mental health care system in Ghana, which has repeatedly been overlooked thereby influencing individuals and agencies to make urgent calls for its attention and remedy (Read & Doku, 2012; Ofori-Atta, Read & Lund, 2010). A survey to provide data on the Mental Health System in Ghana for the year 2011 by Roberts, Mogan and Asare (2014), discovered that services were significantly underfunded with only 1.4% of the health expenditure going to mental health, and spending very much skewed towards urban areas. It was also revealed, there were 123 mental health outpatient facilities, three psychiatric hospitals, seven community based psychiatric inpatient units, four community residential facilities and one day treatment centre, which is well below what would be expected for Ghana's economic status.

Furthermore, a situational analysis of the status of mental health care in Ghana by Ofori-Atta et al. (2010, p99) revealed “there are shortfalls in the provision of mental health care
including insufficient numbers of mental health professionals, aging infrastructure, widespread stigma, inadequate funding and an inequitable geographical distribution of services”. Due to these findings, they concluded that there is the need for community-based services to be delivered in the primary care setting to provide accessible and humane mental health care.

Previously, Antwi-Bekoe and Mensah (2009), made a claim that health professionals such as community nurses and pharmacist become the first and often only point of formal contact for those suffering from mental illness in Ghana though their preparation for this type of care is minimal. Indeed, evidence suggests that, “in low-income and middle-income countries, support for primary care services to enable them to identify and treat people with mental disorders, with training, assistance, and supervision by available specialist mental health staff is the best way to extend mental health care to the population” (Desjarlais, Eisenberg, Good, & Kleinman, 1995).

Treatment seeking according to Rogler and Cortes (1993) is the pathways taken to reach treatment and the types of treatments sought. The term ‘treatment-seeking’ has recently begun to be used to delineate seeking help from specific health treatment providers and seeking help from generic support and community services. It appears a varied source of treatment options are often available for individuals who suffer from mental illness (Okello & Neema, 2007). According to Dixon (2012), individuals who suffer from mental illness in Ghana are more likely to visit traditional healers for treatment because of the availability and affordability of the healers, especially in rural areas of the country. To add to that, evidence has shown that were traditional healers are not preferred, religious healers and leaders
become the next line of option for people suffering from mental health problems (Appiah-Poku, Laugharne, Mensah, Osei & Burns, 2004).

This phenomenon is not only exclusive to the Ghanaian population. Literature on help seeking among mentally ill patients has generally suggested that for majority of these individuals, treatment seeking in a psychiatric hospital may not be their first or even their last option since mentally ill patients often visit various place in effort to seek treatment (Boldero & Fallon, 1995; Girma & Tesafe, 2011; Gureje, Acha, & Odejide, 1995; Okello & Neema, 2007)). Salem, Yousef and Sabri (2009), also concluded that many patients suffering from psychiatric disorders seek non-professional care before attending specialized services. In addition, Ismail, Wright, Rhodes and Small (2005) made conclusions in their study among South Asian samples that patients commonly turned to traditional healers in search for better health. Conclusively, delay in professional help-seeking is a worldwide problem, and the treatment seeking can be delayed for years or even decades (Wang et al., 2007)

“The history of social psychiatry posits that cultural conceptions of mental illness have intense effects on help seeking, stereotyping, and the kinds of treatment structures we create for people with mental illnesses. The role of cultural conceptions in shaping these processes is still evident since large proportions of people with mental disorders remain untreated” (Kessler, McGonagle & Zhao, 1994, p11). Pathways into treatment are subject to a host of factors suggesting that individual’s beliefs and perceptions are still important. For example, Kisekka (1990) reported that while men are more likely to be taken to psychiatric hospital for treatment, because they are perceived as a threat, women with mental health problems seek treatment more commonly at shrines, churches, or with primary care providers for somatic complaints. In addition to the role of cultural conceptions in the treatment seeking process, attitudes towards professional mental health treatment may be an important factor in mental
health service seeking and utilization (Brown et al., 2010). Mentally ill patients who often end up at the psychiatric hospital as a last resort may more likely have negative attitudes toward professional mental health services. Still for others, this may be due to the lack of education or knowledge about the causes of mental illness and availability of effective treatment interventions by well-trained professionals. Others factors such as time, distance, shame, and religious beliefs may in addition prevent them from first looking to the professionals for treatment. People's attitudes are usually influenced by traditional beliefs in supernatural causes and remedies, and this belief system often leads to an unhelpful or health-damaging response to mental illness, stigmatization of mentally ill persons and those who attempt suicide, and reluctance or delay in seeking appropriate care for these problems (Okasha, 2002).

Research on severe mental illness, such as schizophrenia, has suggested that patients in developing countries may have a better prognosis in terms of functional and clinical outcomes than those in developed countries (Hopper & Wanderling, 2000). In addition, it is noted that seeking appropriate treatment at the early onset of mental illness is essential for better prognosis and the improvement of the quality of life of the individual (Bagder, McNiece, & Gagan, 2000; Girma & Tesfaye, 2011; Okello & Neema, 2007). These assertions may however not reflect in the Ghanaian population since it is common for health professionals and policy makers in Ghana to claim that the psychiatric hospital is “the last point of call” after treatment at shrines and churches has failed (Ae-Ngibise et al., 2010; Ewusi-Mensah, 2001; Ohene, 2002).

According to Girma and Tesfaye (2011), early recognition of the symptoms of mental illness and appropriate treatment is important to restoring the mental as well as the physical and
social health of an individual. It is in this vein that international campaigns to improve the
treatment of mental disorders in low-income countries emphasize the need to increase
knowledge about professional mental health treatment and access to psychotropic medication
as central to optimal treatment, particularly for psychosis or schizophrenia (Patel et al., 2007).
Considering that majority of patients with mental illness in Ghana still visit several places
such as traditional healers and spiritual healers (Dixon, 2012), others also choose the option
of self care at home. It is however unfortunate that practices by these healers have been a
source of much controversy since there have been concerns about the procedures that are
utilized by majority of these healers and the skepticism about the effectiveness of the
conventional treatments they employ (Ae-Ngibise et al., 2010; Read et al., 2009). In spite of
these, some studies have suggested the need to formally integrate efforts by traditional and
religious healers into the mental health care system in Ghana since the cultural perceptions
that relate to mental illness will always influence indigenous individuals to always seek them
(Read & Doku, 2012). Others also argue that it is important because the actions of the
traditional and religious healers only represent an attempt to cater for the severely ill in the
absence of formal support (Dixon, 2012)

1.2 Problem Statement

Mental and behavioural disorders are common, affecting more than 25% of all people at
some time during their lives. They are also universal, affecting people of all countries and
societies, regardless of age, gender and income (WHO, 2011). Literature on treatment
seeking or help seeking behaviours among mentally ill patients from the early centuries have
often supported the notion that individuals who suffer from mental illness do not often visit
the psychiatric hospitals but rather, other informal sources of treatment (WHO, 2003). There
has been a carrion call to improve mental health literacy and mental health infrastructure to
enhance professional treatment seeking and close up the widening gap for mental treatment (Ofori-Atta, 2010). It is interesting to note that this situation of individuals resorting to professional care at the heightened level of their symptoms seem to be a global phenomenon (Boldero & Fallon, 1995; Girma & Tesafe, 2011; Gureje, Acha & Odejide, 1995).

Most low-income and middle-income countries give low priority to mental health policies despite evidence that mental disorders cause a high and growing disability burden and long-term effects on quality of life, and that treatments for mental disorders are relatively cost effective, compared with those for other conditions. “Scarcity of resources for mental health, inequity in access to them, and inefficiencies in their use have serious consequences, the most direct of which is that most people who need care get none” (Russel, 2008). The treatment gap—the proportion of those who need but do not receive care—is high for mental disorders in the Ghanaian population as indicated by WHO (2001). We cannot escape the deduction that most of those who need care for mental disorders do not receive effective care. The consequences include an enormous amount of disability, human suffering, and economic loss. Admittedly, treatment seeking behaviours cannot be deduced from one or various isolated factors. For example, a certain treatment seeking practice can be correlated with only etiology, but in the illness models, etiologies often have other implications that give meaning to behaviour (Okasha, 2012). To be able to correctly understand treatment seeking behaviours, these factors need to be contextualized.

Jorm et al. (1997) found that the public’s beliefs about mental disorders and the best treatment options differ greatly from the beliefs of health professionals. This means that patients with mental illness may have very different views from health practitioners about what interventions are helpful for them, what influences their help-seeking behaviour and
adherence to treatment. Consequently, it would seem important to prioritize the patient’s perspective in designing treatment. This also means that it is important that health professionals are aware of their patients’ lay beliefs about illness and the alternative treatments that they may choose (Ismail et. al., 2005)

In recent times, there has been tremendous effort to address the ailing situation of the mental health service delivery in Ghana. “a new impetus for mental health in Ghana has seen the establishment of mental health NGOs, the drafting of a new mental health bill, increased training for psychiatrists and psychiatric nurses, proposals for training new cadres of primary health care specialists in mental health, and increased media attention” (Read & Doku, 2012, p29). However as previously stated, the popularity of prayer camps and shrines in the treatment of mental disorders in Ghana cannot be disregarded (Read & Doku, 2012). Turkson (1997) suggested that epidemiological studies of mental illness in Ghana should include beliefs about mental illness as well as factors influencing treatment seeking decision-making. Overall, there is the need for mental health research to focus attention on the help seeking or treatment seeking decision-making among Ghanaians and the factors that influence these decisions as there seem to be a general perception that psychiatric treatment has still not gained much popularity among many Ghanaians.

1.3 Aim and Objectives of the Study

The main aim of the study is to find out how mentally ill patients in Ghana perceive their illness, and how attitudes toward professional mental health treatment and demographic variables influence their treatment seeking behaviour. The study is driven by the following specific objectives:
1. To examine illness perceptions of people living with mental illness and to find out if difference exists between mentally ill patients and sickle cell patients.
2. To examine the choice of treatment for patients who have positive attitudes toward professional mental health treatment and those who have negative attitudes toward professional mental health.
3. To explore the demographic predictors of mental illness treatment seeking behaviour.
4. To examine the effect of type of mental illness diagnosis on onset of treatment seeking.
5. To determine if a significant difference exist in the choice of treatment among persons living with mental illness.
6. To examine the general health of mentally ill patients who contact the psychiatric hospital first for treatment and those who do not.

1.4 Relevance of the Study
To date, little research has examined how individual illness perception and attitudes towards professional mental health treatment influence treatment seeking specific to Ghanaians. International campaigns to improve the treatment of mental disorders in low-income countries emphasize the need to increase health literacy especially concerning etiology and risk factors for mental disorders, their signs and manifestations, and help seeking in general (Avanzo et al., 2012). Others have also called for mental health services integration (Abbo et al., 2009) and access to psychotropic medication as central to optimal treatment, particularly for psychosis or schizophrenia (Patel et al., 2007). The improvement of psychiatric treatment may not necessarily be beneficial to the mentally ill in Ghana if steps are not taken to improve access to these treatments. To be able to improve access would mean finding out the
factors that hinder access or the decision to seek these treatments in the first place. The decision to seek out health services is a complex decision. For any study into the reasons underlying health provider choices and health seeking behaviour, it is important to identify the health providers that individuals frequent (Russel, 2008).

The present study will therefore seek to examine the varying factors that influence the treatment seeking behaviours of these patients, which will in turn inform policy-making decisions in mental healthcare in the formal sector. The findings of the study will also examine factors that may cause patients to seek other treatment choices such as traditional and religious treatments. It is believed that when these factors are addressed the formal healthcare system in Ghana and its treatment methods will become more attractive and accessible to patients.

In conclusion, identifying the key factors relevant for the treatment seeking behaviour of mentally ill patients is helpful for planning health policy interventions. In addition, a systematic analysis of the sequence of treatment options will provide insight into patient’s patterns of resort and suggest a tentative theory for how lay people make medical choices, which is the impetus of the present study.
CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction
The main aim of the present study is to find out the factors that influence coping and treatment or help seeking behaviour among the mentally ill in Ghana. The theories relevant to the study are reviewed in this chapter. The chapter also includes review of related studies. The review of related studies covers four main areas namely; mental illness and treatment seeking behaviour, availability of mental health services and treatment seeking, socio-demographic variables and treatment seeking behaviour and perceptions of mental illness and treatment seeking behaviour. The chapter also discusses the rationale of the study, statement of hypotheses and operational definition of terms.

2.2 Theoretical Framework
The present study employs two different theories, which are relevant in explaining possible determinants of treatment seeking behaviour or decision-making among the mentally ill. These theories are discussed as follows:

2.2.1 Illness Perception Model (Levantal, Nerenz & Steele, 1984)
The illness perception model postulates that individuals form common-sense beliefs about their illness in order to understand and cope with health threats (Levantal et al., 1997). Individuals are seen as actively trying to understand their symptoms and illness. This process of understanding is what drives the patient’s coping and emotional responses to the health threat or illness. The process is an on-going one whereby information about the illness or changes in symptoms may cause a re-appraisal of the individual’s perceptions of the illness.
This may in turn cause a shift in the patient’s coping patterns, help seeking or emotional response.

The illness perception model has proven its utility in the prediction of behaviour in individuals suffering from physical illness or injury. The focus has now shifted to how illness perception could be applicable in mental health problems. Research has revealed that patient’s perceptions about their illness are usually around five main components. These components have been well established in physical illness but it is likely there may be some differences in patients with mental illnesses. The first of these components are the causal beliefs patients have about their illness. Causal beliefs are often prominent after the diagnosis of an illness, as the individual seeks to understand why they have developed the condition and these beliefs are often drawn from common cultural understandings about a particular illness (Petrie, Broadbent & Kydd, 2008). Causal attributions may also influence the type of treatment patients seek out for their condition and the types of lifestyle changes they make to try and manage or eradicate their illness. Research has for example shown that psychosocial factors are often believed by the public as the likely cause of depression whereas organic disorders such as a genetic problem or a brain disorder are seen as the most likely causes of schizophrenia (Jorm et al., 1997a; Schomerus, Matchinger, & Angermeyer, 2006). Based on these causal beliefs, psychotherapy tends to be preferred over medication in the treatment of depression, while medication is seen as more appropriate for disorders seen as having biological causes; such as schizophrenia (Jorm et al., 1997b; Lauber, Nordt, & Rossler, 2005).

Other components of illness perception include identity (thus symptoms the patients believe to be part of the illness and illness categorizing), perception about the timeline or duration of
the illness (acute or chronic), perception of control or cure (how the condition is treated and the effectiveness of available treatment methods) and consequence which is the perceived effect or outcome of the illness on the patient’s life.

2.2.2 Health Service Utilisation Model (Andersen & Newman, 1973)

This model also referred to as the Andersen or socio-behavioural model posits that three factors influence health behaviour; predisposing factors, enabling factors and need factors. The model was specifically developed to investigate the use of biomedical health services. Later versions have extended the model to include other health care sectors, traditional medicine and domestic treatments (Weller, Ruebush & Klein, 1997). The predisposing factors include age, gender, religion, prior experience of illness, education, general attitudes towards health services, and knowledge about the illness among others. Enabling factors include availability of services, financial resources to afford services and social support. Finally, need factors according to this model are, perception of severity, total number of days in bed, days missed from school or work, and help from outside to give care. A combination of these factors will lead to a treatment action that could be self- treatment, traditional healers, primary care giver among others.

Kroeger (1983) revised Andersen’s model through extensive literature review and concluded that there are several interrelated explanatory models that influences health behaviour. These factors just as Andersen model are grouped into three; firstly, an individual’s traits or predisposing factors which include age, sex, marital status, status in the household, household size, ethnic group, degree of cultural adaptation, formal education, occupation, assets (land, livestock, cash, income), and social network interactions. Secondly, characteristics of the disorder and their perception which include chronic or acute, severe or trivial, etiological
model, expected benefits of treatment (modern versus traditional), and psychosomatic versus somatic disorders. Finally, characteristics of the service (health service system and enabling factors): accessibility, appeal (opinions and attitudes towards traditional and modern healers), acceptability, quality, communication and costs.

Kroeger’s (1983) model is very relevant to the present study as it predicted that patient’s perceptions about mental illness, attitudes towards professional mental health services, type of illness and some socio-demographic variables would influence treatment seeking behaviour. Following from the model, socio-demographic variables are the predisposing factors or individual traits, illness perception and type of illness represent the characteristic of the disorder and their perception while attitudes towards professional mental health services represent characteristics of the service or health service system and enabling factors. The interplay of these variables will predict treatment seeking behaviour.

2.3 Review of Related Studies

2.3.1 Mental Illness and Treatment Seeking Behaviour

Treatment seeking behaviour in cases of mental illness is determined by several factors. For instance, a study by Mensah and Yeboah (2003) using 1,290 Ghanaian psychiatric patients reported that over 80% stopped or interrupted psychotropic medication due to reasons such as side effects (fatigue and drowsiness), a preference for healing from spiritual churches, and feeling better.

Similarly, a study done in Nigeria among 81 schizophrenic patients who have undergone psychotropic treatment revealed that about 50% did not return for follow-up, and adherence to antipsychotics was poor, even among those who responded well to treatment (Adeponle,
Baduku, Adelekan, Suleiman, & Adeyemi, 2009a; Adeponle, Thombs, Adelekan, & Kirmayer, 2009b). The most common reason for default was feeling well, followed by financial difficulty, side effects, distance from psychiatric services, and feeling embarrassed about the illness.

Help seeking as far as mental illness is concerned can be formal (thus seeking professional help) or informal (help from other sources either than professional). It is very common for individuals to seek one form of help or the other or sometimes seek both. People may seek informal help at the beginning of problem and then seek professional help when they see the need. In a survey among 710 Italian students, Avanzo et al. (2012) investigated the most preferred source of help for mental health problems between informal and formal. Results showed that only few of the sample reported that they would not seek any form of help at all (9%). The most preferred source of help was friends, followed by parents, then partner, and then psychologist and psychiatrists. The least preferred source of help for these participants was the clergy. A significant number of the participants reported that they would seek both formal and informal treatment (55%); few said they would seek formal help only (5%). There were gender differences when it came to preference of help from friends and psychologist, with more females preferring help from friends and psychologist than males.

From the above study, it is clear that help seeking among the sample studied does not necessarily differentiate between formal and informal help seeking as majority said they would seek both. Rather, it implies that help seeking is a general attitude and thus it does not matter the source of help that is sought but what may be important is the perception of effectiveness of a particular source to provide the help needed. It is also not surprising that friends are the most preferred source of help. These are adolescents hence friends play an
important role in their lives. This raises a question about whether age influences help-seeking behaviour among people with mental health problems. What is however not clear from this study is the pathway to help seeking; thus, which source would be contacted first before the next. It is possible close relations will be contacted initially and depending on the outcome of the guidance provided, an individual may then turn to professional help.

In a related study of 522 Australian secondary school students on mental health literacy and eating disordered behaviour; the beliefs of adolescent girls on treatment and treatment seeking of Bulimia nervosa was conducted by Mond et al. (2007). Results showed that primary care practitioners, mothers and close female friends were most highly considered as potential sources of help. Self-help interventions, such as the use of vitamins and minerals, were also highly regarded, while participants were less positive about the benefits of mental health specialists and ambivalent about the use of anti-depressant medication. Most participants believed that the problem described would be difficult to treat, and that relapse was likely even with the appropriate treatment. An additional finding of note was that among participants with a high level of eating disorder symptoms, recognition of the fact that they had an eating problem was poor. The researchers concluded that beliefs likely to be conducive to low and/or inappropriate treatment-seeking for eating problems may be common among adolescent girls. This study suggests that there are certain psychological problems that individuals tend to believe a mental health professionals help would not be of help. An example in this case is eating disorders. Given this situation, they would therefore seek help from other sources either than mental health specialists since they do not believe they might benefit from mental health treatment. From this assumption, it is not erroneous to conclude that the type of illness may not necessarily predict whether a person would seek help or not but would highly predict the type of help or treatment an individual would seek.
Hence beliefs about the effectiveness of a particular type of treatment are very crucial in determining the source of treatment to seek.

Mond et al. (2004) in another related study found out that young adult women mostly said they would seek the help of a general practitioner first. However there was an age effect whereby older participants (33-45 years) chose the general practitioner as the one to approach first while the younger participants (18-32) more often chose a family member or close friend. This confirms an earlier argument that age may influence treatment seeking behaviour, especially the source from which help would be sought.

To examine psychological processes that influence the decision-making process to contact primary care in individuals with emerging psychosis, Skeate, Jackson, Birchwood and Jones (2002) investigated the influence of coping style, health locus of control and past health help-seeking behaviour on duration of untreated psychosis. The researchers used patients from two urban mental health facilities who qualified for the diagnosis of schizophrenia and were in the early stages of treatment. About 42 participants were involved in the study. Results revealed that those with a long duration of untreated psychosis are more likely to use avoidance as coping strategy when faced with health threat and are less likely to have visited their general practitioner in the last 6 years before the onset of their illness than those with short duration of untreated psychosis.

The finding signifies that psychological factors play a role in help-seeking behaviour. Thus individuals who are generally blunted to health threats are less likely to seek treatment during illness. The duration of untreated psychosis is then prolonged since those who visited their general practitioners in the last 6 years before the psychosis also had a brief duration of untreated psychosis before seeking help. The question about what factors makes an individual
endure illness without seeking help for a long duration of time has thus become relevant at this point.

2.3.2 Availability of Mental health Services and Treatment Seeking

There exist diverse mental health treatment services provided from various sources (both formal and informal) globally, and an individual may decide to choose a particular service based on several factors (Desjarlais, Eisenberg, Good, & Kleinman, 1995). For instance studies in Haiti has uncovered that in Haiti, illness explanations and help-seeking behaviours vary greatly depending on factors such as location, religion and social class (Derosiers & Fluerose, 2002). Individuals use resources rationally, and often hold multiple or hybrid models of health and illness. As a result, the same person may seek help from multiple sources, when available. Mentally ill people can also be seen as victims of powerful forces beyond their control and thus receive the support of the community (Derosiers & Fluerose, 2002). However, shame may be associated with the decline in functioning in severe mental illness and the family may be reluctant to acknowledge that a member is ill (Gopaul-McNicol, Benjamin-Dartigue, & Francois, 1998). This will certainly interfere with decision to seek treatment.

Salem, Saleh, Yousef, and Sabri (2009) reported that many patients suffering from psychiatric disorders seek non-professional care before attending specialized services. This can be attributed to the various beliefs that individuals hold about the causes of mental illness. Contrary to this report however, a quantitative survey of 1000 women in Accra by Ae-Ngibise et al. (2010) reported that most (88%) of the respondents said they would seek help from the psychiatric hospitals and only a minority (8.2%) said they would consult traditional healers.
Mental health treatment sources (other than medical treatment) in Ghana are varied. “Akomfo” (‘‘traditional healers’’) and Pentecostal ‘‘prayer camps’’ also offer treatment for mental illness. Studies of help seeking for chronic conditions such as diabetes and HIV/AIDS in Ghana similarly reveal that whilst medication may alleviate symptoms, failure to eradicate the disease can prompt a search for other forms of treatment (Awusabo-Asare & Anarfi, 1997; de-Graft Aikins, 2003; Mill, 2001). Ohene (2002), a Ghanaian psychiatrist, noted that patients who attend hospital with symptoms of mental illness expect that medication will effect a “total cure” (p. 47) a failure to do so may lead to the conclusion that medical treatment has failed.

In Tanzania, Whyte (1991) also found that, whilst psychotropic drugs were said to have ‘‘helped a bit,’’ only traditional healers were believed to bring about complete recovery since only they addressed spiritual causes. As Teuton, Dowrick, and Bentall (2007) argued, “the limited influence and apparent ineffectiveness of allopathic medicine in mental health provide a rationale for spiritual explanations and interventions for “madness”’’ (p. 1271). This signifies that availability of professional mental health services alone does not predict whether a person will seek professional treatment or not but the perceived effectiveness of the available services is an important determinant.

Asante et al. (2010) have also reported that many Ghanaians took combinations of “abibiduro” (African medicine) and pharmaceuticals, as well as “going for prayers” at church. One pastor put this way, “aduro kakra, mpaebob kakra”—“a little medicine, a little prayer”. This was the case even for conditions such as malaria when a “natural” causation, a mosquito bite, and the effectiveness of antimalarial medication is widely recognized. In effect, this approach to healthcare in the perspective of most Ghanaians “covers all bases”,
thus addressing spiritual factors if these are suspected; beseeching God’s grace to empower the medicine; and perhaps adding a herbal tonic to enhance bodily strength.

Some studies have suggested that traditional and religious healers are consulted at some stage by many patients with mental illness. Such healers are mostly the first care-givers to a large proportion of the patients. These patients are not different from those who consult orthodox medical practitioners either in demographic features, presenting complaints, or nearness to service (Gureje, Acha & Odejide, 1995). Nsereko et al. (2011) conducted a research that revealed that in some Ugandan communities, help for mental problems are mostly sought from traditional healers initially whereas western form of care is usually considered as a last resort. The factors found to influence help seeking behaviour within the community include: beliefs about the causes of mental illness, the nature of service delivery, accessibility, cost and stigma.

In contrast however, other studies have also revealed that more people seek professional treatment first and only few people seek help from traditional or religious healers at the initial stage of their illness. For instance a study done by Appiah-Opoku, Laughaurne, Mensah, Osei and Burns (2004) which sought to find out previous help sought by patients presenting to mental health services in Kumasi-Ghana, revealed that out of the 322 patients, presenting to the four study sites, only 6% saw traditional healers and 14% saw a pastor before reporting to the health center and many had previously used other mental health units in Kumasi. This signifies that the trend of treatment seeking in modern times may probably be changing.
2.3.3 Socio-demographic variables as related to treatment seeking behaviour of the mentally ill

Some socio-demographic factors have been suggested by research to predict treatment seeking behaviour. Ethnicity has been one of such factors identified in the literature. An example is a study by Shim, Compton, Rust, Druss and Kaslow (2009) using a national co-morbidity survey replication among Non-Hispanic whites, African-American and Hispanic race with the aim of investigating the influence of race-ethnicity and some socio-demographic factors on attitudes and beliefs towards treatment. The researchers, based on previous studies, predicted that ethnic minorities were more likely to have a more negative attitude towards mental health treatment. Contrary to predictions, results suggests that African Americans and Hispanics (minority) may have more positive attitudes toward mental health treatment seeking than non-Hispanic whites. According to the United States Surgeon’s General (2001) however, when it comes to mental health services utilisation, it is reported that racial-ethnic minority groups report lower rates of accessing mental health services. This has been attributed to negative attitudes towards mental health treatment. The result from Shim et al.’s (2009) study using a large sample suggests that other factors rather than negative attitudes may account for the lower rates of mental health services utility among racial minorities. This implies that ethnicity in itself does not predict treatment seeking behaviour but the relationship may be mediated by other factors.

A study by Sorsdahl et al. (2009) in South Africa on traditional healers in the treatment of common mental health problems found out that about 13% of the respondents consulted traditional and religious healers while 21% consulted Western treatment only while 7% consulted both western and alternative treatment. Treatment seeking from a traditional healer was found to be predicted by some socio-demographic variables such as older age, black
race, unemployment, lower educational background, experiencing a traumatic event and having an anxiety or substance-related disorder. After adjusting for the effects of other variables in the model, participants older than 50 years had an increased likelihood of consulting a traditional healer compared to the 18–29 year olds. Black respondents were 9.1 times more likely to consult traditional healers than white, coloured and Asian respondents. Having completed high school decreased the odds of consulting a traditional healer. Also, having an employment, having a substance abuse disorder or an anxiety disorder was associated with consulting a traditional healer for emotional and mental health concerns. This particular study draws attention to the relevance of socio-demographic variables in treatment seeking.

Studies investigating the influence of socio-demographic variable on treatment seeking behaviour have been conducted in cases of physical illness. This in a way can help in understanding treatment seeking when it comes to mental health problems. In Grover, Kumar and Jindal’s (2006) study where they looked at socio-demographic determinants of treatment-seeking behaviour among chest symptomatics in Northern India, they found out that about 67% of participants had taken some self-initiated action to seek help. The first initiated action however varied by socio-demographic variables. There was significantly more number of urban people (93.9%) who took self-initiated action at home than the rural people. Also, more males, people from higher socioeconomic background, and older people (46-65 years) started self-treatment but this wasn’t statistically significant. About 66% had contacted health agency for treatment and as the age advances, more people contact a health agency for help. Out of the participants who sought help from a health agency, 34.4% had gone to private allopathic practitioner and 33% had gone to government health agencies. More males had seen private
allopathic practitioners than females. Overall, more rural respondents endured symptoms for a longer duration before seeking help than the urban respondents.

In another study aimed at investigating gender differences in delayed treatment seeking behaviour for cataracts, Tanchangya, Khan, Bayashakh and Wichaidit (2012) analysed existing clinical records for patient characteristics based on sex and the role of gender in delayed cataract surgery. Findings showed that, after controlling for hypertension, diabetes, side of eye with cataract, and age above 65, women were more likely to come to surgery at a later stage (thus after VA became less than 6/60) than men (adjusted odds ratio = 1.19). Gender therefore seems to play a role in treatment seeking behaviour with females less likely to seek early treatment as compared to males. The study was however done in Bangladesh which practices a patriarchal and more conservative social system (Tanchangya et al., 2012) in which women’s mobility and independence is limited. In their context, decisions-making concerning healthcare does not entirely depend on the woman but her parents or husband. Women will therefore only seek treatment when these significant others deem it necessary. This finding might therefore not apply to more liberal societies where women are empowered to take major decisions and responsibilities.

In Contrast to Tanchangya et al.’s (2012) study, Mackenzie, Gekoski and Knox’s (2006) also explored age, gender differences and underutilization of mental health services as the influence of help-seeking attitudes. Their study revealed that older age and female gender were associated with more positive help-seeking attitudes. Age and gender also interacted with marital status and education and had varying influences on different attitude components. Age and gender in addition, influenced intentions to seek professional psychological help. While women exhibited more favourable intentions to seek help from
mental health professionals than men; older adults exhibited more favourable intentions to seek help from primary care physicians than younger adults. This shows that findings on the role of age and gender in predicting treatment seeking behaviour are thus inconsistent.

In another study investigating gender differences in teen willingness to use mental health services conducted by Chandra and Minkovitz (2006), it was found that gender differences exists in treatment seeking as girls were twice as likely as boys to report willingness to use mental health services. Boys were also found to have less knowledge and experience with mental health and perceived more stigma than girls. Utilisation was influenced by parental control as those who turned to parents were more likely to seek formal help. This implies that there is more parental control for girls compared to boys.

2.3.4 Mental illness perceptions and treatment seeking behaviour

Various researches give evidence to the fact that causal knowledge about mental illness is very diverse in the Ghanaian community. It cannot be argued however that the various beliefs and perceptions are entirely bad in themselves because for example, the widespread belief that misuse of drugs is the cause of mental illness may be regarded as good, in view of its possible restraining effect on the use of illicit or psychoactive substances. However, since this is only true for a very limited number of mental disorders, and since the public often views the misuse of substances as a moral failing, this belief may translate to a notion of mental illness as being self-inflicted. Such a view is more likely to elicit condemnation rather than understanding or sympathy. Beliefs about mental illness are very crucial in treatment seeking and adherence to treatment (Helman, 2000, Ismail et al. 2005 & Ae-Ngibise, 2010)
Vanheusden et al. (2009) in their study sought to investigate beliefs about mental health problems and its influence on treatment seeking among Dutch young adults. They looked at beliefs about cause, consequences, controllability and timeline of mental health problems and treatment seeking. 2,258 young adults were used in a cross-sectional survey. Results revealed that belief in intra-psychic causes, negative consequences, and treatment control were associated with increased probability of mental health service utilization while higher levels of personal control were associated with less likelihood of service use; with treatment control and negative consequences being very strong predictors of mental health service use. This means that when one believes that the causes of mental health problem are intra-psychic and that there are adverse consequences for mental illness and they believe that treatment would help them, they are more likely to seek professional mental health treatment whereas when the person believes that he or she could help themselves, then they are less likely to seek treatment. This clearly shows that knowledge about mental illness is very crucial to treatment seeking behaviour. An interesting observation made is that there was an interaction effect between personal control and sex. Personal control was linked with decreased service use in male while it was not significant in females.

In a study by Adewuya and Makanjuola (2008), beliefs in supernatural factors and the misuse of psychoactive substances were the most prevalent perceptions about the causes of mental illness. Consequently, there is a widespread appeal for traditional healers to treat mental illness. It is also evident that views about causation are strongly associated with stigmatizing attitudes to mental illness (Haghighat, 2001; Hayward & Bright, 1997). Traditional beliefs that attribute psychiatric disorders to moral transgression and view patients as dangerous lead to feelings of shame and fear of persons with mental illness. Such community values and beliefs influence treatment seeking behaviour, treatment outcomes, and even determine the way mental health is practiced (Gater et. al. 1991; Nguyen, 2003).
Beliefs regarding the causes of mental illnesses can either be the natural or the supernatural. These beliefs vary depending on an individual’s level of education and socioeconomic background. In less educated areas of the countryside, there exist a number of supernatural explanations of mental illness which include possession by spirit, black magic, or astrological misalignment (Gater et al. 2005).

In Abbo’s (2011) study in which she used a mixed method design to investigate profiles and outcomes of traditional healing practices for severe mental illness in two districts in eastern Uganda, it was found out that the communities had local names for mania, schizophrenia and psychotic depression. They also had multiple explanations for the mental illnesses, hence sought treatment from multiple sources. More than 80% of the patients with psychosis had used both biomedical and traditional healing systems, with those who combined the two having a better treatment outcome.

A study conducted in Haiti by Desrosiers and Fluerose (2002) revealed that among this population, mental illness, problems in daily functioning and problems in academic achievement may all be seen as the consequences of a spell, a hex, or a curse transmitted by a jealous person. In such cases, people generally do not blame themselves for their illness or see themselves as defective. Rather, based on this notion of etiology, there exists the perception that a curse is often aimed at a person who is deemed attractive, intelligent, and successful. Mental illness is also occasionally attributed to failure to please spirits, including those of deceased family members (Desrosiers & Fluerose, 2002). This external attribution may influence recovery, in that people can call upon the “lwa-s” (spirits) to intervene on their behalf to assist healing. Hence, people often rely on their inner spiritual and religious strength to deal with their problems.
Research conducted in other parts of the world within the paradigm of mental health literacy has revealed that the knowledge and beliefs of the public concerning mental disorders are generally not helpful to the use of evidence-based treatments (Jorm, 2000; Jorm et al., 1997). For instance, Jorm (2000) reported that members of the public have been found to be skeptical about the benefits of specialist treatment for mental disorders, while preferring the use of self-help interventions and alternative therapies. There also is a perception that treatment is difficult and ineffective in the long term. There is a wide variety of influences of people’s beliefs about the causation of illness on treatment, which may include culture and religion. These causal beliefs of mental distress were found to be significant predictors of attitudes towards help seeking among British Asians (Jorm, 2000).

This evidence in addition to others aforementioned, all point to the fact that a person’s beliefs or perception about mental illness has a great influence on the type of help they would seek. If a person views mental illness as spiritual or originating from a supernatural source then they are more likely to seek treatment from mental health services that treat mental illness from the supernatural or spiritual perspective. On the other hand, if the person believes that mental illness is a medical condition, he or she would seek medical treatment first.

In Ghana for example, we often hear statements such as “3nye hospital yade3”, (“it is not hospital illness”) which reflects the fact that there are certain illnesses that are seen as ones to be treated in the hospital especially some physical illnesses and others are not. A recurring illness fuelled suspicions of “something behind it” such as witchcraft, demonic possession or a curse, in which case it would lie beyond the reach of the hospital doctor and his pills, however potent (Konadu, 2007, p. 164). ‘‘Spiritual sickness’’ is defined in opposition to
“hospital sickness,” precisely because chronic illness by definition cannot be cured by medical science. The failure of psychiatry to achieve a permanent cure therefore confirms its spiritual nature.

Jegede (2002) asserts that among the Yoruba people of Nigeria, culture influences perceptions about illness and thus influences treatment seeking behaviours. Ill health among Yoruba people is attributed to negative destiny (“ayanmo buruku”) while good health is attributed to positive destiny (“ayanmo rere”). Individuals will usually patronage the traditional healing system first in case of illness, and only seek the hospital treatment when all other attempts have not been successful.

However, the argument that beliefs about etiology of illness influence the choice of treatment option may not apply to all patients. This was revealed by a study conducted in Ethiopia by Girma and Tesafe (2011). Findings from this study showed that there was a paradox between belief about the causes of mental illnesses and the type of treatment sought, as a large proportion of respondents felt that mental illness was caused by supernatural means but also believed that it was curable by biomedical treatment. Modern psychiatric services in Ethiopia like many other developing countries are very scarce, inaccessible, and relatively expensive for the majority of the population. Therefore, patients usually resort to modern mental health-care services only after they have failed to recover after receiving traditional treatments. It is also a common practice in Ethiopia for family members to care for and support persons with mental illness at home.

This clearly shows that treatment seeking behaviour among this population is not necessarily influenced by beliefs about etiology of illness but rather the availability and accessibility of the treatment options. Rural populations for instance have inadequate access to care, since
mental health professionals in most low-income and middle-income countries tend to live in and around the largest cities. In the case of Ghana, majority of people travel long distances to receive mental health treatment at the three psychiatric hospitals; namely, Accra Psychiatric Hospital, Ankaful Hospital and Pantang Hospital which are located in the southern part of the country. Thus, there is imbalance in the coverage of mental health problems in the country.

It has therefore become necessary to move beyond perceptions or beliefs about mental illness and its influence on help seeking to look at other factors that may influence help seeking among people with mental illness. In view of this, there is growing interest in patients' representations of their illness for understanding and the psychological impact of illness (Skelton & Croyle, 1991). Interest has also risen in explaining patterns of care seeking and adherence to treatment advice (Cameron, Leventhal & Leventhal, 1993; Leventhal & Cameron, 1987) and examining the responses to psychological interventions, particularly those with a cognitive-behavioural focus (Pimm, Byron, Curson & Weinman, 1994).

Nsereko et al. (2011) conducted a study among a Ugandan sample and this revealed that factors that influence help-seeking behaviour within the community include beliefs about the causes of mental illness, the nature of service delivery, accessibility, stigma and cost.

Indeed, perceptions of stigma can also influence the kind of help sought. Rew’s (1997) study with Hispanic young women in the United States revealed that they tended to seek informal help when the need was sexual or psychological, because those needs were seen as particularly sensitive. By extension, in communities where the perception of stigma associated with mental health problems is high, individuals will less likely seek formal treatment since that would mean accepting “madness”.
2.4 Summary
This study discussed theories related to the treatment seeking behaviour of patients living with mental illness and literature based on the demographic variables of patients, attitude toward professional mental health services and illness perceptions as they relate to treatment seeking behaviour were examined.

2.5 Rationale of the Study
Globally, numerous researches have studied the treatment seeking or help seeking behaviours for mental illness. emphasizing on the pathways to care, attitudes of the mentally ill toward professional mental health seeking, the barriers to treatment seeking and what influences individuals to choose a particular source of treatment over the other (Aniebue & Ekwueme, 2009; Bekele, Flisher & Basheretebeb, 2003; Gater et al.,1991; Girma & Tesfaye (2001).

According to Read and Doku (2012), however, there is little attention on beliefs and attitudes towards mental illness in Ghana, which may influence help-seeking behaviour, although there is much speculation among the general population about the spiritual attribution of mental illness. In Ghana, help-seeking behaviours have generally been viewed in a limited fashion where a few studies over the years have provided current information on the pattern of treatment seeking, types of diagnosis and the socio-demographic factors influencing the orientation towards help-seeking (Fosu, 1995).

In their literature review of mental health research in Ghana, Read and Doku (2012) concluded that there is still a limitation in both qualitative and quantitative research in the area of mental health among Ghanaian samples.
Reviewing literature available in the Ghanaian arena, none of these studies had specifically looked at the treatment seeking behaviour of people living with mental illness in regional psychiatric hospitals in Ghana and to specifically examine how attitudes toward professional mental health services influences the choices these individuals make.

Furthermore, unlike studies that examined the treatment seeking behaviour of mental patients only this current study will further compare these behaviours with a control group of patients suffering from a much-related chronic medical condition (Sickle cell disease). This study will therefore provide a basis for comparison between these two samples. In similar fashion, the study will also provide further knowledge on the reported general health of patients who seek formal treatment right from the onset of symptoms and others who delay in seeking formal treatment.

In conclusion, this current study is intended to bridge the gap between global studies of the treatment seeking behaviours of mentally ill patients with that of Ghanaian samples and in addition make comparisons with a control group.

2.6 Statement of Hypotheses

From the theories and related studies reviewed, the following hypotheses were proposed:

1. There will be a significant difference in the perceived causes of illness among people living with mental illness and those with a chronic medical condition like sickle cell disease.

2. There will be a significant difference in the perceived timeline, control and consequences of illness among people living with mental illness and those with a chronic medical condition (SCD).
3. Attitudes toward professional mental health treatment will be strongly associated with the choice of psychiatric hospital as the first treatment option by mentally ill patients.

4. Demographic variables (age in categories, gender, marital status, educational background, religion, employment status, and income level) will predict treatment seeking behaviour significantly.

5. The type of mental illness diagnosis will have a significant association with onset of treatment seeking.

6. There will be a significant difference in the first choice of treatment among persons living with mental illness, with more patients choosing traditional or religious healers than psychiatric treatment.

7. Mentally ill patients who visit the psychiatric hospital as a first choice of treatment will have a more positive general health than those who do not.

**Research Variables:**

**Independent variables:** illness perception (cause, timeline, consequence, cure/control), attitude toward professional mental health treatment and demographic variables (age, income, employment status, marital status, education and region of residence).

**Dependent variable:** treatment seeking behaviour (early treatment, late treatment and source of treatment) and general health.
2.7 Operational Definition of Terms

Treatment seeking behaviour: early and late treatment seeking and the source of treatment sought (formal and informal supports) including psychiatric hospital, general hospital, traditional healers and religious leaders.

Illness perception: the perceived cause, timeline, consequences and cure/control of a patient’s own illness representations as measured by the illness perception scale

Attitude toward mental health treatment: the attitudes of patients toward professional mental health treatment services

Positive attitude toward professional mental health treatment: includes all patients who scored above 52 (the overall mean) on the Attitude toward mental health treatment scale.

Negative attitude toward professional mental health treatment: includes all patients who scored less than the total mean of participants (52) on the Attitude toward mental health treatment scale.

Early treatment seeking: to seek treatment within the first six months of the onset of illness symptoms.

Late treatment seeking: to seek treatment after the first six months of the onset of illness symptoms.
CHAPTER THREE
METHODOLOGY

3.1 Introduction
This chapter provides detailed information on the research design employed in achieving the research objectives in addition to methods used in the collection of empirical data (instruments), characteristics of study population, research design, sample, sampling technique, and procedure for data collection.

3.2 Population
The population for this study consisted of all persons with psychiatric illnesses receiving care at the three psychiatric hospitals in Ghana, namely, Accra Psychiatric Hospital in the Greater Accra Region, the Pantang Hospital also in Accra and Ankaful Psychiatric Hospital in the Central Region of Ghana. These three facilities were chosen because they are the three publicly recognized to provide care for persons with any form of mental illness. Participants who served as controls were sampled from Sickle Cell Disease (SCD) patients at the Ghana Institute of Clinical Genetics (GICG) at the Korle-Bu teaching hospital. SCD patients were considered as appropriate because it is one of the common chronic illnesses in Ghana and like mental illness, is surrounded by myths and stigmatization. The GICG was chosen because it serves as the major referral point of care for persons living with SCD across the nation and thus, likely to be representative of the core of the population of persons living with SCD.

3.3 Participants/ Sampling Technique
One hundred and fifty patients made up of 100 persons living with mental illnesses and 50 persons living with sickle cell disease were purposively and conveniently sampled for the study. To determine the approximate sample size, a sample size determination table by
Krejcie and Morgan (1970) which is based on the .05 confidence level was used. The sample size of 150 was deemed appropriate after taking into consideration the availability of sample and purpose of the research. Patients living with mental illness were sampled from the three public psychiatric hospitals in Ghana, which are the Accra Psychiatric Hospital in the Greater Accra Region, the Pantang Hospital also in Accra and Ankaful Psychiatric Hospital in the Central Region of Ghana. SCD patients were sampled from the Ghana Institute of Clinical Genetics of the Korle-Bu Teaching Hospital. The sample characteristics are summarized in the Table 1 below;
Table 1

Demographic Characteristics of Participants in the Study

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mental Illness (n=100)</th>
<th>Sickle Cell Disease (n=50)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean=34.73</td>
<td>Mean=28.90</td>
</tr>
<tr>
<td>Age in years</td>
<td>SD=11.65</td>
<td>SD=10.07</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>65 (65%)</td>
<td>23 (46%)</td>
</tr>
<tr>
<td>Female</td>
<td>35 (35%)</td>
<td>27 (54%)</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>26 (26%)</td>
<td>8 (16%)</td>
</tr>
<tr>
<td>Single</td>
<td>72 (72%)</td>
<td>42 (84%)</td>
</tr>
<tr>
<td>Divorced/Separated</td>
<td>2 (2%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No formal education</td>
<td>6 (6%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Basic education</td>
<td>44 (44%)</td>
<td>9 (18%)</td>
</tr>
<tr>
<td>Secondary/Technical</td>
<td>29 (29%)</td>
<td>17 (34%)</td>
</tr>
<tr>
<td>Tertiary</td>
<td>21 (21%)</td>
<td>24 (48%)</td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christianity</td>
<td>82 (82%)</td>
<td>48 (96%)</td>
</tr>
<tr>
<td>Islam</td>
<td>15 (15%)</td>
<td>2 (4%)</td>
</tr>
<tr>
<td>Traditional</td>
<td>3 (3%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Employment Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>27 (27%)</td>
<td>12 (24%)</td>
</tr>
<tr>
<td>Unemployed</td>
<td>73 (73%)</td>
<td>38 (76%)</td>
</tr>
<tr>
<td>Income (GHC)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No income</td>
<td>70 (70%)</td>
<td>38 (76%)</td>
</tr>
<tr>
<td>Below 500</td>
<td>19 (19%)</td>
<td>5 (10%)</td>
</tr>
<tr>
<td>Between 500-1000</td>
<td>8 (8%)</td>
<td>4 (8%)</td>
</tr>
<tr>
<td>Between 1000-2000</td>
<td>1 (1%)</td>
<td>2 (4%)</td>
</tr>
<tr>
<td>Above 2000</td>
<td>2 (2%)</td>
<td>1 (2%)</td>
</tr>
</tbody>
</table>
From the table 1 above, the mean and standard deviation of the ages of participants are presented as well as the frequencies and percentages of other demographic variables.

### 3.4 Inclusion and Exclusion Criteria

#### Inclusion Criteria

Participants of the current study all met the following criteria:

- Clinically diagnosed mentally ill patients (based on DSM-5 criteria) for mental illness sample and clinically diagnosed sickle cell disease patients for control sample.
- Aged between 18 and 70.
- Ability to give consent in line with Institutional Review Board requirements. That is anyone who volunteered to participate by accepting the risks, benefits and procedures related to this study.

#### Exclusion criteria

Patients who fell under the following criteria were all excluded from the study:

- Patients who have no insight into their condition.
- Patients with sickle cell who were in crises.

### 3.5 Research design

This study seeks to examine the treatment seeking behaviour among persons living with mental illness and persons living sickle cell by using questionnaires to gather their views about their general health, illness perception, and attitudes toward professional mental health treatment. Thus, the study yields itself to a cross-sectional survey design, which involves collecting the required data from the respondents at one point in time using questionnaires. This design allowed for the selection of a cross-section of persons with mental illness and
persons with sickle cell disease to represent the populations of mental illness and sickle cell disease respectively.

3.6 Measures:

All patients (mental illness and sickle cell) were assessed using a questionnaire made up of information on their socio-demographic characteristics and three other questionnaires; General Health Questionnaire (GHQ), Illness Perception Questionnaire (IPQ) and the Attitudes toward mental health treatment (ATMHT). An adapted form of a prescribed set of questions from the Pathway to Care Encounter Form was also used to assess the treatment seeking behaviour of the respondents. The various measures are described into details below.

Pathways to Care Encounter Form (WHO, 2006)

The Pathway to Care Encounter Form is a format developed by the World Health Organization and it studies the pathways of patients with mental disorders (Gater et al, 1991). It has been used in several studies that were aimed at improving the understanding of prior care-seeking and treatment of patients seen at mental health services. The form gathers information on patterns of treatment seeking, durations and previous treatments before reaching the mental health service. A number of studies have successfully used this encounter form to make essential contributions to mental health care through their findings. Among the numerous researchers that used the Encounter form are Gureje, Acha and Odejide (1995), Girma and Tesfaye (2011), Amaddeo, Zambello, Tansella and Thornicroft (2001), Gater et al. (2005) and Bekele, Flisher and Baheretebeb (2003). An adapted form of this instrument was used in the present study to examine the treatment seeking behaviour of the participants in the study.
General Health Questionnaire-GHQ-12 (Goldberg, 1972)

The General Health Questionnaire (GHQ), which is a measure of current mental health originally developed by Goldberg in the 1970s, was used to assess the current mental health of the participants in the study. The scale asks whether the respondent has experienced a particular symptom or behaviour recently. Each item is rated on a four-point scale (less than usual, no more than usual, rather more than usual, or much more than usual). It gives a total score of 36 or 12 based on The GHQ-12 is brief, simple, easy to complete, and its application in research settings as a screening tool is well documented. The most common scoring methods are bi-modal (0-0-1-1) and Likert scoring styles (0-1-2-3). It gives a total score of 36 or 12 based on the selected scoring method. Higher scores indicate a poor general health and lower scores indicate a better general health. Various researches have used it and reports high. The GHQ-12 has been shown to have a Cronbach's alpha coefficient of 0.87 (Montazeri, et al., 2013). Cronbach alpha coefficient and evidence from various researches suggests that there is no tendency for the GHQ to work less efficiently in developing countries.

Illness Perception Questionnaire (Weinman, Petrie, Moss-Morris & Horne, 1996)

The Illness Perception Questionnaire (IPQ), which is a method for assessing cognitive representations of illness, was used to assess the views held by patients about their illnesses. The IPQ is a theoretically derived measure comprising five scales that provides information about the five components that have been found to underlie the cognitive representation of illness. The five scales assess Illness Identity - the symptoms the patient associates with the illness, Illness Cause - personal ideas about etiology, Illness Time-line - the perceived duration of the illness, Illness Consequences - expected effects and outcome and Illness Cure/Control - how one controls or recovers from the illness. In this current study, the items
that were used excluded questions on the illness identity subscale since it was not a focus of the study. Thus, items were limited to the constructs of illness cause, timeline, consequences and cure/control. The IPQ scale has been shown, through various studies to have good levels of both internal consistency and test-retest reliability. The timeline scale reports a Cronbach Alpha of 0.73, Consequences 0.83 and finally Control/Cure, 0.73. (Weinman, Petrie, Moss-Morris & Horne, 1996)

**Attitudes toward Mental Health Treatment (Fisher & Turner, 1970)**

A modified version of the Attitudes toward Mental Health Treatment Scale (ATMHT) was used in this research. The ATMHT comprises 20 items with a 4-point likert scale, and is intended to reflect an individual’s attitude toward professional mental health treatment. The ATMHT is a modified version of the 29-item Attitudes toward Seeking Professional Psychological Help Scale (Fisher & Turner, 1970). The instructions asked participants to rate their attitudes about seeking mental health treatment from any mental health professional (e.g., psychiatrist, psychologist, social worker, counselor, or primary care physician). Higher scores indicated more positive attitudes about seeking mental health treatment while lower scores indicate a more negative attitude about seeking mental health treatment. Internal consistency of the full scale is found to be 0.75 (Brown et al., 2010).

**Socio-demographic Information**

Information about demographic variables included questions on: age, gender, marital status, educational background, religion, employment status, level of income and region of residence.

**3.7 Data Collection Procedure**

Ethical clearance was obtained from the Institutional Review Board (IRB) of Noguchi Memorial Institute for Medical Research (NMIMR), University of Ghana, Legon. An
An introductory letter from the Department of Psychology was sent to the three Psychiatric hospitals to seek approval. The introductory letter also stated the purpose of the study and expected outcomes. After the hospitals involved in the study gave the go ahead to conduct the study, dates were arranged for the data collection. A pilot study was first conducted to ascertain the reliability of the instruments used before commencing with actual data gathering. On the days of the data collection, prospective participants were informed of the study and told that whether they took part or not had no bearing on their treatment and care at the facility. The consent form was further explained to individual patients to ensure that it is well understood. Similar procedures were repeated at all the involving hospitals. However, the psychiatric patients were offered the option of several days to decide on taking part in the study. Those who consented to taking part in the study and wanted the interview in privacy at the hospital were given the opportunity. Confidentiality was maintained by using only code numbers given to the participants to identify them. Patients who reported any form of distress were offered psychotherapy to make them feel better and referrals were made to a psychiatrist where necessary.
CHAPTER FOUR

RESULTS

4.1 Introduction

This chapter presents results of the analyses done with the data collected after completed forms was checked for completeness, consistency and accuracy and finally entered into a computer. Analysis was done in two stages. First was a preliminary analysis to determine the descriptive statistics of the scales that were used. A second analysis was done to test the hypotheses stated. The SPSS version 16.0 was used to test the various hypothesis using Independent t-test, Chi square test and logistic regression. The justification for the various test choice and result of analysis is further discussed.

4.2 Preliminary analysis

Results of the preliminary analysis are presented in table 2 below:

Table 2

Means, standard deviations, normality of the distribution of scores and cronbach alpha of scales.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>SD</th>
<th>Skewness</th>
<th>Kurtosis</th>
<th>α</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IPQ</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cause</td>
<td>3.33</td>
<td>.67</td>
<td>-.45</td>
<td>-.54</td>
<td>.69</td>
</tr>
<tr>
<td>Timeline</td>
<td>3.01</td>
<td>.63</td>
<td>-.43</td>
<td>-.61</td>
<td>.95</td>
</tr>
<tr>
<td>Control</td>
<td>2.51</td>
<td>.49</td>
<td>.71</td>
<td>1.55</td>
<td>.58</td>
</tr>
<tr>
<td>Consequence</td>
<td>2.44</td>
<td>.53</td>
<td>.29</td>
<td>.54</td>
<td>.71</td>
</tr>
<tr>
<td><strong>ATMHT</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>50.68</td>
<td>5.55</td>
<td>.66</td>
<td>.63</td>
<td>.73</td>
</tr>
<tr>
<td><strong>GHQ</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>19.86</td>
<td>6.39</td>
<td>1.06</td>
<td>1.49</td>
<td>.82</td>
</tr>
</tbody>
</table>

IPQ-Illness Perception Questionnaire
ATMHT- Attitude toward Mental Health Treatment
GHQ- General Health Questionnaire
Table 2 above shows results of the descriptive statistics. The skewness and kurtosis scores above shows that most of the scores fall within the acceptable range of +1 and -1 which shows that they normally distributed and thus satisfy the condition for the use of parametric tests. Few scores were above the range though but did not substantially deviate from the normality. The result of Cronbach alpha scores for the scales above also indicates that the scales were reliable enough to be used for the purpose of the study.

4.2 Testing of Hypotheses

Hypothesis 1: There is a significant difference in the perceived causes of illness among people living with mental illness and those with sickle cell disease

To test this hypothesis, the independent t-test was used as two independent groups of patients (Mental illness and SCD) are being compared on their perceived causes of illnesses. The results from the statistical analysis are summarized in the table 3 below;
Table 3

Summary of independent t-test of perceived causes of illness between mentally ill patients and SCD patients

<table>
<thead>
<tr>
<th>Perceived Causes of Illness</th>
<th>MENTAL ILLNES (M)</th>
<th>SCD (M)</th>
<th>t</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Germs/Virus</td>
<td>4.19</td>
<td>4.44</td>
<td>1.42</td>
<td>.159</td>
</tr>
<tr>
<td>Diet</td>
<td>4.09</td>
<td>4.44</td>
<td>1.91</td>
<td>.059</td>
</tr>
<tr>
<td>Pollution of the Environment</td>
<td>4.01</td>
<td>4.48</td>
<td>2.52</td>
<td>.013</td>
</tr>
<tr>
<td>Genetics/Hereditary</td>
<td>3.56</td>
<td>1.96</td>
<td>6.32</td>
<td>.000*</td>
</tr>
<tr>
<td>Chance</td>
<td>2.51</td>
<td>4.36</td>
<td>7.15</td>
<td>.000*</td>
</tr>
<tr>
<td>Stress</td>
<td>2.64</td>
<td>4.40</td>
<td>7.13</td>
<td>.000*</td>
</tr>
<tr>
<td>Own Behaviour</td>
<td>3.39</td>
<td>4.58</td>
<td>5.59</td>
<td>.000*</td>
</tr>
<tr>
<td>Other People</td>
<td>3.15</td>
<td>4.68</td>
<td>7.32</td>
<td>.000*</td>
</tr>
<tr>
<td>Poor care in the past</td>
<td>3.46</td>
<td>4.56</td>
<td>5.00</td>
<td>.000*</td>
</tr>
<tr>
<td>State of mind</td>
<td>3.12</td>
<td>4.46</td>
<td>6.57</td>
<td>.000*</td>
</tr>
</tbody>
</table>

Bonferroni adjustment = .005, * = significant at .005 alpha level.

From the table 3 above, it was observed that at the .005 level of significance, significant differences were observed between persons with mental illness and sickle cell on their perceived causes of their illnesses with regard to Genetics/Hereditary [(t=6.32, ρ < .005), Chance [(t=7.15, ρ < .005), Stress [(t=7.13, ρ < .005), Own Behaviour [(t=5.59, ρ < .005), Other People [(t=7.32, ρ < .005), Poor Care in the Past [(t=5.00, ρ < .005) and State of Mind [(t=6.57, ρ < .005).
However, there were no statistically significant differences between persons with mental illness and sickle cell on their perceived causes of their illnesses with regard to Germs/Virus (t=1.42, p >.005), Diet (t=1.91, p > .005) and Pollution of the environment (t=2.52, p > .005). The hypothesis one that there is a significant difference in the perceived causes of illness among people living with mental illness and those with sickle cell disease is those supported.

**Hypothesis 2:** There is a significant difference in the perceived timeline, control and consequences of illness among people living with mental illness and those with sickle cell disease.

This hypothesis was tested using the independent t-test as two independent groups of patients (Mental illness and Sickle cell disease) are being compared on their perceived Timeline, Consequence and Control of their illnesses. The results from the analysis are summarized in the table 4 below;

**Table 4**

Summary of independent t-test of Perceived timeline, control and consequence of mentally ill patients and sickle cell patients

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mental illness (M)</th>
<th>Sickle cell disease (M)</th>
<th>df</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timeline</td>
<td>3.24</td>
<td>2.56</td>
<td>148</td>
<td>7.34</td>
<td>.00*</td>
</tr>
<tr>
<td>Consequence</td>
<td>2.39</td>
<td>2.54</td>
<td>1.67</td>
<td>.05</td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>2.31</td>
<td>2.90</td>
<td>8.46</td>
<td>.00*</td>
<td></td>
</tr>
</tbody>
</table>

Bonferroni Adjustment=.02, * = significant at the .05 alpha level
An examination of the table 4 above shows that statistically significant differences exist between persons with mental illness and sickle cell in their perceived Timeline (t= 7.34, p <.02), and Control (t= 8.46, p <.02). However, no statistically significant difference was found between persons with mental illness and sickle cell in their perceived Consequence (t= 1.67, p >.02). Therefore, the second hypothesis that there is a significant difference in the perceived timeline, control and consequences of illness among people living with mental illness and those with sickle cell disease is supported.

**Hypothesis 3:** attitudes toward professional mental health treatment will be strongly associated with the choice of psychiatric hospital as the first treatment option by mentally ill patients.

This hypothesis was analyzed using the Chi-square test of independence as the two variables are categorical. The results are summarized in the table 3 below;

**Table 5**

<table>
<thead>
<tr>
<th>Attitudes</th>
<th>The choice of a psychiatric hospital</th>
<th>df</th>
<th>$\chi^2$</th>
<th>$\rho$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>as first treatment option as second</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>treatment option as third treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>option</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td>33</td>
<td>14</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Negative</td>
<td>20</td>
<td>18</td>
<td>11</td>
<td>6.92</td>
</tr>
</tbody>
</table>

From the Chi-square table above, the results indicate that the relationship between attitude towards professional mental health treatment and choice of treatment is statically significant at the .05 level of significance, $\chi^2 (1, N=100) = 6.92, \rho < 0.05$. Therefore, the seventh
hypothesis that attitudes toward professional mental health treatment will be strongly associated with the choice of psychiatric hospital as the first treatment option by mentally ill patients is supported. This means that patients who have positive attitudes toward professional mental health treatment were more likely to contact the psychiatric hospital as their first choice of treatment.

**Hypothesis 4:** Demographic variables (age in categories, gender, marital status, educational background, religion, employment status, and income level) will predict onset of treatment seeking significantly.

The logistic regression was used to analyze this hypothesis as the dependent variable (early versus late treatment) is categorical. The results of the analysis are summarized in the table 6 below;
Table 6

Logistic Regression analysis of treatment seeking behaviour as a function of socio-demographic characteristics

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>Wald</th>
<th>Sig</th>
<th>Odd Ration</th>
<th>95% CI for exp(b)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>exp(b)</td>
<td>Lower</td>
</tr>
<tr>
<td>Age</td>
<td>-0.059</td>
<td>0.035</td>
<td>0.852</td>
<td>0.943</td>
<td>0.507</td>
</tr>
<tr>
<td>Sex</td>
<td>-0.558</td>
<td>1.572</td>
<td>0.210</td>
<td>0.572</td>
<td>0.239</td>
</tr>
<tr>
<td>Marital Status</td>
<td>0.069</td>
<td>0.021</td>
<td>0.884</td>
<td>1.072</td>
<td>0.424</td>
</tr>
<tr>
<td>Education</td>
<td>-0.074</td>
<td>0.086</td>
<td>0.770</td>
<td>0.928</td>
<td>0.565</td>
</tr>
<tr>
<td>Religion</td>
<td>-0.026</td>
<td>0.004</td>
<td>0.953</td>
<td>0.974</td>
<td>0.407</td>
</tr>
<tr>
<td>Employment</td>
<td>-0.941</td>
<td>1.267</td>
<td>0.260</td>
<td>0.390</td>
<td>0.076</td>
</tr>
<tr>
<td>Income</td>
<td>-0.405</td>
<td>0.793</td>
<td>0.373</td>
<td>0.667</td>
<td>0.273</td>
</tr>
<tr>
<td>Constant</td>
<td>3.219</td>
<td>1.277</td>
<td>0.258</td>
<td>25.000</td>
<td></td>
</tr>
</tbody>
</table>

The table 6 shows the results of the direct logistic regression analysis predicting early or late treatment seeking by persons with mental illness from their socio-demographic characteristics. According to the Wald test, none of the socio-demographic characteristics of persons living with mental illness reliably and significantly predicted the duration of symptoms before treatment which is early or late treatment seeking. Age ($\chi^2 = 0.035$, df = 1, $p > .05$), Sex ($\chi^2 = 1.572$, df = 1, $p > .05$), Marital Status ($\chi^2 = 0.021$, df = 1, $p > .05$), Education ($\chi^2 = 0.086$, df = 1, $p > .05$), Religion ($\chi^2 = 0.004$, df = 1, $p > .05$), Employment ($\chi^2 = 1.267$, df = 1, $p > .05$), and Income ($\chi^2 = 0.793$, df = 1, $p > .05$). Therefore, the third hypothesis that demographic variables (age in categories, sex, marital status, educational background, religion, employment status, and income level) will predict early or late treatment seeking behaviour significantly is not supported.
Hypothesis 5: the type of mental illness diagnosis will have a significant association with onset of treatment seeking.

The Chi square test was used to examine the association between type of mental illness and duration of symptoms before seeking treatment as the two variables are all categorical. The results from the analysis are summarized in the table 7 below:

Table 7
Summary of Chi Square analysis of the association between type of diagnosis and onset of treatment seeking.

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Early Treatment</th>
<th>Late Treatment</th>
<th>df</th>
<th>$X^2$</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(N)</td>
<td>(N)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety Disorder</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>5.481</td>
<td>.360</td>
</tr>
<tr>
<td>Major Depression</td>
<td>17</td>
<td>18</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>8</td>
<td>14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Related</td>
<td>5</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>11</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>49</strong></td>
<td><strong>51</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A critical examination of table 7 above shows that there is no statistically significant association between the type of psychiatric diagnosis and treatment seeking behaviour at the .05 alpha level, $\chi^2 (5, 10) = 3.481$, $p > .05$. This shows that the type of psychiatric diagnosis does not relate with early or late treatment seeking behaviour. Therefore, the fourth hypothesis that the type of mental illness diagnosis will have a significant association with treatment seeking behaviour is not supported.
**Hypothesis 6:** There will be a significant difference in the first choice of treatment among persons living with mental illness, with more patients choosing traditional or religious healers than psychiatric treatment.

This hypothesis was analyzed using the Chi-square test to determine if the observed frequencies are statistically different. The results are presented in table 8 below.

**Table 8**

**Chi-square table showing results of first treatment option by mentally ill patients**

<table>
<thead>
<tr>
<th>Treatment Choice</th>
<th>Observed N</th>
<th>Expected N</th>
<th>Residual</th>
<th>$\chi^2$</th>
<th>df</th>
<th>$\rho$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric</td>
<td>51</td>
<td>25</td>
<td>26</td>
<td>38.16</td>
<td>3</td>
<td>.00</td>
</tr>
<tr>
<td>general hospital</td>
<td>22</td>
<td>25</td>
<td>-3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religious</td>
<td>15</td>
<td>25</td>
<td>-10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Traditional</td>
<td>12</td>
<td>25</td>
<td>-13</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The results above shows that a significant difference exist in the first choice of treatment by mentally ill patients but in a different direction as predicted because more patients sought psychiatric hospital as their first choice of treatment at the .05 level of significance, $\chi^2(3, N=100) = 38.16$, $\rho<.05$. Thus, the hypothesis that there will be a significant difference in the first choice of treatment among persons living with mental illness, with more patients choosing traditional or religious healers than psychiatric treatment, is not supported.

**Hypothesis 7:** Mentally ill patients who visit the psychiatric hospital as a first choice of treatment would have a more positive general health than those who do not.

This hypothesis was analyzed using the independent t-test, which compares two group means. The results are summarized in table 9.
Table 9

Summary of independent t-test of General Health Questionnaire differences between Patients who sought Psychiatric and Other Treatments

<table>
<thead>
<tr>
<th>First Treatment Sought</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>df</th>
<th>t</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Treatment</td>
<td>51</td>
<td>19.55</td>
<td>5.90</td>
<td>98</td>
<td>.638</td>
<td>.525</td>
</tr>
<tr>
<td>Other Treatments</td>
<td>49</td>
<td>18.69</td>
<td>7.45</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

An examination of the independent t-test table above shows that there is no statistically significant difference in general health of mentally ill patients who sought psychiatric treatment and those who sought other treatments as their first choice at the .05 alpha level, t(98) = .638, ρ > .05. Therefore, the fifth hypothesis that mentally ill patients who visit the psychiatric hospital, as a first choice of treatment would have a more positive general health than those who visit other treatment centers is not supported.

4.3 Summary of Findings

The following gives a summary of the results of the tested hypothesis in this study:

- Among the perceived causes of illness, mentally ill patients did not differ from sickle cell patients on germs or virus, diet, and pollution as a perceived cause of illness. There was however a difference between the two in terms of genetics, chance, stress, own behaviour, other people, poor care in the past and state of mind as a perceived cause of illness.

- A significant difference exists between mentally ill and sickle cell patients when compared on perceived timeline and control of their illness. However, there is no
significant difference when the two groups are compared on their perceived consequence of their illness.

- Attitude toward professional mental health treatment is strongly associated with the choice of psychiatric hospital as the first treatment option by mentally ill patients. This means that patients who have positive attitudes toward professional mental health treatment were more likely to contact the psychiatric hospital as their first choice of treatment.

- The demographic variables; age, gender, marital status, educational background, religion, employment status, and income level do not significantly predict treatment seeking behaviour.

- The type of mental illness diagnosis (Anxiety disorder, major depression, schizophrenia, substance related disorder, bipolar disorder and others) has no significant association with early or late treatment seeking behaviour.

- There is a significant difference in the first choice of treatment among persons living with mental illness, with more patients choosing psychiatric treatment as their first choice of treatment than general hospital, religious and traditional healers.

- Among the mentally ill sample, those who contacted the psychiatric hospital as a first choice of treatment do not have a more positive general health than those who contacted the psychiatric hospital as a second or third choice of treatment.
CHAPTER FIVE

DISCUSSION

5.1 Introduction

The aim of this study is to find out how mentally ill patients perceive their illness and how attitudes toward professional mental health treatment and demographic variables influence treatment seeking behaviour. To achieve this aim, specific objectives were stated. The objectives included, to examine illness perceptions of people living with mental illness and to find out if difference exists between mentally ill patients and sickle cell disease patients. Also, to examine the choice of treatment for patients who have positive attitudes toward professional mental health treatment and those who have negative attitudes toward professional mental health, and to explore the demographic predictors of mental illness treatment seeking behaviour. Others were, to examine the effect of type of mental illness diagnosis on onset of treatment seeking, to determine if a significant difference exist in the choice of treatment among persons living with mental illness and finally, to examine the general health of mentally ill patients who contact the psychiatric hospital first for treatment and those who do not.
5.2 Discussion of findings

Illness perception among people living with mental illness and those with Sickle cell disease

The first objective of this study was to examine illness perceptions of people living with mental illness and to find out if difference exists between mentally ill patients and sickle cell disease patients. To examine this objective, it was hypothesized that there would be a significant difference in illness perception between people living with mental illness and those with sickle cell disease. Findings reveal that pertaining to perceptions about the causes of illness, both mentally ill and those with sickle cell disease did not differ significantly on germs or virus, diet, and pollution as a perceived cause of illness. Thus, both groups believed that their conditions are neither caused by germs/virus nor by diet and pollution. This signifies that in seeking for treatment for mental illness and sickle cell disease patients would hardly consider options perceived as interventions that deals with germs or virus, diet management or sanitation as perceived cause of illness is found to influence the type of treatment sought (Desrosiers & Fluerose, 2002; Vanheusden et al., 2009).

However when it comes to genetic causes, chance, stress, own behaviour, other people, poor care in the past and state of mind as a perceived caused of illness, a difference existed between people with mental illness and those with sickle cell disease. More people with mental illness saw the cause of their illness as genetic compared to those with sickle cell disease. On the other hand, more people with sickle cell disease saw their illness as being caused by chance, stress, own behaviour, other people, poor care in the past and state of mind as compared to those with mental illness. With regards to perception of timeline, mentally ill patients perceived the duration of their illness as more chronic or longer compared to sickle
cell disease patients, with perception of control, sickle cell disease patients believed that their condition was more controllable compared to mentally ill patients. They however did not differ significantly in terms of perceptions about consequences of illness, as both groups saw the consequences of their conditions as negative.

Following the tenet of the illness perception model, which states that causal attribution of illness determines the kind of treatment sought, the findings of the present study should suggest that a significant number of mentally ill individuals would seek medical treatment compared to SCD patients. This is because majority of people living with mental illness thought it was genetic and chronic and hence they may not think they could help themselves. However, many patients with SCD may seek self-treatment or others before reporting for medical care since they attribute their illness to chance, stress, state of mind etc. and also thought their condition can be controlled. In contrast, the present study found no significant difference in early and late treatment seeking behaviour between patients with mental illness and those with SCD. This may be because SCD is usually diagnosed earlier, often in childhood, compared to mental illness due to early onset of symptom and other crisis complications involved. SCD patients may report at the primary care centers earlier and more frequently than those with mental illness. The result therefore shows that perception about the cause of illness alone does not determine treatment seeking behaviour. In similar fashion, Girma and Tesafe (2011) reported that beliefs about etiology of illness does not necessarily influence the treatment seeking behaviour as their study revealed that in Ethiopia, though people believed that mental illness was caused by supernatural means, they also believed that it was curable by biomedical treatment. This may explain the results in this present study where a significant number of SCD patients sought general medical treatment as the first option of treatment though they perceived their illness to be caused by external factors like
stress, own behaviour, other people and poor care in the past. In addition, the fact that both groups viewed their illnesses as being associated with negative consequences may influence them to seek early treatment. This is in line with Vanheusden et al.’s (2009) study which found that belief in intra-psychic causes, negative consequences, and treatment control were associated with increased probability of mental health service utilization.

Attitude towards professional mental health treatment and psychiatric treatment seeking

The study also seeks to examine the choice of treatment for patients who have positive attitudes toward professional mental health treatment and those who have negative attitudes toward professional mental health. The hypothesized was stated that, attitudes toward professional mental health treatment will be strongly associated with the choice of psychiatric hospital as the first treatment option. Results showed attitude toward professional mental health treatment is strongly associated with the choice of psychiatric hospital as the first treatment option by mentally ill patients. This means that patients who have positive attitudes toward professional mental health treatment had an increased likelihood to contact the psychiatric hospital as their first choice of treatment as opposed to those who have negative attitudes toward professional mental health treatment. Reporting Negative attitude towards professional mental health treatment has been found as an important barrier to treatment seeking in variety of samples. These negative attitudes towards mental health treatment may include perception of stigma and perceptions about the effectiveness of treatment and treatment providers. In Ghana in particular, this negative attitude may be as a result of the cost of treatment for mental health. The cost of treatment is not only limited to cost of consultation and medication; which is mostly free in Ghana, but also involves time spent seeking treatment at the psychiatric hospital and loss of income from not working. Negative
attitude may also stem from dislike for medication or side effects of drugs and the negative perceptions that individuals may hold about mental health professionals.

On the other hand, positive attitudes involve issues like the patients trust in the competence and empathetic nature of mental health professionals. Patients who held positive believes about professional mental health services were not concerned about their age or ethnicity and cultural differences. Rather, they indicated their believe in professional health providers as well trained and thus fully trusted them for better interventions. This is believed to be an important aspect of the decision-making process of choosing treatment sources by patients.

It is therefore not surprising that the study found out these individuals with more positive attitudes towards professional mental health treatment sought psychiatric treatment as the first option of treatment. This implies that individuals who chose early psychiatric treatment perceive less stigma associated with seeking professional mental health treatment and also believe that mental health services can effectively reduce mental health problems since they mostly agreed that it is the most effective way to deal with mental health problems. This finding is therefore consistent with Wrigley, Jackson, Judd and Komiti (2005) findings that revealed that among a rural sample, lower perceived stigma and perceived helpfulness of general practitioner predicted medical help seeking.

Coppens et al., (2013) also found stigma and negative attitude towards mental illness and professional treatment as barriers to treatment seeking among depressed people in four European countries. In addition, Ey, Henning and Shaw (2000) found that among medical and nursing students, most of them expressed stigma towards professional help seeking and
distressed students who were not in treatment had more negative attitude towards professional help seeking than distressed students who were in treatment.

**Demographic variables and treatment seeking behaviour**

Another important aim of the study is to explore demographic predictors of treatment seeking behaviour. It was predicted that age, gender, marital status, educational background, religion, employment status, and income level will predict treatment seeking behaviour significantly. Findings however showed that none of these demographic variables predicted treatment seeking behaviour significantly.

This finding is inconsistent with studies which found these variables as significant predictors of treatment seeking. Some studies have reported that older age predicted delayed treatment seeking (Sorsdahl et al., 2009; Tanchangya et al., 2012) while others also report that older age predicted willingness to seek treatment and positive attitude towards treatment seeking (Mackenzie, Gekoski & Knox, 2006). In the present study however there was no difference between younger adults and older adults. This may be due to the fact that there was not much variation in the age as there were not many older adults. The mean age for the psychiatric sample was about 35 years and that of sickle cell patients was about 29 years. Though the age ranged from 18 to 68, only one participant each belonged to the 18 years and 68 years age bracket.

With regard to gender, studies have reported females as more likely to seek treatment than males (Chandra & Minkovitz, 2006; Mackenzie, Gekoski & Knox, 2006) but some reported that females were less likely to seek early treatment (Jindal, 2006; Tanchangya et al., 2012). There was no significant difference between men and women in treatment seeking in the present study. It may be due to the fact that gender differences found in other studies could be
explained by other variables such as attitude towards treatment seeking and since men and women did not differ in their attitude towards treatment seeking, they also would obviously not differ significantly on treatment seeking. Perhaps the gender differences may have to do with the type of treatment sought and not whether treatment is sought early or not (Avanzo et al., 2012).

Marital status, educational background, employment status, and income level were also reported by studies to predict treatment seeking behaviour (Elhai, Voorhees, Ford, Min & Frueh (2014); Sorsdahl et al., 2009), which is inconsistent with the present finding. In the present study, majority of participants earn no income, most were single and unemployed, and this may have accounted for the finding. In addition, these were individuals who have already sought treatment but perhaps the findings would be different among those who did not seek treatment at all. In Ghana, treatment of certain chronic conditions such as mental illness and SCD are highly subsidized hence income or employment may not determine whether a person would seek treatment or not. To add to this, mental illness and SCD are chronic health conditions, and most likely, treatment would be sought due to the severity of distress felt regardless of demographic characteristics. Most of the participants in this study were influenced by a family member to seek help, which implies that the decision to seek help was not entirely determined by the patients themselves, which explains why their individual characteristics did not have much potent influence in predicting their treatment seeking behaviour. The finding also suggest that psychological factors may be more important in predicting treatment seeking compared to demographic variables (Skeate et al., 2002). Wu, Liu, Chang and Sun (2014) however found a significant association between demographic variables (age, sex, education, marital status and religion) and help-seeking preferences.
Pathways to mental health treatment in Ghana

It was hypothesized that there will be a significant difference in the first choice of treatment among persons living with mental illness, with more patients choosing traditional or religious healers than psychiatric treatment. This is because psychiatric treatment is often perceived as a last option among the mentally ill in Ghana and other African countries (Adenponle et al., 2009, Asante et al., 2010; Mensah & Yeboah, 2003; Salem et al., 2009).

Contrary to this, results of this study shows that there is a significant difference in the first choice of treatment among persons living with mental illness, with more patients choosing psychiatric treatment as their first choice of treatment than general hospital, religious and traditional healers.

The findings from the current study suggest that the pathway to care among psychiatric patients is probably changing in these present times. The observed trend was that 51% of mentally ill patients reported that the psychiatric hospital was their first point of contact for treatment, 22% for general medical care, 15% for religious healers and the least was traditional healers as first point of treatment contact with only 12% of the mental illness sample. This trend also suggests that efforts’ being made to enhance mental health literacy and treatment is yielding positive results even though much is left to be done.

In conclusion, the common understanding that most individuals with mental illness would first seek traditional or religious treatment before reporting for treatment at the psychiatric hospital or general medical services is not supported going by this study.
Type of mental illness diagnosis and treatment seeking

The study also seeks to examine the effect of type of mental illness diagnosis on the onset (early and late) of treatment seeking. The assumption was that type of mental illness diagnosis, would have a significant association with onset of treatment seeking. According to World Health Report (2001), many people with depression and anxiety disorder go undiagnosed because they usually do not seek treatment. It is upon this tenet that the present study predicted that the type of illness would actually have a significant association with treatment seeking. Findings however showed that a person’s diagnosis was not associated with early or late treatment seeking behaviour. This may be due to the fact that the association between type of illness and treatment seeking may be influenced by the severity of the illness. Once the illness is severe, the person is likely to seek early treatment and severity was not tested in the present study. The WHO (2001) reports that under-diagnosis of mental disorders is more common in mild rather than severe cases. It is possible that most of the patients used in the current study regardless of their diagnosis were experiencing severe symptoms. Having an anxiety or substance abuse disorder was however found by Sorsdahl et al., (2009) to be significantly associated with the type of treatment sought.

Early psychiatric treatment and general health among mentally ill patients

Another objective of the study is to examine the general health of mentally ill patients who contact the psychiatric hospital for treatment and those who do not. Findings reveal that a significant number of participants sought psychiatric treatment as their first treatment option but no significant difference exists between those who sought psychiatric treatment first and those who sought other treatments before reporting to the psychiatric hospitals with respect to their reported general health. Since mental health is closely linked with physical health (WHO, 2009), lack of effective treatment is expected to strongly related with poor general
health. The present finding suggests that those who chose psychiatric treatment and those who chose, general medical, traditional or religious treatment as first treatment options did not differ significantly when it comes to their present general health. This may be due to the fact that most patients sought at least some form of help in the first 6 months of their illness. Early treatment seeking could bring some relief to them though it might not give them a permanent solution for their mental illness, as most of those who did not seek psychiatric treatment first sought general medical care that could help improve their general health. Besides majority of those who sought psychiatric treatment as a second and third option still did so within the first year of their illness. In addition, participants have been undergoing psychiatric treatment for some time before being recruited for the study; therefore, any differences in their general health at the beginning of their treatment may not be significant after they have undergone treatment for some time.

5.3 Limitations

The study is not without limitations. Limitations include the use of self-report measures which relies on the individual’s honesty and how much they remember. This may affect the accuracy of the information being given. Results could also be influenced by social desirability. The findings of the study are restricted to individuals who are currently undergoing formal treatment (psychiatric and general medical care). It cannot be generalized to those who have not sought formal treatment at all and those who sought first but prematurely terminated treatment to seek help elsewhere. Those seeking treatment from traditional and religious healers at the time of data collection were not represented in the present study. In spite of these limitations, the findings of the study offer relevant contribution to knowledge on the perceptions about mental illness, attitudes towards
professional mental health treatment and treatment seeking behaviour among people with mental illness in Ghana.

5.4 Recommendations

The present study reveals that the most important determinant of treatment seeking among people with mental illness is attitude towards professional mental health treatment. It therefore implies that, to make headway in the campaign to improve psychiatric treatment of mental illness, and to get those who need help to get the essential and most effective help, attention should be aimed at efforts to improve people’s attitude towards psychiatric treatment or professional mental health treatment. This could be achieved through sensitization and improving mental health literacy among the public. Once people understand their conditions and know the available treatments, their attitudes may become more favorable.

One important aspect of attitude towards professional mental health treatment is the perceived effectiveness of the treatment available. Stakeholders in psychiatric treatment should therefore work on improving the effectiveness of treatment offered in the treatment of various disorders. Ideally, there should be a variety of effective treatment regimens from which patients can be given the opportunity to choose what works for them. Patients should also be educated on what each treatment entails, duration of treatment and the expected efficacy. This would go a long way to improve attitudes towards professional mental health treatment and in turn enable individuals seek early treatment in the event of mental illness, and those already in treatment would also adhere to treatment.
5.5 Directions for future studies

The present study only looked at patients in the three psychiatric hospitals; future studies should include those in prayer camps, shrines and patients who adhere to self-care. Future studies can also compare urban folks and rural folks on attitude towards professional mental health treatment and actual treatment seeking. Most of the participants in the present study were residing in the three regions in which the psychiatric hospitals are located (Central and Greater Accra) only few reported that they resided outside those regions. Due to this, not much is known about the treatment seeking behaviours of those outside these regions. Future studies should extend the sample to other regions outside Central and Greater Accra regions.

Finally, future studies can also conduct a qualitative study to explore the specific mechanisms underlying treatment seeking behaviour and the in-depth appraisals for the pathways of treatment seeking.

5.6 Conclusion

The study aimed to find out how mentally ill patients perceive their illness and how attitudes toward professional mental health treatment and demographic variables influence the treatment seeking behaviour. Findings show that many of the mentally ill patients perceived their illness as genetic compared to sickle cell disease patients who thought their illness was caused by chance, stress, own behaviour, other people, poor care in the past and state of mind. However, both groups did not differ when it comes to early and late treatment seeking. Mentally ill patients who have positive attitude towards professional mental health treatment sought psychiatric treatment as the first choice of treatment as compared to those who sought psychiatric treatment as the second or third choice of treatment. Demographic variables did not predict treatment seeking. It was also revealed that the most sought treatment for mental
illness among people living with mental illness was psychiatric treatment, followed by
general medical treatment, few of the participants sought religious and then traditional
healers, meaning the least preferred source of treatment was traditional healers.

In conclusion, the most important predictor of treatment seeking among people with mental
illness is attitude towards professional mental health treatment. Future studies should
however extend the study to those at shrines, prayer camps and those administering self-care
as well as mentally ill individuals residing in other regions of Ghana that do not have
psychiatric hospitals.
REFERENCES


Ae-Ngibise, K., Cooper, S., Adiibokah, E., Akpalu, B., Lund, C., & Doku, V., (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*(6), 558-67.


countries baseline survey prior to the OSPI-Europe intervention. *Journal of Affective Disorders, 150*, 320-329.


*Patient Education and Counseling, 10,* 117-138.


APPENDICES

APPENDIX A: Demographic Questionnaire

Please respond to the following questions with the appropriate answers:

Age: ______

Age Category
1. 18-30
2. 31-50
3. 51-70

Sex
1. Male
2. Female

Marital Status
1. Married
2. Single
3. Divorced/Separated

Educational background
1. No formal education
2. Basic education
3. Secondary/Technical education
4. Tertiary (undergrad, graduate, post-graduate)

Religion
1. Christian
2. Muslim
3. Traditional
4. Any other

Employment Status
1. Employed
2. Unemployed
Level of income (monthly income in Ghana Cedi)

1. No income
2. Below 500
3. Above 500 - 1,000
4. Above 1000 – 2,000
5. above 2,000

Region of Residence

1. Greater Accra
2. Central
3. Western
4. Volta
5. Ashanti
6. Eastern
7. Northern
8. Upper East
9. Upper West
10. Brong Ahafo
APPENDIX B: Pathway to Care Questionnaire

Basic Information

1. Name of facility at which the form is filled in
   1. Accra Psychiatric hospital
   2. Pantang Hospital
   3. Ankaful Psychiatric Hospital
   4. Korle-Bu teaching Hospital

2. Patient’s diagnosis
   1. Anxiety Disorder
   2. Major Depression
   3. Schizophrenia
   4. Substance related
   5. Bipolar
   6. Sickle cell
   7. Others

Please respond to the following questions with the appropriate answers as applies to your condition.

The Decision to First Seek Treatment

3. Who was first seen?
   1. Traditional healer
   2. Religious healer
   3. Medical practitioner/general hospital
   4. Psychiatric hospital
   5. Others

4. Duration of symptom before first contact (in months)
   1. Less than 1 month
   2. After 1 month - 6 months
   3. After 6 months – 1 year
   4. After 1 year – 3 years
   5. After 3 years and above
5. Who initiated first contact?
1. Myself
2. Family relative
3. Friend/neighbors
4. Workmates/schoolmates
5. Employers
6. Police
7. Medical practitioner
8. Others

6. What treatment(s) was offered?
1. Non-psychotropic medication
2. Herbal/traditional medication
3. Prayers/fasting
4. Psychotropic medication/Psychotherapy
5. No treatment

7. Who was seen second?
1. Traditional healer
2. Religious healer
3. Medical practitioner/general hospital
4. Psychiatric hospital
5. Others

8. Duration of symptom before second contact (in months)
1. Less than 1 month
2. After 1 month - 6 months
3. After 6 months – 1 year
4. After 1 year – 3 years
5. After 3 years and above

9. Decision taken by whom?
1. Myself
2. Family relative
3. Friend/neighbors
4. Workmates/schoolmates
5. Employers
6. Police
7. Medical practitioner
8. Others

10. What treatment(s) was offered?
1. Non-psychotropic medication
2. Herbal/traditional medication  
3. Prayers/fasting  
4. Psychotropic medication/Psychotherapy  
5. No treatment  

11. Who was seen third?  
1. Traditional healer  
2. Religious healer  
3. Medical practitioner/general hospital  
4. Psychiatric hospital  
5. Others  

12. Duration of symptom before second contact (in months)  
1. Less than 1 month  
2. After 1 month - 6 months  
3. After 6 months – 1 year  
4. After 1 year – 3 years  
5. After 3 years and above  

13. Decision taken by whom?  
1. Myself  
2. Family relative  
3. Friend/neighbors  
4. Workmates/schoolmates  
5. Employers  
6. Police  
7. Medical practitioner  
8. Others  

14. What treatment(s) was offered?  
1. Non-psychotropic medication  
2. Herbal/traditional medication  
3. Prayers/fasting  
4. Psychotropic medication/Psychotherapy  
5. No treatment
APPENDIX C: Illness Perception Questionnaire

We are interested in your personal view of how you now see your (illness). Please indicate how much you agree or disagree with the following statements about your illness.

**Rated: 1= strongly agree, 2= agree, 3= neither agree nor disagree, 4= disagree, 5= strongly disagree**

<table>
<thead>
<tr>
<th>Cause</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A germ or virus caused my illness</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>2. Diet played a major role in causing my illness</td>
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<td>3. Pollution of the environment caused my illness</td>
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<td>4. My illness is hereditary- it runs in my family</td>
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<td>2</td>
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<td>5</td>
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<td>5. It was just by chance that I became ill</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
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<tr>
<td>6. Stress was a major factor in causing my illness</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
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<td>7. My illness is largely due to my own behaviour</td>
<td>1</td>
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<tr>
<td>8. Other people played a large role in causing my illness</td>
<td>1</td>
<td>2</td>
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<td>5</td>
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<tr>
<td>9. My illness was caused by poor care in the past</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
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<tr>
<td>10. My state of mind played a major part in causing my illness</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<tbody>
<tr>
<td>11. My illness will last a short time</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>12. My illness is likely to be permanent rather than temporary</td>
<td>1</td>
<td>2</td>
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<td>5</td>
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<tr>
<td>13. My illness will last for a long time</td>
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<td>2</td>
<td>3</td>
<td>4</td>
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<tbody>
<tr>
<td>14. My illness is a serious</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>condition</td>
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<tr>
<td>15. My illness has had major consequences on my life</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>16. My illness has become easier to live with</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>17. My illness has not had much effect on my life</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>18. My illness has strongly affected the way others see me</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>19. My illness has serious economic and financial consequences</td>
<td>1</td>
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<td>20. My illness has strongly affected the way I see myself as a person</td>
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<th>2</th>
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<tbody>
<tr>
<td>21. My illness will improve in time</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>22. There is a lot which I can do to control my symptoms</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>23. There is very little that can be done to improve my illness</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>24. My current treatment will be effective in curing my illness</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>25. Recovery from my illness is largely dependent on chance or fate</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>26. What I do can determine whether my illness gets better or worse</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>


APPENDIX D: General Health Questionnaire (GHQ – 12)

Please read carefully.

We will like to know how your health has been in general, over the last few weeks. Please read the questions below and each of the four possible answers. Circle the response that best applies to you. Remember that we want to know about present and recent complains, not those that you had in the past.

Thank you very much for your co-operation.

Have you recently…

1. been able to concentrate on whatever you are doing?
   - better than usual
   - same as usual
   - less than usual
   - much less than usual
   (1) (2) (3) (4)

2. lost much sleep over worry?
   - not at all
   - no more than usual
   - rather more than usual
   - much more than usual
   (1) (2) (3) (4)

3. felt that you are playing a useful part in things?
   - more so than usual
   - same as usual
   - less so than usual
   - much less than usual
   (1) (2) (3) (4)

4. felt capable of making decisions about things?
   - more so than usual
   - same as usual
   - less so than usual
   - much less than usual
   (1) (2) (3) (4)

5. felt constantly under strain?
   - not at all
   - no more than usual
   - rather more than usual
   - much more than usual
   (1) (2) (3) (4)

6. felt you couldn’t overcome your difficulties?
   - not at all
   - no more than usual
   - rather more than usual
   - much more than usual
   (1) (2) (3) (4)

7. been able to enjoy your normal day-to-day activities?
   - more so than usual
   - same as usual
   - less so than usual
   - much less than usual
   (1) (2) (3) (4)
8. been able to face up to your problems?

<table>
<thead>
<tr>
<th>more so than usual</th>
<th>same as usual</th>
<th>less so than usual</th>
<th>much less than usual</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
</tr>
</tbody>
</table>

9. been feeling unhappy and depressed?

<table>
<thead>
<tr>
<th>not at all</th>
<th>no more than usual</th>
<th>rather more than usual</th>
<th>much more than usual</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
</tr>
</tbody>
</table>

10. been losing confidence in yourself?

<table>
<thead>
<tr>
<th>not at all</th>
<th>no more than usual</th>
<th>rather more than usual</th>
<th>much more than usual</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
</tr>
</tbody>
</table>

11. been thinking of yourself as a worthless person?

<table>
<thead>
<tr>
<th>not at all</th>
<th>no more than usual</th>
<th>rather more than usual</th>
<th>much more than usual</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
</tr>
</tbody>
</table>

12. been feeling reasonably happy, all things considered?

<table>
<thead>
<tr>
<th>more so than usual</th>
<th>same as usual</th>
<th>less so than usual</th>
<th>much less than usual</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
</tr>
</tbody>
</table>
APPENDIX E: Attitudes toward Mental Health Treatment Scale (ATMHT)

Using the scale below, please indicate the level of your agreement with the following statements by choosing the number that most closely corresponds to your beliefs.

**Response categories are as follows:** 4= (strongly agree), 3= (agree), 2= (disagree) and 1= (strongly disagree).

<table>
<thead>
<tr>
<th>Statement</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Professional mental health services can effectively reduce mental health problems.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. If I sought mental health services, it is likely I would find a therapist that I would feel comfortable opening up to.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. In my community, people take care of their emotional problems on their own; they don’t seek professional mental health services.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. Mental health professionals are well trained.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. If I were experiencing a mental health breakdown, I am confident that taking medications would provide me with relief.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. I do not fully trust mental health professionals.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. I feel confident that I could find a therapist who is understanding and respectful of my ethnicity/culture.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. Mental health professionals don’t really care about you, they are just there for a paycheck.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. Due to time and financial constraints, seeking mental health services is not a feasible option for me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. Professional mental health treatment would not be helpful for me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
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<td></td>
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<td>---</td>
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</tr>
<tr>
<td>11. My family would support me seeking mental health services.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12. Mental health services are only effective if your therapist matches your culture and/or ethnicity.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13. Most therapists have a lot of book smarts, but no street smarts</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14. I would be comfortable seeing a therapist that is a lot younger than me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15. I believe that therapy is the most effective way to deal with mental health problems.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16. Most mental health professionals have negative beliefs about the mentally ill.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17. Seeking professional mental health services is a last resort.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18. I would be comfortable seeing a therapist who is of a different ethnicity than I am.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>19. I know people who have had negative experiences when they sought professional mental health services.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>20. I would seek help from my family and friends, before seeking help from a mental health professional.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
APPENDIX F: Consent Form

Title: Treatment Seeking Behavior of Patients Living with Mental Illness in Regional Psychiatric Hospitals in Ghana.

Principal Investigator: Esther Mmabilla Azeem

Address: Department of Psychology, University of Ghana, Legon

General Information about Research

This research is being conducted to find out how mentally ill patients seek for treatment solutions to their illness. Depending on what one believes and how he or she views mental illness, a particular treatment avenue will be preferred. I therefore want to know the various treatment centers that you probably visited to seek for treatment before reporting to the Psychiatric hospital and your personal opinion about professional mental health service.

You will be involved in a one-on-one interview and also choose an appropriate answer that applies to you from a number of questions. This procedure will take place at this hospital that you are currently seeking treatment but your privacy is assured. Materials that will be used are pencil, eraser, question papers and answering sheets.

Possible Risks and Discomforts

There are minimal risks in this study. Although it is unlikely, completing the questionnaires may cause some distress. I hope to use my clinical experience to offer therapy to you in event that you become distressed and referral to a psychiatrist will be made where necessary. You are assured that your participation in this research will have no negative bearing on your treatment in this facility.

Possible Benefits

Results from this research may not directly benefit you but will help create awareness about the importance of seeking for early and reliable treatment for symptoms of mental illness from accredited mental health care institutions. You may also have recognition of your own beliefs and attitude towards psychological disorder and treatment strategies.
Confidentiality

Information that you provide in this study is going to be kept strictly confidential and your identity will be protected to the best of my ability. To ensure this, your name will not be required if you agree to participate. You will however be given a code number to identify the questionnaire given you.

Compensation

For your effort and time I am going to give you a snack at the time you finish answering the questions and taking the interview. This is not to pay you but to compensate you and to say thank you.

Voluntary Participation and Right to Leave the Research

Participation in this research is entirely voluntary and you are free to withdraw at any time you wish to without any penalty.

Contacts for Additional Information

In the event that you need to contact me for answers to important questions about the research or whom to contact in case of research-related injury, please contact me Esther Mmabilla Azeem on mobile number: 0243-858-473 or email, estherazeem@yahoo.com.

Your rights as a Participant

This research has been reviewed and approved by the Institutional Review Board of Noguchi Memorial Institute for Medical Research (NMIMR-IRB). If you have any questions about your rights as a research participant you can contact the IRB Office between the hours of 8am-5pm through the landline 0302916438 or email addresses: nirb@noguchi.mimcom.org or HBaidoo@noguchi.mimcom.org. You may also contact the chairman, Rev. Dr. Ayete-Nyampong through mobile number 0208152360 when necessary.
VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research title ‘Treatment Seeking Behaviour of Patients with Mental Illness in Regional Psychiatric Hospitals in Ghana’ has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

____________________________________________________
Date                                             Name and signature or mark of volunteer

If volunteers cannot read the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

____________________________________________________
Date                                             Name and signature of witness

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

____________________________________________________
Date                                             Name / Signature of Person Who Obtained Consent
APPENDIX H: Ethical Approval

NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH
Established 1979

INSTITUTIONAL REVIEW BOARD

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        +233-289-522574
Fax: +233-302-502182/513202
E-mail: nrir@noguchi.mimicom.org
Telex No: 2556 UG, GH

My Ref. No: DF-22
Your Ref. No: 8th, May, 2013

ETHICAL CLEARANCE

FEDERALWIDE ASSURANCE PWA 00001824
NMIMR-IRB CPN 093/12-13
IRB 00001276
IORG 0000908

On 8th May, 2013, the Noguchi Memorial Institute for Medical Research (NMIMR) Institutional Review Board (IRB) at a full board meeting reviewed and approved your protocol titled:

TITLE OF PROTOCOL: Treating Seeking Behaviour of Patients Living with Mental Illness in Regional Psychiatric Hospitals in Ghana

PRINCIPAL INVESTIGATOR: Esther Mahilla Azeeem, MPhil Candidate

Please note that a final review report must be submitted to the Board at the completion of the study. Your research records may be audited at any time during or after the implementation.

Any modification of this research project must be submitted to the IRB for review and approval prior to implementation.

Please report all serious adverse events related to this study to NMIMR-IRB within seven days verbally and fourteen days in writing.

This certificate is valid till 7th May, 2014. You are to submit annual reports for continuing review.

Signature of Chairman: ___________________________
Rev. Dr. Samuel Ayete-Nyampong
(NMIMR – IRB, Chairman)

cc: Professor Kwadwo Koram
    Director, Noguchi Memorial Institute
    for Medical Research, University of Ghana, Legon