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**KNOWLEDGE AND PERCEPTIONS OF MENTAL DISORDERS AMONG
ADUALTS IN ZUARUNGU AND SUMBRUNGU COMMUNITIES, IN
NORTHERN GHANA**

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DECLARATION

I hereby declare that the work contained in this thesis has not been previously submitted to meet the requirements for an award at this or any other institution of higher learning. To the best of my knowledge, this thesis contains no material previously published or written by another person except where due reference is made. I bear sole responsibility for any shortcomings.

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DEDICATION

This work is dedicated to my parents; Mr. and Mrs. Roland Adombiri-naba, to my siblings Ruben Adombiri-naba, Martina Adombiri-naba and Philomena Adombiri-naba and to my beloved daughter Darrelle Tuu.



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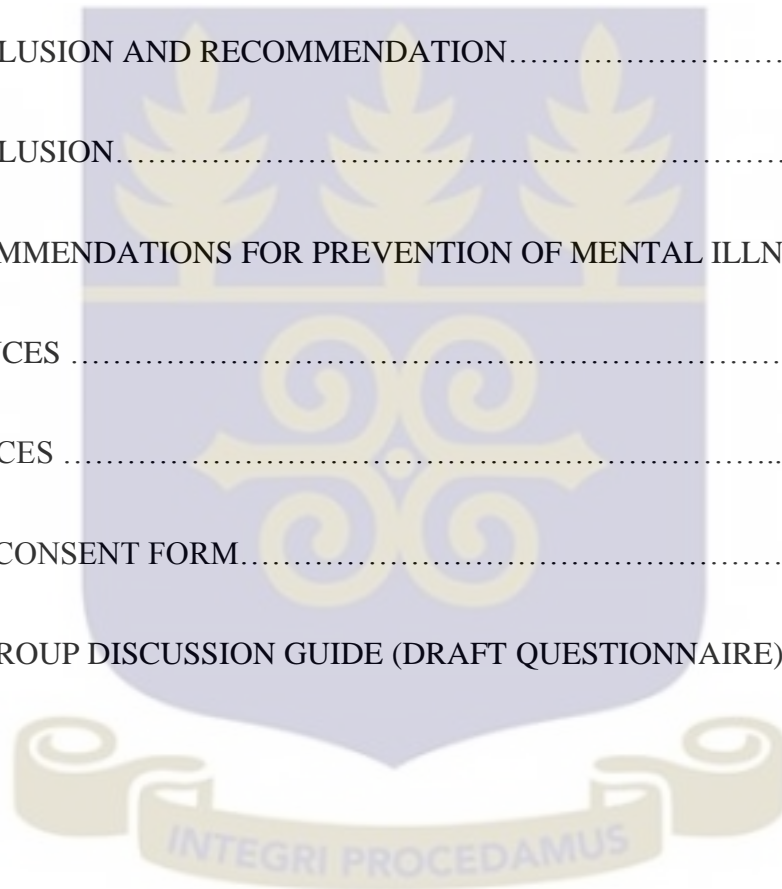
ABOVE ALL, I GIVE GLORY AND HONOUR TO GOD.

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LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
HIV	Human Immune Virus
HPA	Health Promotion Agency
MHA	Mental Health Atlas
MDG	Millennium Development Goals
NAMI	National Alliance of Mental illness
SRT	Social Representation Theory
USA	United State of America
WHO	World Health Organization



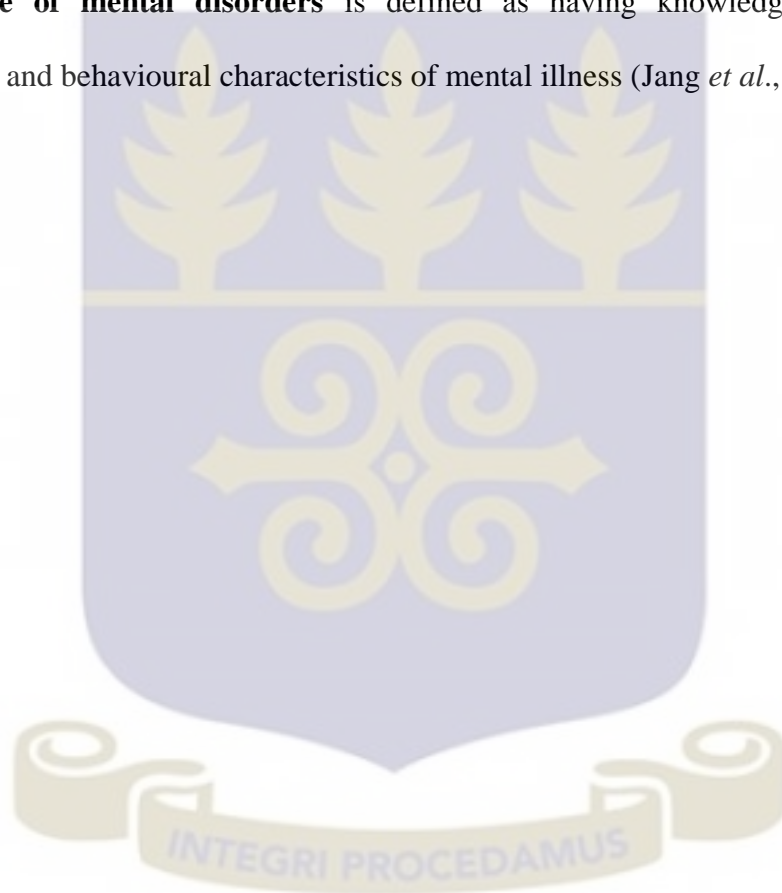
DEFINITION OF TERMS

Mental disorders is a medical condition that disrupts a person's thinking, feeling, mood, ability to relate to others and daily functioning (NAMI)

Attitude is explained as a construct not directly observable but precedes behaviour and guides one's choices and decision making factors.

Perception is beliefs about some mental disorders.

Knowledge of mental disorders is defined as having knowledge on the cause, prevalence and behavioural characteristics of mental illness (Jang *et al.*, 2012).



ABSTRACT

Mental illness has been a burden to many nations including Ghana, and has contributed greatly to disability worldwide. Many factors determine mental illness in people and it is important to know the knowledge and perception people hold about mental illness. This is because, knowledge of mental illness may lead to better outcomes for those with mental disorders, either by facilitating early help-seeking or by helping other people to identify early signs of mental disorders and seek help. It will also inform their perceptions about mental illness which will lead to positive attitudes towards the mentally ill.

This study was exploratory and qualitative using focus group discussions and in-depth interviews. Forty-one (41) adults participated. Six focus groups were carried out, with the aid an interview guide, three in each community. Two of the groups were men only, two were women only and two were mixture of men and women. Collected data was transcribed, developed in to themes and analysed.

The findings of this study revealed that community members have some level of knowledge of mental illness. Four meaningful illness causal belief dimensions have been identified as: life style factors, Supernatural factors, biological (genetic) factors, and psychological trauma. Majority of the respondents hold negative beliefs about mental illness and thus behave negatively towards the mentally ill.

This study brought together diverse research relevant to the topic and recommended education as a strategy to modify existing misconceptions about mental disorders. This research may also serve as a source of evaluation for further research into mental disorders.

CHAPTER ONE

1.0 GENERAL INTRODUCTION

1.1 Introduction

This chapter provides an overview of the study. It presents the background to the study, problem statement, purpose of the study, research objectives, significance of the study and organisation of the study.

1.2 Background

Ordinarily, human beings take health for granted until something goes wrong with our bodies. World Health Organisation ([WHO], 1948) defines health as a state of complete physical, mental and social well being and not merely the absence of diseases or infirmity. The definition maintains that biological, psychological and social factors are all important determinants of health and illness. Mental Health as defined by WHO (2004) is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. American Psychiatric Association in Diagnostic and Statistical Manual 4th edition (DSM – IV, 1999) also described mental illness as clinically significant patterns of behavioural or emotional functioning that are associated with some level of distress, suffering (pain, death), or impairment in one or more areas of functioning (e.g. work, social and family interactions); at the basis of the impairment may be biological, or environmental factors, or a combination of them. Health and illness are therefore closely associated with moods and feelings and a sense of balance or equilibrium. According to the (National Alliance of Mental Illness [NAMI],

2008) mental illness is disrupts a person's thinking, feeling, mood, ability to relate to others and daily functioning. It is also defined as a broad range of problems including cognitive, emotional and behavioural that impact the daily lives of people in their jobs or home and affect their relationships with others (Johnstone, 2001).

People assess their own health subjectively, according to their own norms and expectations. Social norms also play important roles in defining certain behaviours as normal or abnormal (mental disorder as violation of social norm). Thus what is considered normal may not be in the same in all societies; leading to Cultural Relativity (Horwitz, 1982). Horwitz (1982) identifies Incomprehensibility and Cultural Relativity as the two elements common to all cultural concept of mental illness. Horwitz related Incomprehensibility to the inability of the general population to understand the motivation behind the behaviour; and Cultural Relativity as those rules, conventions and understandings conceived within a culture that categorizes behaviour as normal or abnormal. Therefore a behaviour that is recognized as evidence of mental illness in one society may be viewed as normal in another society and vice versa. However, many serious mental disorder have been considered problems by people of every society regardless of when they lived, where they lived or what values they had, which suggests that social values must yield to objective reality in these instances.

Research has demonstrated that the prevalence of mental disorders worldwide is about 15% and rises to 40% if stress related disorders are included (WHO, 2001; Hwu, Yeh, & Chang, 2007). Unfortunately, governments have continued to assign a low priority to preventing and treating mental disorders (Devries & Wilkerson, 2003). Global

Burden of Disease study shows that mental disorders affect one out of four people during their life time (WHO, 2001; Hwu, et al., 2007). Anxiety and mood disorders are the most common mental problems worldwide (Mathers, & Loncar, 2006; der Ham, Wright, Van, Doan, & Broerse, 2011).

Global Burden of Disease study shows that mental disorders affect one out of four people during their life time (Hwu, et al., 2007). Anxiety and mood disorders are the most common mental problems worldwide (Mathers, & Loncar, 2006; der Ham, et al., 2011). According to WHO (2007) at least 2, 816,000 (13%) of the adult population are likely to be affected by mental disorders globally in the year 2020, and approximately 650,000 (3%) adults are suffering from severe mental disorders and a further 2,166,000 (10%) adults from moderate to mild mental disorders. This growing burden is poorly addressed in low-income and middle-income countries, resulting in widespread poverty, as well as worsening health and economic losses for the affected individuals, their families and communities Jenkins, Baingana, and Ahmad (2011). WHO projects that depression will be the second leading cause of burden of disease in 2020 (Mathers, & Loncar, 2006) and depression is expected by 2030 to rise to the second leading cause of global disease burden and will be the leading cause of disability in high income countries, second only to HIV/AIDS in middle-income countries and third only to HIV/ AIDS and prenatal conditions in low-income countries (Mathers & Loncar, 2006).

Jenkins, et al. (2011) estimated that the prevalence rate of common mental disorders in Africa ranges between 8% and 43%, depending on the population sampled and the instrument used). In Ghana, mental illness remains a major health issue. Sipsma, Ofori-Atta, Canavan, Osei-Akoto, Udry, & Bradley, (2013) revealed that, the prevalence of

psychological distress is substantial among both men and women. It constitute nearly 20% of the sample had moderate or severe psychological distress. They added that women who are disempowered and lack control in their intimate relationships are more vulnerable. In the Bolgatanga Municipality, there is a record of 559 cases of psychosis, 421 cases of epilepsy, 113 cases of substance abuse disorders, 55 cases of depression, 38 cases of neuroses, other forms of disorders accounted for was 179 in 2012. In addition to this, a total of 5029 cases of re-attendance were recorded (Upper East Regional Hospital Health Records, 2012). Yet, mental health remains a neglected topic, with limited interventions aimed at decreasing the burdens of mental diseases (Jacob, *et al.* 2007). It is therefore not surprising that out of the health expenditure of 4.5% of Ghana's gross national product, the government health budget is 1.4% (amounting to 31\$ per head and year), the remainder being paid for by external donors or user fees (WHO, 2007). Ironically, the National Health Insurance Scheme which was passed in parliament in 2003 to ensure universal healthcare services for all residents in Ghana, exempts mental illness from the insurance scheme (WHO, 2007). This means that patients with mental illness do not qualify to register with the insurance scheme (WHO, 2007). Implying that when a mentally ill patient has physical illness he will have to pay upfront for the cost of that physical illness. Given the substantial contribution of mental disorders to the global burden of disease, it is surprising that mental health is not included in the United Nations Millennium Development Goals (Millennium Development Goals [MDG] Report, 2007). WHO reported in 2005 that 59 out of the 185 countries that provided information to the WHO Atlas project including 21 countries in sub-Saharan Africa still do not have a budget line for mental health in the ministry of health budget (Mental Health Atlas [MHA], 2005). What then is the fate of the mentally ill and what do the public belief and know about mental disorders?

Surveys in several countries have shown that many members of the public do not correctly recognise disorders (Crabb, Stewart, Kokota, Masson, Chabunya, & Krishnadas, 2012; Quinn, 2007). In addition, interest has risen in the attitudes towards mental disorders and in interventions designed to increase popular knowledge and reduce the negative attitudes (Jorm, Christensen, & Griffiths, 2005; Gureje, Lasebikan, Ephraim-Oluwanuga, Olley, & Kola, 2005). The results of these studies show that the population has limited knowledge about mental disorders. In addition, these studies highlight the presence of negative attitudes in the population towards mental illness.

The frequency and widespread suffering caused by mental disorders make our understanding of them critical. Mental health is an integral and essential component of health (Prince, Petel, Saxena, Maj, Maselko, Philllips, & Rahman, 2007). Mental disorders make a substantial independent contribution to the burden of disease and accounts for more than 30% of years of life lost worldwide (Prince, et al., 2007).

In Africa and Asia supernatural phenomena like witchcraft and possession by evil spirits are seen as the main causes of mental disorders (Gureje *et al.*, 2005; Crabb et al., 2012). In Ghana, Barke, Nyarko, & Klecha (2011) reported that although mental illness is like any other illness, majority of the respondents saw it as a consequence of lack of Self discipline and will power. Good mental health literacy in people will lead to better outcome for those with mental disorders, either by facilitating early help seeking by those with disorders, or by helping other people to identify early signs of mental disorders and seek help (Kelly, Jorm, & Wright, 2007). This present study therefore examined the knowledge and perceptions of mental illness and brought together diverse research relevant to the topic as well as identified gaps in the area.

1.3 Problem Statement:

Although the benefits of public knowledge of physical diseases are widely accepted, knowledge about mental disorders has been comparatively neglected (Jorm 2000; Health Promotion Agency [HPA], 2006). Despite these problems of growing burden of mental disorders, not much has been done to understand community's knowledge and perceptions of mental illness in the Upper East Region and for that matter in Ghana. It is in light of this that this study examined the knowledge and perceptions (representation of mental) of mental illness. The findings of which, will serve as a reference point as well as a catalyst to promote other studies. The study employed the Social Representation Theory (Moscovici, 1981) to understand how lay people understand and interpret mental illness.

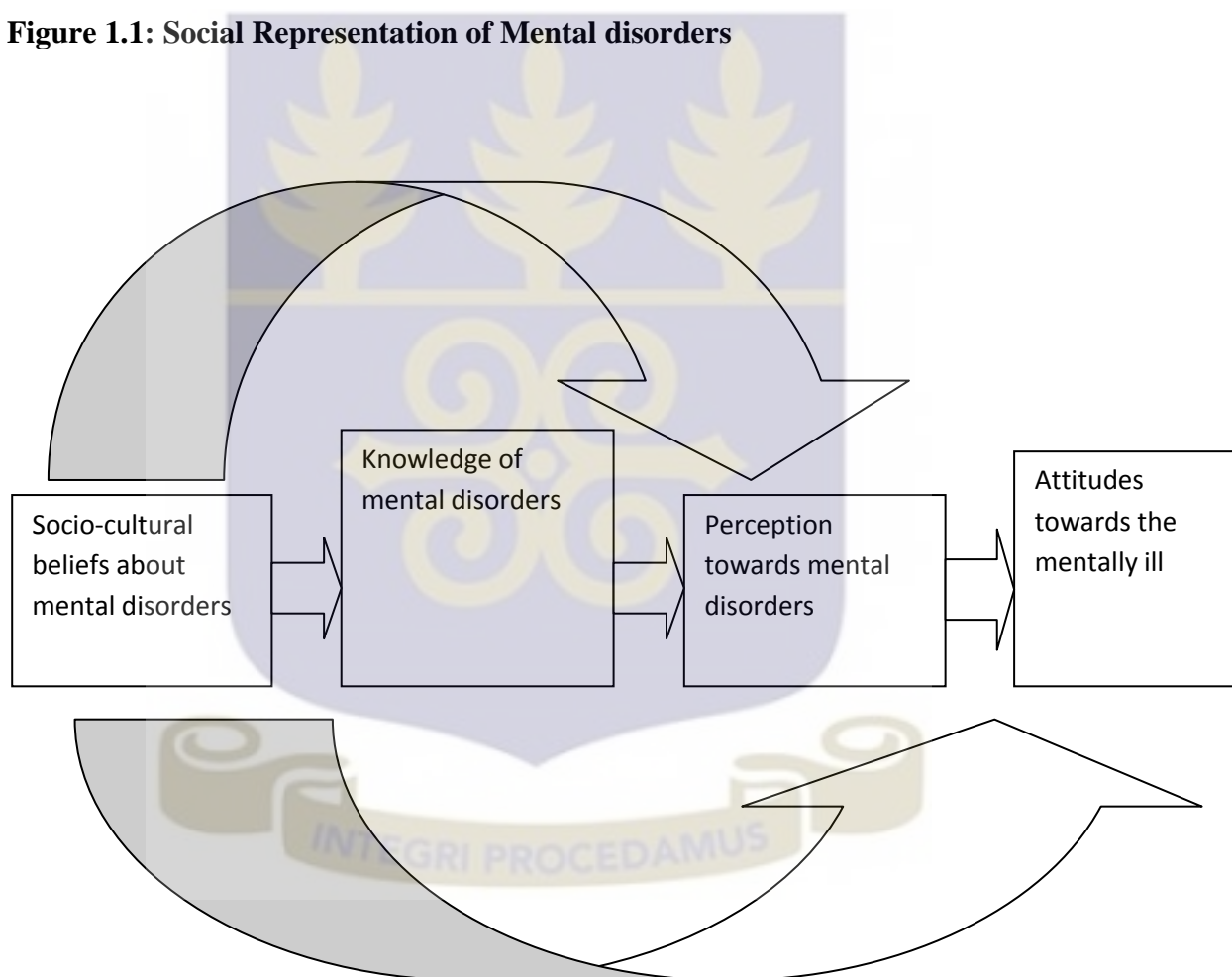
1.4 Conceptual Framework: Social Representation Theory (SRT)

SRT posits that knowledge of the world is a collective construction which expresses the understanding of a community (Farr, 1996; Moscovici, 1981). It describes how people's beliefs are socially constructed and reflect the understanding of a community as well as how individuals and social groups make sense of, and locate themselves in, their social worlds through the development of a shared body of common sense knowledge which provides a sense of familiarity and understanding (Farr, 1996; Farr& Moscovici, 1984).

The theory therefore looks at people's pattern of thinking concerning mental illness, acquired through messages they are exposed to from daily interaction and how that influences attitudes towards the mentally ill.

SRT thus, attempts to provide a framework for understanding the dynamic process through which historically and culturally specific belief systems about mental disorder are formed and circulated (Moscovici, 1976). Mental illness has occurred throughout history and has played an important part in the formation of their knowledge and beliefs regarding mental illness. Below is a diagram of a social representation of mental illness.

Figure 1.1: Social Representation of Mental disorders



Source: own construction

1.5 Justification of the Study

The trauma experienced from mental disorders cannot be over emphasized. The economic burden and mental agony on the family in particular are of significant note. More importantly, the prevalence of mental disorders in the community is still rising. Whereas the public know a lot about other major health problems such as cancer and heart disease, they lack the same degrees of knowledge about mental disorders and although the concept of mental disorders have been defined in many studies, Scholarly articles and research on mental disorders in Ghana have concentrated so much in Southern Ghana to the neglect of Northern Ghana. As a result this research seeks to serve that purpose as it intends to bring out issues confronting rural Northern communities on mental disorders. This study would also help bridge the knowledge gap created by previous researchers and scholars of mental disorders. This will also serve as a source of evaluation for further research into mental disorders.

1.6 Objectives:

1.6.1. Main Objective

The main objective of this study is to assess the knowledge and perceptions of mental health disorders among the people of Sumbrungu and Zuarungu.

1.6.2. Specific Objectives

- 1) To examine the peoples knowledge about the causes of mental illness.
- 2) To examine the perceptions of the people about mental illness.
- 3) To examine the attitudes of people towards the mentally ill.

4) To recommend actions to improve people's knowledge and perception about mental illness.

1.7 Organization of the study:

This study is presented in five chapters: Chapter one consist of the introduction, background information, statement of the problem, purpose of the study, research objectives, assumptions, significance of the study, the organization and limitations of the study ,.

Chapter two is the literature review which entails the theoretical and empirical literature on the subject under study.

Chapter three contains the Research Design and Methodology which describes the data collection procedure, survey design, study population, sampling techniques and how data is analyzed.

Chapter four presents the data analysis and discussion of the research findings. Chapter five is the summary, conclusions and Recommendations of the study for policy makers and future research. Relevant references and appendices are also presented at the end of the dissertation.

1.8 Scope and Limitation of the Study:

This study had basically three constraints. One of which was the constraint of time. This study used qualitative data collection methods specifically FGD and in-depth interviews which are time consuming. Consequently, this did not allow for the interview of a lot more community members.

The other shortcoming was the inadequacy of literature with regard to related studies in this field concerning Upper East Region and for that matter Ghana. As a result, the study relied mostly on works carried out in other countries mainly in Vietnam, Nigeria, South Africa and Ethiopia among others.

Its generalizability is limited due to the focus on small sample size from two communities. However, the qualitative design allowed for an information-rich analysis of community members perspectives that could be expanded in future studies.



CHAPTER TWO

2.0 Literature review

2.1 Introduction

This chapter presents a critical review of the literature on knowledge and perceptions of mental disorders. It is worth noting that generally research discussing the knowledge and perception of mental disorder in Ghana is very limited. Relevant studies in both developing and developed countries are reviewed with particular emphasis on the findings and methodological issues in developing countries. A search was conducted through published journals which were relevant to the topic. Some of the thematic areas under review include knowledge of mental illness, attitudes towards mental illness and perceptions about mental illness. In addition a search was conducted using the references of the articles obtained in the electronic search.

2.2The Basics of Social Representation Theory (SRT)

SRT was developed by Serge Moscovici in 1961 based on Emile Durkheim's 1898 collective representations (Moscovici, 1984). It was introduced into contemporary social psychology as an alternative to the individualistic approach which Howarth (2006a) purported dominates the field.

Moscovici (1984) social representations (SRs) are embedded in the history and culture of the society and so determine the psychological understanding of the social world and provide a common-sense framework for interpreting experiences which manifest themselves in public discourses.

Representations are therefore seen as social creations forming part of social reality and not “individually produced replicas of perceptual data” (Billig, 1993; Moscovici, & Perez, 1997).

2.3 Understanding the Concept of Mental illness:

Mental illness and mental health are terms not easy to define. The misunderstandings about the definitions have led to incorrect use of the terminologies that help reinforce myths and even prevent people getting help when they really need it. The term mental illness often conjures up images of a person tortured by ghost or demons only he or she sees or by the voices no one else hears.

These are distorted views of mental illness which overrules the fact that most people who have mental illness are in touch with reality and not all of them have hallucinations and delusions. These views also overlook the important reality that people suffering from mental illness can effectively return to normal, productive lives if they receive early and appropriate treatment.

Mental illness is thus defined as a broad range of problems including cognitive, emotional and behavioural that impact the daily lives of people in their jobs or home and affect their relationships with others (Johnstone, 2001).

Mental illness has occurred throughout history and has contributed significantly to community knowledge and perceptions of mental illness. Primitive mental illness was usually associated to religion. In early Greek times, supernatural beliefs were regarded as the causes of mental illness. The ancient Greece saw Hippocrates attribute mental illness to imbalances of the four basic fluids (yellow bile, black bile, phlegm and blood). They

also believed the brain was responsible for mental and emotional purpose. The middle age came back to supernatural cause. In the early 20th century, mental illness was associated to biological factors (Zartaloudi & Madianos, 2010). Today, surveys indicate that people attribute mental illness to one or more of these factors mentioned above.

Different people from different cultures hold varied beliefs regarding what causes mental illness. Among most none western cultures, supernatural phenomena such as witchcraft and possession by evil spirits are seen as major causes of mental illness (Gureje *et al.*, 2005; Crabb *et al.*, 2012).

Whilst some western cultures attribute mental illness to psychosocial factors, to some non western cultures, mental illness is not considered merely a personal failure but also a disgrace to the family. These beliefs can affect family members. Therefore, the families of mental patients often conceal the fact from others (Hinshaw, 2000).

Research on mental health in Vietnam suggest that, the burden of mental illness is high and appears to be rising, but then, the health system still pays little attention to mental illness. Access to mental health care is limited and few health policies address mental health (Harpham & Tuan 2006). The study also reveals that, for a long time the national plan of action focused only on the treatment of schizophrenia and epilepsy in hospitals. Although epilepsy is a neurological disorder, it is often (as is the case in Vietnam) treated as a mental illness by psychiatrists because people with epilepsy often have considerable psychiatric co-morbidity and share many of the same problems with the mentally ill regarding training, planning of services and treatment (Mbuba & Newton 2009).

Fisher, Morrow, Nhu Ngoc, & Hoang Anh, (2004) found that 33% of the women attending general health clinics in Ho Chi Minh City were depressed after giving birth and 19% of them explicitly acknowledged suicidal thoughts. Giang, (2006) also found a

prevalence of 5.4% of mental distress in a rural area in Vietnam. Only 42% of those people, however, received treatment for their problems and only 5% sought treatment at official mental health facilities. Help-seeking behaviour of the Vietnamese is influenced by Vietnamese concepts of mental illness and health, which are based on a mixture of traditional and modern beliefs.

In New Zealand, people with experience of mental illness have been found to be among those disability groups with the lowest rates of employment, at 44%, with only approximately 27% being in full-time work (Jensen, Sathiyandra, Rochford, Jones, Krishnan, & McLeod, 2005). People with experience of mental illness are also the most likely of all disability groups in New Zealand to be in receipt of a benefit, with 48% of people with experience of mental illness claiming some sort of benefit (Jensen et al, 2005).

Again, in the United States of America (USA) age and race can influence employment, younger people with experience of mental illness are significantly more likely to be employed than older people with experience of mental illness, and Caucasians with experience of mental illness are significantly more likely than people of colour who have experience of mental illness to attain employment (Wewiorski & Fabian, 2004).

2.4 Knowledge and perceptions of mental disorders

Knowledge of mental illness is defined as having knowledge on the cause, prevalence and behavioural characteristics of mental illness (Jang, Lim, Oh, Lee, Kim, & Lee 2012). Mental illness is a significant contributor to global disease burden and this is expected to increase over the coming decades. Despite the increasing effect of mental illness to the burden of disease worldwide, knowledge on mental disorders has been comparatively

neglected to knowledge of physical diseases (Jorm, 2000 : HPA, 2006). There is therefore increasing debate about how mental illness is understood and defined across different cultures and traditions and how this may influence society's response (Gureje *et al.*, 2005: Sadik, Bradley, Al-Hasoon, & Jenkins, 2010)

In America, researchers at George Mason University in Virginia conducted a study of 300 articles containing references to mental illness that were taken from six different 1999 U.S. newspapers. Few of these stories presented positive images of people with mental illness or depicted people with mental illness as productive. This study and others like it have led researchers to conclude that the public, based on what they see in the news media, are likely to presume that people with mental illness are primarily burdens to society and incapable of contributing in positive ways to their communities (Wahl, 2001). The study shows that only 7% of all stories about mental illness included mental health consumer's viewpoints (Wahl, 2001).

The scarcity of first-person accounts by people with mental illnesses in these stories limits the perspectives available to readers and conveys the false impression that people with mental illnesses are incapable of developing opinions and speaking on their own behalf.

In Asia results of a study in Vietnam showed a general lack of knowledge on mental health among relatively well educated urban residents in central Vietnam. "Mad" and "insane" were commonly used to describe mental illness. However some few people were able to identify schizophrenia. Respondents generally believe stress or tension and excessive study or thinking are the causes of mental illness. These findings points at culture specific perceptions of mental health in relation to stress and mental overload (der Ham *et al.*, 2011).

A study in Iraq by Sadik, Bradley, Al-Hasoon, and Jenkins (2010). shows that the respondents have a fair knowledge on the factors that cause mental illness. over half (51.32%) or (61.5%) of respondents agree that mental illness is caused by brain disease or genetic inheritance respectively and nearly half (46.39%) belief that substance abuse is the cause of mental illness and about two third (67.24%) believe mental illness is caused by something bad happening to you while less than a third (30.17%) thought mental illness is God's punishment and nearly two third (59.23%) view personal weakness as the cause

Sadik *et al* also reveals a mixed attitude towards mental illness with a large number of the participants (70.66%), (65.37%) and (54%) holding negative attitude towards mentally ill people in relation to marriage, treatment and friendship respectively. Majority (83.35%) blame the patients for their condition. However, over half (54.22%) of respondents said they will be caring and sympathetic towards mentally ill people. And 52.67% said people with experiences of mental illness should be prevented from giving birth. Again 75.66% of respondents said they will not disclose it to people if they have mental illness and 54.97% respondents will feel ashamed if their relative is diagnose with mental illness.

Studies carried out in Africa (Kabir, Iliyasu, Abubakar, & Aliyu, 2004; Deribew & Tamira 2005), suggest that overt psychotic behaviour that attracts public attention and is socially disruptive is associated with mental illness, in any society. These results suggest that perceptions of the severity of mental illnesses are strongly related to the recognition of those illnesses and related symptoms, and that both are strongly influenced by a lack of knowledge and awareness. Deribew and Tamirat (2005) revealed that the respondents ranked schizophrenia as the most severe condition, while depression and anxiety were considered the least severe.

In Karfi village in northern Nigeria, Kabir, et al. (2004) revealed that, the most perceived symptoms of mental illness by respondents included aggression or destructiveness (22.0%), talkativeness (21.2%), eccentric behaviour (16.1%) and wandering (13.3%). Drug misuse in forms of alcohol ingestion, cannabis and other psychoactive street drugs were identified as major causes of mental illness (34.3%), followed by effect of divine wrath or God's will (18.8%), magic or spirit possession (18.0%), and accidents or trauma (11.7%). Few respondents however, attributed mental illness to: heredity, family conflicts and financial distress or poverty.

In some sub-Saharan African cultures, evidence suggests that supernatural phenomena such as witchcraft and possession by evil spirits are seen as important causes of mental disorder. For example, in nearby Malawi, literature reveal that, majority of participants attributed mental illness to substance abuse and spiritual causes such as spirit possession and God's punishment. About 95% attributed mental disorders to alcohol and illicit drug abuse, 92.8% to brain disease, 82.8% to spirit possession and 76.1% to psychological trauma. The least of respondents associated mental disorder to God's punishment 21.9%, followed by biological factors 32.8% and then poverty 43.3%, (Crabb et al. 2012).

A study in Nigeria revealed a remarkably poor knowledge about mental illness. Not only do they believe mental illness is due to possession by evil spirits or divine punishment, there is also a widespread belief that misuse of drugs is the cause of mental illness. This view is not wrong. However, since this is only true for a very limited number of mental disorders and since the Public often views the misuse of drugs as moral failing, this belief may be translated to a notion of mental illness as being self inflicted. Such a view is more likened to condemnation rather than understanding (Gureje *et al.*, 2005).

In surveys of community attitudes to mental illness in South Africa, members of the general public have been found to attribute mental illness to stress or a lack of will power rather than a medical illness (Hugo, Boshoff, Traut, Zungu-Dirwayi, & Stein, 2003).

The story is not different in Ghana Barke *et al.*, (2010) had majority of their participants reject the view that mental illness is like any other illness rather it was seen as a consequence of lack of self discipline and will power.

Traditionally, mental illness has not been well understood by the general public, resulting in poor attitudes and stigmatization towards persons with mental illness (Youssef, Bachew, & Bodie 2012).

2.5 Attitude towards mental disorders

The word ‘attitude’ was originally derived from the Latin word ‘aptus’ meaning to ‘fit and ready for charge’, but this old version of interpreting attitude has now been replaced by more meaningful ones. Today attitude is explained as a construct not directly observable but precedes behaviour and guides ones choices and decision making factors. Attitudes are perceived as responses that locate objects of thought on dimensions of judgment. Objects of thought are the issues or the people about whom opinions are based and dimensions of judgment describe the range over which evaluations extend as from good to bad or from positive to negative.

In 2006, a study conducted by Health Promotion Agency (HPA) for Northern Ireland on public attitudes perceptions and understanding of mental health in Northern Ireland, revealed that there is a strong (98%) recognition that anyone can experience mental health problems. 91% of participants, said that people with mental health problems

should have the same rights as anyone else. 54% of respondents however, stated that they would not want people to know if they are suffering from mental illness.

A comparative study between Japan and Australia on stigma in response to mental illness shows that Japanese have higher negative attitudes towards mental illness than Australian respondents. 58.0% and 73.8% will not vote for a politician with depression and chronic schizophrenia respectively compared to 30.1% and 45.7% of Australians respondents. Also, 38.6% and 61.1% of Japan respondents will not employ someone with depression and chronic schizophrenia respectively as against 21.6% and 32.4% of Australian respondents. Again, more 45.4% and 46.0% against 13.9% and 14.0% of Australian respondents opine that depression and schizophrenia respectively were signs of personal weakness. And 40.2% and 35.8% participants of Japan against 14.6% and 13.9% of Australian participants think that depression and schizophrenia respectively are not real mental illness. However, more 42.2% and 67.5% Australian, than 18.6% and 45.6% Japanese, said that people with depression and schizophrenia respectively were unpredictable (Griffiths, Nakane, Christensen, Yoshioka, Jorm, & Nakane, 2006).

Wagner, Manicavasagar, Silove, Marnane, and Tran, (2006) found that, Vietnamese people could not differentiate clearly between the terms 'stress', 'depression' and 'anxiety', which are used as different words for a single psychological construct. It is notable that participants in the study sometimes gave traditional explanations for mental illnesses, but much less frequently than modern explanations. A possible explanation for this finding is that respondents answered in a socially desirable way in which modern views of mental health would be more socially desirable than traditional views. Attitudes towards the different mental illness vignettes in the study area were mostly negative for the alcoholism vignette, followed by the schizophrenia vignette. These results suggest that, people have the most negative attitudes towards mental illness associated with

socially disruptive behaviour. This result is in line with findings from Deribew and Tamirat (2005).

In Malawi, Crabb et al. (2012), had majority (63.3%) of respondents opine that they would be afraid to have a conversation with a mentally ill person. 68.5% of participants said they would be able to maintain a friendship with a mentally ill person. However, less than half: 8.1%, 18.6% and 40.6% of the respondents said they would be ashamed if their relative is diagnosed with mental illness, marry a person with experience of mental illness and share a room with a mentally ill person respectively.

In Nigeria, People with mental illness were believed to be mentally retarded, a public nuisance and dangerous. This therefore informed majority of Participants decision not to have social interactions with those with mental illness (Gureje *et al.*, 2005). About 83% reported that they would be afraid to have a conversation, 78% said that they would be upset or disturbed about working on the same job, 81% reported that they would not share a room, and 83% responded that they would feel ashamed if people knew that someone in their family had been diagnosed with a mental illness. Only 17% reported that they could maintain friendship with a person with mental disorder (Gureje *et al.*, 2005).

Also, a study of attitudes towards 10 physical and mental illnesses in the Ethiopian population by Mulatu (1999) revealed a gap in attitude depending upon the illness characteristics. The diagnoses with the strongest stigma attached were leprosy, schizophrenia and tuberculosis, with less than 20%, of the participants prepared to work with, be friends with or marry a person with schizophrenia. Less than 25% of the participants were prepared to work with, be friends with or marry a person with leprosy and with less than 33%, of the participants were prepared to work with, be friends with or marry a person with tuberculosis.

In Ghana, Ngissah (1975) compared the attitudes of 564 American High School and College students from Sacramento (California) with 280 Ghanaian High School and College Students from Accra towards the mentally ill. Result shows a more negative and rejecting attitudes towards mentally ill persons in the Ghanaian sample. 57.9% of the Ghanaian respondents held the view that mental illness in the family brings shame on the family name and 57.5% that it is wise to keep it a secret as much as possible. 60.4% of the Ghanaian participants felt that mental illness is not an illness like other illnesses, 78.9% agreed that patients in mental hospital are like children and 71.8% subscribed to the opinion that anyone hospitalized for a mental illness should be banned from voting. Also a qualitative study by Quinn (2007) revealed that many relatives of mentally ill persons were worried about stigma and negative attitudes from society and the extended family.

According to Sodzi-Tetteh (2007), most people do not want their relatives to specialize in mental health because of the stigma attached to mental illness. Some people refuse to go for their treated and discharged relatives from the hospital. Yet others even give wrong address so that they will not be traced. Surprisingly, some health workers believe that, a patient with mental illness can never truly be cured.

Sodzi-Tetteh (2007) draws the conclusion that the stigma towards mental illness is more serious than one can imagine. He stressed that this stigma affects everything from the policy adoption stage through commitment to implementation of the policy including community based care. He argues that the plight of the mentally ill would have been better if not for the neglect by politicians and people of Ghana.

According to Barke *et al.* (2010), stigmatisation of mental illness is a serious problem faced by the mental health system. Findings of this study show that, only 22.9% of

participants endorsed that it is best to avoid people with mental illness. This positive attitude extended to potential marriage with only 27.6% agreeing that it would be foolish for a woman to marry a man who has suffered from mental illness. Although 54.6% asserted that no one has the right to exclude the mentally ill from their neighbourhood, 42.1% believed that the mentally ill should be isolated from the community and 39.7% would not want to live next door to someone who has been mentally ill. However, locating mental health services in residential areas was not regarded as dangerous by 76.9–80.0% of the respondents.

In general, 66.8% of the participants felt that the society ought to adopt a more tolerant attitude, although 56.3% judged that the mentally ill are a burden on society, the responsibility to provide the best possible care for the mentally ill was widely acknowledged by 80.3% of the participants, spending tax money for that purpose was endorsed by 63.3% of participants.

However, it is difficult to generalise attitudes towards mental illness even within the same geographical region of the African continent (Crabb *et al.*, 2012).



CHAPTER THREE

3.0 Methods

3.1 Introduction

This chapter describes the research methodology. A description of the research design, research setting, target population, sampling size and sampling strategy are given.

Research instruments used and the ethical issues relating to the study are also given

3.2 Research design

The study is essentially exploratory. This research design is relevant to the study because of its flexible and change adaptable nature. It is also a valuable means to seek new insight, to ask questions and to assess phenomena in a new light. Its ‘two-phase’ approach makes it easy to implement and straight forward to describe and report. This section therefore, presents an overview of the methods to be used in collecting and analyzing the data for the study. The section further includes the description of the research design, population, sample and sampling techniques, data collection and analysis.

3.3 Research Setting

All data were collected in two communities: Sumbrungu and Zuarungu within the Bolgatanga municipality of the Upper East region of northern Ghana. Approximately 160,000 people live in these communities 90% in rural settlements. Subsistence farming is the main occupation, and poverty is widespread. There is a single rainy season from April to September, during which most precipitation falls in brief, intense storms that can flood fields and cause significant erosion. The municipality has an average of 70 rain days and 600 – 1,400 mm of rainfall per year. Although many of the communities soils

are inherently fertile and have good water holding capacity, their productivity has been degraded by intensive use. The area's soils are now characterised by low fertility, low water holding capacity and susceptibility to sheet erosion. During the dry season, many rivers and streams dry up, vegetation withers, livestock suffer severe weight losses and as many as 70% of households send at least one member to seek employment in southern Ghana for up to six months.

The socio-economic characteristics of the area are based mainly on a very complex network of cultural systems and extractive activities based on land. Crop production and livestock rearing are the major gainful activities with only a relatively few percentage engaged in formal jobs and informal jobs such as trading, vulcanizing, artefacts making and wood cutting. Other activities that sustain the lives of women are basketry, 'pito' brewing, Shea Butter processing, Dawadawa and groundnut oil processing.

There are few health facilities throughout these communities and the Bolgatanga regional hospital serves as a referral facility. The data indicate that there is an acute shortage of essential health staffs with a total number of (213) available staffs against required number of (447) health personals. There are also many transportation challenges. Sumbrugu like Zuarungu is five (5) miles outside the regional capital of Bolgatanga where the municipal hospital is located the only facility in the region where you can find a unit allocated for mental health.

These setting have been chosen because of the increasing cases of mental disorders and easy access to the participants. Though there are higher records of other cases such as malaria and acute respiratory which records 59,670 and 13,173 respectively for the year 2012 as against 6,394 mental cases, but neglect of mental cases makes it problematic.

3.4 Variables for the study

The variables for the study include demographic characteristics, knowledge, perception, attitudes and mental disorders.

3.5 Study population

The study population were adults residing in two communities: Zuarungu and Sumbrungu in the Bolgatanga Municipality.

3.6.0 Sample

Overall 41 adults who have family member(s) with mental illness were purposively selected to participate in the study. These people were selected to participate in the study because they had first hand experiences with person with mental illness. They comprise 23 males and 18 females. Two of the participants participated in in-depth interviews and the remainder in focus groups.

3.6.1 Sampling Technique

A community volunteer who worked with the mentally ill lead the researcher to the houses of the mentally ill. The Researcher interviewed any adult family member who was willing to participate in the study were recruited.

3.6.2 Eligibility criteria

Participants were adults from eighteen (18) years to sixty (60) years.

Participants were resident in the area for at least twelve (12) months.

3.6.3 Focus Group Discussion

Focus Group Discussions (FGD) and in-depth interviews were used to obtain primary data from respondents with the help of one (1) research assistant trained on the interview guide and on interview techniques. Two in-depth interviews and six focus groups made up of six (6) participants in three groups and seven (7) participants in the other three groups were conducted. There were two male groups, two female groups and two mixed groups.

The FGDs were used to explore the people's subjective beliefs and representations of mental illnesses. All interviews were audio recorded, conducted in the local language, and transcribed into English and notes taken on verbal and non-verbal communication. Permission was sought before the notes taking and the audio-recording. The interview solicited information regarding the participant's demographic characteristics, knowledge on mental disorders, perceptions and beliefs about mental disorders and attitudes towards mental disorders.

Focus Group Discussions (FGDs) was used for this study because they have traditionally been employed in the social sciences and have much to offer studies on health related issues (Pope & Mays, 2006). Also, FGD highlight (sub) cultural values or group norms; and so makes FG a data collection technique particularly sensitive to cultural variables.

Table 1: Focus group discussion participants

Participants	Number 39 (22 males and 17 females)
Zuarungu (males only group)	13 (7 males and 6 females)
Zuarungu (mixed group)	6 (4 males and females 2)
Sumbrungu (males only group)	14 (7 males and 7 females)
Sumbrungu (mixed group)	6 (4 males and 2 females)

3.7 Data Collection Techniques

The researcher first explained the aims of the focus group discussion and established the ground rules for the session before discussing the issues. The participants were encouraged to freely express their views. Participants were gathered in a semi-circle around the interviewer. Questions were posed to the group, and the interviewer recorded responses from participants one by one, moving the hand-held microphone closer to the respondent who was speaking. Session lasted between 60 and 90 minutes. The venues were the community health care centre for the discussions for Zuarungu community and the community social centre for Sumbrungu. A prepared guide was used to ensure that discussions covered all the important themes of the study. Appropriate and relevant documents were reviewed to complement the primary data sources.

3.8 Data collection instrument

An interview guide, a tape recorder, field notebook and a field diary were used to collect data.

3.9 Quality Control

To establish reliability of the analysis, an independent coder was employed to code about 30% of the transcripts, selected at random, using the coding scheme of the researcher. There was more than 80% agreement in codes (i.e. the concordance rate). A second person was made to read through the work.

3.10 Ethical Consideration: Permission and invitation to participate

Permission to conduct FGDs in the community was sought from community leaders. Permission to conduct the in-depth interviews was sought from the participants.

Information about the objectives of the discussion and the purpose of the overall study were provided to each potential participant. Confidentiality with regard to their participation and anonymity with regard to their stored data were assured, and each participant was asked for his or her verbal consent to participate in the interview or focus group discussion. Permission to audio-record the discussions was also sought and obtained. In conducting both IDIs and FGDs, each participant was assigned a unique ID number and no name was recorded. Participants did not receive any monetary incentive for participating in the discussions. However, a cake of soap was provided as a token of

appreciation for participation. This study was approved by the Ghana ethics review committees.

3.11 Pre-test of interview guide:

The interview guide was pre-tested on adults at Tindonsubligo. This was done to find out the appropriateness of the guide and the necessary corrections and modifications were made on questions that were not well understood before the guide was used for the study proper.

3.12 Conclusion

This chapter discussed the research design, population, sample and sampling design. Data collection instruments, the data collection process, pre-testing, data collection instruments, data processing and analysis, ethical consideration as well as limitations of the study



CHAPTER FOUR

4.0 DATA ANALYSIS AND PRESENTATION

4.1 Introduction

In this chapter the results of the study are described and the analyses of the data presented. The taped interviews were transcribed verbatim according to the aim of the study and the resulting texts analysed by using thematic analysis. Transcripts were analysed using basic deductive approach (Maykut & Morehouse, 1994).. An attempt was first made to extract broad themes from the transcripts and then progressed to identifying coded themes. In establishing themes, considerations were given to statements of meaning that were present in most of the relevant data. In an attempt to ensure, the credibility of the findings independent coders were used to verify the themes extracted from the data. This allowed the researchers to progressively focus the interviews and observations, and to decide how to test the emerging conclusions. Quotes from respondents were used to support the emerging patterns of concepts from the data.

The findings are reported according to the themes of the study. The chapter would be divided into six sections. The first section would comprise the data analysis, the second section reports the demographic characteristics of the participants third section is on the knowledge of mental illness, the fourth section looks at the attitudes of the people towards the mentally ill, the fifth section reports on the perceptions of the people about mental illness and the final section would draw at final conclusions of findings.

4.2 DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS:

The respondents fell within the ages of eighteen (18) and sixty (60). Forty-one (41) participants were interviewed from two different communities. Out of the total number of participants, twenty-four (24) of them were males and the remaining seventeen (17) were females. The commonest religion is Christianity with a record of twenty-seven (27) participants, followed by Traditional religion with twelve (12) respondents and the least being Islamic which registered only two (2) participants. Most participants have attained some level of education with the highest being basic. However, sixteen participants have not had any education. With regards to marital status most participants were married, with seven participants being single, six widows and only one divorce case. A greater number (28) of respondents were self-employed with the common occupation being farming, trading and basketry. However, there were few (5) unemployed cases.

4.3 knowledge of mental illness:

Knowledge of mental illness is defined as having knowledge on the cause, prevalence and behavioural characteristics of mental illness (Jang *et al.*, 2012).

4.3.1 Understanding of mental illness.

Social representations theory as applied to a health threat issue involves consideration of the cause of the disease (Howarth, 2007; Moscovici, 1981,1984, Morant, 2006). The participants were therefore asked about their knowledge of mental illness. The participants described mental illness in bio-psycho-social term. For the biological causes, the participants believed the illness is caused by mal-functioning brain; accidents

resulting in head injuries; eating foods that do not agree with the person's system and so caused abnormal changes in the brain. The belief in the abnormal function of the brain was universal among the participants. Those who hold these beliefs also indicated that the abnormal functioning of the brain or system causes the person to behave abnormally. That is, puts up behaviours that are not consistent with the majority of the people or at variance with the society's norms.

Some also believe mental illness has supernatural cause, such as destiny and punishment from a deity for not fulfilling an obligation. The three excerpts below reflect the beliefs

Male from Sumbrungu

"What I know is that society expects everybody to behave in a certain manner so if one behaves contrary to that then it is considered abnormal".

Male from Zuarungu

"...mental illness is in two dimensions: is a sickness that could result from an accident or a punishment for the failure of one to fulfil his or her part of a contract with a deity".

Female from Zuarungu

"Is a condition in which a person state of mind is not functioning properly there by making the person elicits some abnormal behaviour persistently".

4.3.2 How to identify a mentally ill person (Manifestation of mental illness).

When asked about the behaviours exhibited by the mentally ill, the following were mentioned: “Moodiness, shouting, laughing, talking to oneself, shabbily dressed, too neat, dirty and naked”. However, there were differences in responses to features of mentally ill people. Whereas some of the participants used physical appearance to describe mentally ill (e.g. dirty, unkempt) others used behaviours to denote the mentally ill. Some of the terms they used were “anti social”, and “beyond the norms of human behaviour”. These differences show that the respondents did not see mental illness as the same and recognised that some conditions are severe than others. Below are some views of participants:

Female from Zuarungu

“A mentally ill person always behaves differently from other members of society. He does things that no one expects him to do. His or her behaviour doesn’t conform with the behaviours of society”.

Female from Sumbrungu

“There are some group of mentally ill people who are always very quiet, reserve and isolated from people. They are also, mostly absent minded a behaviour which was not part of them. If you give them food they will not eat and some may throw the food away”.

Male from Sumbrungu

“Moodiness, do not like confined places, likes shouting, laughing unnecessarily; very aggressive, talking to oneself, always shabbily dressed, too neat, mostly isolated, always dirty, always naked among others”.

Findings of this study show that beliefs about the causes of illnesses are multidimensional and consistent. Four meaningful factors have been identified: life style factors, Supernatural factors, biological (genetic) factors, and psychological trauma. From the above report it could be deduced that the participants had some ideas about the causes of mental illness and how the condition presents. There were also mythical believes and misconceptions in their conceptualization of mental illness

4.3.3 causes of mental illness.

The belief in supernatural (social) causes of mental illness was widespread and consistent. Mental illness was commonly seen by participants as punishment for transgressions and moral failings such as: breaking of taboos, stealing and adultery. Respondents generally believed that adultery could attract a punishment of mental illness as it is deemed an immoral act. Breaking of taboos was a sign of disregard for culture which could attract a punishment of mental illness. Stealing is considered a serious social vice by society and justified by Christians as a sin in the Ten Commandments. It could thus attract a penalty of mental illness. There were beliefs that witches and wizards can also make a person mad. These witches and wizards either places curses on people and this was also universally supported. Other factors such as evil spirits, sorcery and a

pledge made to the gods by people to offer certain sacrifice in exchange for wealth are commonly seen to have caused mental illness. Below are quotes from some participants

Male participant from Zuarungu

“If one does bad things (bad deeds) madness can befall you. Cheating and stealing. If you take something which doesn't belong to you, madness can befall you. The owner can consult a deity or swear against you to go mad. I have ever witness something like that, I hope you know Abubandoosi, he stole his boss's bag of millet, and when she asked him, he threatened to beat her. She went to a juju man and in no time he was roaming naked in the market. It is his bad deeds which led him to that”.

Male participant from Zuarungu

“The bad deeds are many, so if we sleep over them more would come. If you are also plotting against an innocent person, God can reverse it against you because, the person has nothing against you. And if you are mad it has no cure because, you said that somebody should go mad, now you take it”.

Male participant from Zuarungu

“That is the reason why they say God does not owe people but he pays debts, so if somebody is struggling to do something and you say no, God will turn what you are planning against the person to you”.

Female from Sumbrungu

“Killing or murder can also cause mental illness. Usually in our culture, there are certain rites one has to perform when you commit murder or kill somebody. These rites vary depending on the sex of the deceased. But in an instance where you kill a

pregnant woman, it will be difficult to determine the sex of the unborn baby in order to perform the appropriate rite. Failure to perform the right rite can attract mental illness as a punishment”.

Male from Sumbrungu

“The spirit of a bad tree could make one mentally ill. It is a belief that day time is for human beings and the night for spirits .where one come out in the night and encounter such a spirit the result could be mental illness. It usually comes in a form of a person to beg for something and if you refuse to grant his/her request then the punishment is madness”.

When asked how one can know that this person that is begging is a tree and not a human being? He said,

Male from Sumbrungu

“Such a person cannot change completely when one look critically at that person you will see either a leaf of a tree or the back of the tree on the ear or any part of the body but it will not be hidden”.

Another participant buttresses this point, by asserting that,

Female from Sumbrungu

“Mostly when you meet such spirits it becomes difficult for one to run or shout and they make you mad so that you will not be able to narrate what you saw”.

Mental illness is also associated with life style factors such as: disobedience, too much drinking of alcohol, smoking weed, cocaine and cigarettes which is strongly morally sanctioned, representing a form of marginalized and anti social behaviour, particularly among young men. Some participants stated that all alcoholic beverages could cause mental illness when not taken in moderation. Others believed that bottled drinks were more accountable whilst the local alcoholic beverages apart from akapatashie were not harmful.

Male from Zuarungu

Akapatashie are not harmful. A participant shared his view,

“We also buy some of the mental illness, the different types of cigarettes and alcohol people smoke and drink are the causes of mental illness. Buying in the sense that, one actually spends money to acquire these alcoholic drinks, weed, cocaine and the other forms of drugs which causes mental illness. Some people have weak blood whilst others have strong blood so if the weak blooded person imitates the strong blooded person the result will be mental illness”.

Knowledge on the biological causes of mental illness was generally high and unanimous. The role of a family history (genetic) as a common cause of mental illness was undisputed. However, mental illness was more attributed to the male parent of the patient. They believe that a person is born with mental illness because his father or ancestors also had it. Some sample views of the respondents include,

Female from Sumbrungu

“There are different ways that you can get a boil, it can be itching before it starts, and it can also start without itching. So one can get mad not only through the food that you eat but it can also be inherited from the family”.

Some respondents attribute mental illness to psychological trauma such as: so much worrying and over thinking as in this man’s case below,

Male from Zuarungu

“...that which brings about mental illness is your mind, if your mind is not in one piece it can lead to mental illness. It has ever happened to me in Obuasi. I just got up one day and started running but I was taken to the hospital and given injection, I didn’t even know where I was...If you have a lot of problems worrying you it makes your mind divided in that, you would be thinking of so many things at the same time and is more than what your system can take”.

Other notably factors mentioned are, too much learning, family violence, destiny, accident, hunger, poverty, death of a dear one, labour, dog bite, political loss and pressure from oneself, family or society to meet certain obligations or status. Some sample views include,

Female from Zuarungu

“disappointment from a love one can affect a person emotionally which can lead to depression, one can be destined to be mentally ill, bad deeds like stealing, killing or murder can also attract curses of mental illness as a punishment. Witnessing or being the victim of physical or sexual abuse, can also make a person mad. Too much consumption of alcohol and smocking of wee, cocaine or cigarettes can also cause mental illness. Disasters such as flood and earth quack and persistent family violence can cause mental illness among any of the affected persons. Death of important people can also cause mental illness”.

From the above opinions, one may arrive at a conclusion that the population has a fairly reasonable understanding of the causes of mental illness. These findings is similar to findings of Sadik *et al.*, (2010) and Gureje *et al.*, (2005)

4.4 attitudes towards mental illness

There is evidence of widespread negative attitudes towards mental illness among the participants as found by other researchers (e.g. Gureje *et al.*, 2005: Griffiths *et al.*, 2006: Sodzi, 2007). The researcher used the question how will you relate to a mentally ill person to answer this theme. Some few participants are of the view that, the decision to relate to a mentally ill person depends on the stage of the ailment (mild, moderate and severe). Others say they will be nice and friendly to a mentally ill person. However, majority of the participant thinks that mentally ill persons should be avoided because

they are unpredictable, irrational and can never truly be cured. Some sample views of the respondents are captured below:

Female from Sumbrungu

“I know mental illness is in stages. If it is not serious, you have to be nice and friendly towards the person because, by doing so it can help minimise the condition as the victim feels loved. You can even eat with the person if he or she is a relative but if he or she is not a relative, you should not eat with that person. However, if it is the serious type you have to avoid such a person as they are always dangerous and can harm you”.

Why will you not eat with the one that you do not know?

Female from Sumbrungu

“Because, I don’t know the factors that caused the illness and it’s mode of transmission. I will only give him what he wants be it food or water and I will wash the cup or bowl very well after that”.

Male from Sumbrungu

“As for me whether a relative or not, mental illness is mental illness you should not share a cup or bowl with the person until the person is cured of his or her illness. You have to avoid them”.

Female from Zuarungu

“For me, a mentally ill person should be avoided because, they are unpredictable. No matter how a mentally ill person is treated, there will still be reoccurrences and one cannot tell when it will happen”.

Male from Zuarungu

“Mental illness is a bad spirit that affects a person so if you know is a bad spirit, then you have to avoid getting in to contact with that spirit and you can only do this by avoiding the person that is carrying the spirit”.

Others believe there are different types of mental illness; with different degrees of severity. It can be mild moderate or severe. Those who hold this belief also believe

Male from Zuarungu

“everybody experience some mental illness at a point in time, only that we over look them because they are not severe. So, how one relates with a mentally ill person depends on the type of mental illness”.

From the above views, except for a few respondents, majority of them actually admitted that they will avoid contact with mentally ill people and gave various reasons such as; they being unpredictable and irrational and lack of knowledge on the mode of transmission. The extent of stigmatising attitudes within these communities is in line with findings of Griffiths et al., (2006) where 67.5 respondents of Australia said people with schizophrenia are unpredictable. It is however, contrary to findings of Barke et al.,

(2010). Findings of this study show that, only 22.9% of participants endorsed that it is best to avoid people with mental illness.

The findings are also consistent with the claim of the social representation theorist (Moscovici, 1984; Howarth, 2006). They are of the view that by attributing the bad to the other, and blaming them for their illness, the fear associated with the illness reduces as well as make one feel safe from acquiring the disease. So the other who is “bad” has got his just dessert so why bother to be nice. This representation of mental illness, also reduces the anxiety that the illness evoke in them. Moscovici & Perez, 1997).

4.5 Perceptions about mentally ill people

Public perception regarding mental illness plays an essential role in the formation of stigma. According to Ahmad (2012), Public perception of mental illness is very important to the treatment of it. He explained that, it takes the combined efforts of both community health centres and individual members of society to effectively manage abnormality. This collaboration goes a long way in facilitating recovery and integration of the mentally ill back into society. This section investigates the perceptions of the community members about mentally ill people. Issues like how they will feel if their relative is diagnosed with mental illness? will you marry or permit a relative to marry a person with experience of mental illness?, assuming your partner becomes mentally ill what will you do?, will you employ a person with experiences of mental illness? and do you think mentally ill people should be allowed to give birth? Were all investigated to find out the perceptions of community members as far as the above mentioned issues are concerned. Below are the views of respondents on these issues.

4.5.1 What one will do if a partner should go mentally ill?

In analysing the question what they will do if their partner should go mentally ill, it was noted that whereas more females were ready to end their marriage, most male were more willing to still keep their partners. However, it must be said that over half of the male participants were certain about marrying a second wife. Some of the sample views of the respondents are captured below:

Male from Sumbrungu

“If it is my wife, that one is my property. I cannot do anything about that one. When God gave her to me she was not mentally ill. But, I will marry one and add so that I will not loss much”.

Female from Zuarungu

“As for me I will run back to my father’s house. Because I do not know when his madness will rise, what if a stay with him and he strangle me one day who will be responsible for that”.

Female from Sumbrungu

“If I have a child with him I will take the child to my relative to avoid the situation where he may attack the child and return to my husband hoping that he get well one day”.

What if you do not have a child with him?

Female from Sumbrungu

“hmm, as for that one, (hesitating) if I do not have a child with him, I will only stay with him for about a year and if there is no improvement in his health, as for that one, (hesitating again) am still a young lady I can’t stay like that, I have to also give birth, so I will go back to my parents and start life all over again”.

4.5.2 Will you employ a person with experiences of mental illness?

Employment plays a critical role in the life and recovery of people with experience of mental illness. Most importantly employment contributes to: Social status and identity, self esteem and self respect, clinical improvement and a sense of helping others with experience of mental illness. (Duncan & Peterson, 2007).

However, despite the benefits employment offers to people with experience of mental illness, the reality is that unemployment rates amongst this group are higher compared to the general population. (Duncan & Peterson, 2007).

Data gathered from the field indicate that majority, of the participants will not employ people with experiences of mental illness, others think it depends on the causal factor, however, some few participants said they really do not care about the past ailment so far as the person is healed and is qualify for the job that is enough. Some participants stated that,

Male from Sumbrungu

“I will not even try that what if I take him to my farm and he kills me there who will be responsible for that, is he the only one who knows the job”.

Male from Zuarungu

“If the job is in the opening with minimal risk you can employ him but if it is risky jobs say driving you can’t employ him what if it rises one day in the processes of driving what will becomes the faith of the passenger”.

Female from Zuarungu

“You have to know how the person behaves when the illness rises. If he/she is the calm type I will employ the person if otherwise I will not employ the person”.

From the assertions above it is noted that the result is similar to findings of Griffiths et al., (2006) were 61.1% of Japan respondents stated that they will not employ someone with chronic schizophrenia.

4.5.3 Will you marry or permit a relative to marry a person with experiences of mental illness

The findings of this study point to the negative perception among community members towards mental illness. The general believe in the community which was widely reported and justified by Sodzi (2007), in his article “just don’t get made in Ghana” is that, a mentally ill person can never be completely cured. Almost all the

participants from both communities said they will not marry or permit a relative to marry a person with experience of mental illness? Except for some two participants

Male from Zuarungu

“I will not marry or permit a relative to marry a lady with experiences of mental illness. She is not the only lady on this earth, they say the person is sick, let her be. How cured can a mentally ill person be without reoccurrences or traces of the symptoms of the illness? So far as she has ever been mentally ill leave her and change a wife”.

Male from Zuarungu

“Marriage is beyond carrying the title it includes bearing children, rising and moulding their lives. How can one who has been mentally ill before do this? it will definitely affect the children so you don’t have to risk it”.

Female from Zuarungu

“I will not permit that because some disorders are hereditary in nature so if you marry such person it can bring mental illness to your family or he might behave in a manner that will not be pleasing to you in the future”.

Male from Zuarungu

“In the past, the extended family system was so strong marriage was a business between the families of the parties involve. They were mostly staying under one roof with their extended relations. But these days, is a different thing the nuclei family system is the order of the day. The choice of a marriage partner is solely a decision

of the man or woman. After all, the couple will be staying separately from their extended relations so for me I don't have a problem with that".

Contrary to this statement above, the following exchanges were made among three respondents:

(1st) Male from Sumbrungu

"As for me I don't really care so far as the person is treated and she is well I will marry her".

(2nd) Male from Sumbrungu

"(interrupting), that makes you yourself a mad person. If not, which normal human being will not care about this one? You can risk and marry her if you have enough money to treat her any time it relapses but if you are just a survival like me why won't you change a different one and have you piece of mine after all there are many ladies out there".

(3rd) Male from Sumbrungu

"Leave him, he is only talking who is going to permit him to marry such woman. is he for himself, not when (Baba) the house head is still alive even a girl friend see how he is always particular about it how much more a wife".

(2nd) Male from Sumbrungu

“I think is because he has seen a stranger that is why he is saying this. but I know when it gets to that, he will be the first person to run from it nobody will advise him”.

(3rd) Male from Sumbrungu

“don’t even say that let me ask him this question why are you going out with Dora are there not several ladies around as whom we know have been mentally ill before why not any of them but Dora”.

(1st) Male from Sumbrungu

“ that is because they are not my heart desire but if (God forbid) Dora should go mad today I will still be with her”

“(All laughing)”

(3rd) male from Sumbrungu

“Where again why should God forbid just say it should happen that way. When you see stranger you will be pretending so that they will say you are good as for me i will not court money and buy madness when I know I can get one that is not mad”.

Male from Zuarungu

“I will first of all do a background check to know if it is in the lineage, then I will ascertain from a doctor the chances of relapses. If it is inherited I will not marry her because that will mean that the chances of having mentally ill children will be as high as not having. If even is not inherited but there are chances of relapse I will not marry her but if it just a one instance case I will marry”.

The above responses from participants in the communities indicate that, majority of participants will really not consider marrying a person with experiences of mental illness. Issues such as hereditary, the notion that a mentally ill person can never truly be cured, extended family system and caring for children are some of the main reasons they perceive is very wrong to marry a person with experiences of mental illness. This is in line with Mulatu study in 1999 where less than 20% of the respondents said they could consider marrying a person with experiences of schizophrenia. The findings is however, contrary to findings of Barke et al. (2011), where only 27.6% said that it would be foolish to marry a man who has suffered from mental illness.

4.5.4 Should persons with experiences of mental illness be allowed to give birth?

As an essential component of our culture, there is a high preference for children in Northern Ghana. This is to maintain the family lineage and inheritance. This value for children is so high that, life without children was perceived not worth living (Tabong & Adongo, 2013). Despite this high value for children, majority thinks that, mentally ill people should not give birth, meaning that life is not worth living for the mentally ill people. This reason however, is strongly dependent on the causation factor. Some few participants however, stated that, we should permit the will of God take its course that is, to procreate and fill the earth. Some of the sample views of the respondents are captured below:

Male from Zuarungu

“If God says the person should give birth who are you to say no”?

Male from Sumbrungu

“I think mentally ill people should not be allowed to give birth because if it is a generational thing (genetic) it will definitely affect the children when she give birth”

Female from Sumbrungu

“Some of the illness comes only after a woman experience labour (give birth) so if this is the cause, then the woman should not be allowed to give birth”.

Female from Zuarungu

“Mentally ill people should not be allowed to give birth because they cannot take care of the children. Such children turn to be a burden on society and most of them end up indulging in these social vices because they did not get proper up bringing. There by increasing the social vices cases in the region”.

Male from Sumbrungu

“Although I will not marry one who have been mentally ill before but some people may marry them and ones they are married, then they have to give birth because in our part of the world the main reason why we marry is for procreation”.

The above views expressed by respondents indicate how majority of men than women think that people with experiences of mental illness should be allowed to give birth. It stance to reason that men are only interested in the labour force and the continuity of the family name since the children will be name after the man in the Northern culture without thinking of the implication it has on the victims if we go by the reasons mentioned above. This is in line with finding of Sadik et al. (2010) where over half

(52.67) of respondents thinks that people with experiences of mental illness should be prevented from having children.

4.5.5 How will you feel if your relative is diagnosed with mental illness?

Participants generally feels is shameful, embarrassing and sad to be mentally ill.

Respondents had this to say during the survey:

Male from Zuarungu

“You see, as it stands, I have ever been mad, I just went out and started running. They chased, caught and brought me back home. It took me ten days before I became stable up till date. As we are in this our community, spirit attack people, so let us take up prayer that Almighty God will save us from these spiritual attacks. It is very embarrassing to be mentally ill”.

Female from Sumbrungu

“I will feel sad to have a relative mentally ill because, the whole house will be stigmatised. Besides, that is a sickness that has affected the person and like any other sickness one will not feel happy about that”.

Male from Sumbrungu

“ I will feel ashamed to have a relative diagnosed with mental illness I will not even want people to know that am related to the victim because is like a curse or punishment for evil doing and I will be stigmatised”.

Female from Zuarungu

“I will feel sad because the person will not be able to undertake some activities he/she was engaged in before the illness and also that will bring a bad name to the family especially if it the serious type”.

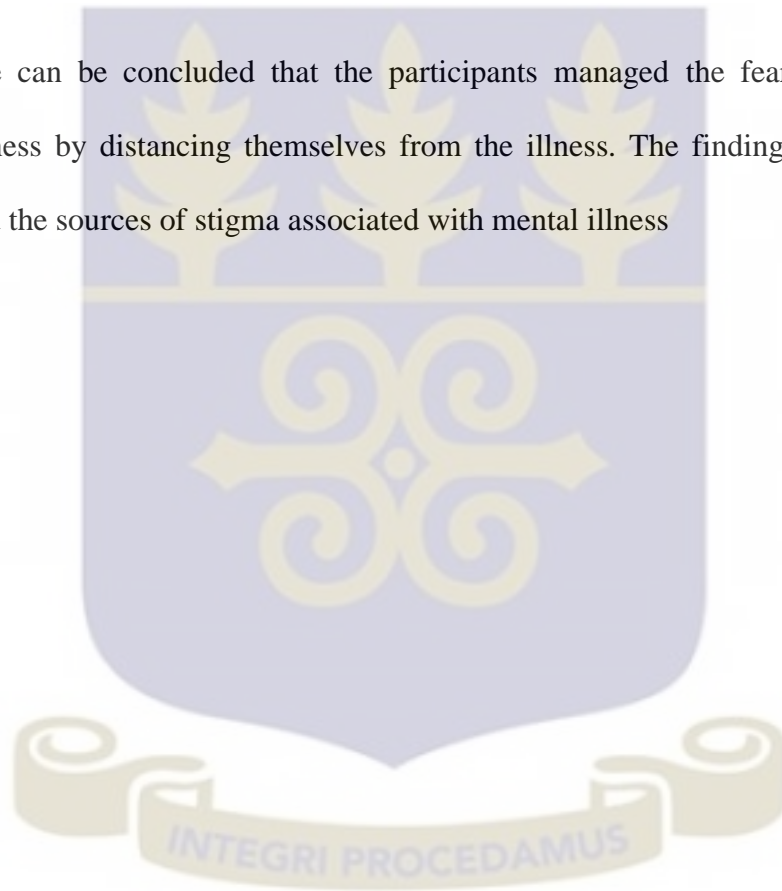
Thirty eight years down the line, it is observed from the assertions above that a finding of this study is in line with that of Ngissah in 1975 where 57.9% of Ghanaian respondents said they will feel ashamed if a family member is diagnosed with mental illness. What one can derive from this is that, there is a gap in educating the people on mental illness. The findings from the field support the findings of the study by Sadik et al. (2010) where 54.97% of the respondents said they will feel ashamed if their relative is diagnosed with mental illness. The finding is also in line with that of a Nigerian study, where 83% respondents said they would feel ashamed if people knew that someone in their family had been diagnosed with a mental illness (Gureje *et al.*, 2005).

4.6 SUMMARY OF FINDINGS:

This study applied the Social Representation Theory to understanding the social representation of mental illness among the participants. A major claim arising from Social Representation Theory (Moscovici, 1984) is that, blaming the mentally ill for their illness allows individuals within the society to feel relatively safe from the illness as well as distance themselves from those affected. Although this claim is plausible, the theory had not been directly tested in Ghana. The study used in-depth interviews (N=2) and focus discussion (6 groups) to explore the participants' social representation of mental

illness; attitudes toward mentally ill and willingness to marry a mentally ill among others. The Social Representations held by the participants reflect their interface between scientific and lay knowledge of mental illness. Though the participants conceptualize mental ill-health in social and spiritual rather than medical terms, they also had understanding of the biological and psychological causes of mental illness. However, they distanced themselves from mental illness and had poor attitudes towards people with mental illness.

The above can be concluded that the participants managed the fear associated with mental illness by distancing themselves from the illness. The finding also helps us to understand the sources of stigma associated with mental illness



CHAPTER FIVE

5.0 CONCLUSION AND RECOMMENDATION

This chapter concludes the study and makes the necessary recommendations. This study sought to examine the knowledge and perceptions of mental illness among adults of Sumbrungu and Zuarungu. To be able to do this, a qualitative approach was used to carry out this study. The findings of the data collected through interviews with selected individuals and focus group discussion were presented in thematic areas and the issues discussed.

5.1 CONCLUSION

This study gives a unique insight into the knowledge and perceptions of mental illness among two rural communities in the Upper East Region of Northern Ghana. The result demonstrated that respondents have some level of knowledge on mental illness. Despite their awareness of the symptoms and some causal factor of mental illness, there is a high level of negative perceptions and attitude towards mental illness. This is because majority of the participants attributed the causes of mental illness to life style factors and supernatural beliefs such as punishment for transgression and moral failing.

These findings therefore show that, there is the need for educational programs on mental illness particularly the causal factors. In developing such programs culture-specific notions of mental illness should be taken into account. The current treat in which we see the a broadening of policies and the passage of the mental health bill could create opportunities for development of successful mental health programs

5.2 Recommendations for prevention of mental illness:

The prevention of mental illness was also unanimous and education of the youth to desist from unhealthy lifestyles like excessive alcohol intake, and smoking was seen as the core preventive strategy especially for the youth as many of the participants' perceived causes are consequences of behaviours during youth. People commonly suggested that government should place a ban on drugs use as well as the importation of such products.

Supernatural causes were regarded as not within the control of the individuals hence difficult to prevent. However, respecting the norms of society is recommended.

The researcher thinks that:

Families in socialising their wards should consider the norms, values and taboos of the community so as to prevent them from violating these norms or breaking these taboos and attracting the consequence of that violation.

People especially women should learn to share their problems with family and friends in order to prevent the accumulated risk of getting mental illness.

People should also learn to forgive one another and as much avoid the curses.

The media should be more mindful of how they represent mentally ill persons in their movies as the young ones learn a lot from the media these days.

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1.0 APENDICES

UNIVERSITY OF GHANA

SCHOOL OF PUBLIC HEALTH

DEPARTMENT OF SOCIAL AND BEHAVIOURAL SCIENCES

TOPIC: KNOWLEDGE AND PERCEPTIONS OF MENTAL HEALTH DISORDERS
AMONG ADULTS OF SUMBRUNGU AND ZUARUNGU.

Focus Group Discussion Guide

Dear Participant,

I am Adombiri-naba Shirley a final year student at the University of Ghana undertaking a study on the above topic in partial fulfilment of a requirement that will lead to the award of Msc in Applied Health Social Science. This is under the supervision of Dinah Baah-Odoom Ph. D.

The interview should take about ninety minutes. I will be taping the session because I do not want to miss any of your comments. Although I will be taking some notes during the session, I can't possibly write fast enough to get it all down. Because we are on tape, please be sure to speak up so that I don't miss your comments.

You are assured that whatever information you provide will be taken with strict confidentiality and will be purely for research purpose. Your responses will not be shared with anybody who is not part of the study team. I will ensure that any information I include in my report does not identify you as the respondent. Participation in this study is voluntary and the participant can choose not to answer any individual question or all the questions. You are however encouraged to fully participate since your opinions are important in assessing the knowledge and perception of mental disorders. The research

will not post any risk to the participants as there will not be any invasive procedure. There will not be any direct benefit of this work to the participants. Are there any questions about what I have just explained? Are you willing to participate in this interview?

Thank you for your willingness to respond to the questionnaire and your co-operation.

1.2 DRAFT QUESTIONNAIRE

This exercise is to find out your personal views on mental illness, and the mentally ill. Please give your personal details below. Your name is not required, and the information you will give will be treated as strictly confidential and used for academic analysis only. It is therefore hoped that you will be as frank as possible in your responses to the questions that follow.

BACKGROUND INFORMATION

Age.....

Sex: Male () Female ()

Religion: Christian () Muslim () Traditional ()
others.....

Education: Basic () Secondary () Tertiary () Vocational () None ()

Marital status; single () married () separated () divorced () widowed () OTHER

[] Please specify.....

Occupation: unemployed () farming () trading () teaching ()
others.....

INSTRUCTION

1. What is your understanding of mental illness?
3. What do you think are the causes of mental illness?
4. How do you distinguish a mentally ill person from a normal person?
5. How will you relate with a person suffering from mental illness
6. What one will do if a partner should go mentally ill?
7. Will you employ a person with experiences of mental illness?
8. Will you marry or permit a relative to marry a person with experiences of mental illness?
9. Should persons with experiences of mental illness be allowed to give birth?
10. How will you feel if your relative is diagnosed with mental illness?
11. What intervention can we put in place to improve knowledge of mental disorders?