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MENTAL HEALTH COMPETENCE IN TWO URBAN POOR COMMUNITIES IN ACCRA, GHANA: A SOCIAL PSYCHOLOGY OF PARTICIPATION APPROACH

BY

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DECLARATION

Except for references to other people's work, which have been duly acknowledged, I declare that this thesis is the result of my own research. It has neither in part nor in whole been presented for another degree.

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DEDICATION

To my late parents – Mr. Richard Boakye and Mad. Sarah Serwaa

Continue To Rest In Perfect Peace

Yes, It Did Happen

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I give thanks to the Almigty God for the life and health to have reached this far in my life.

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ABSTRACT

Poor communities in Africa are disproportionately affected by mental disorders globally. Current research proposes that improving mental health in poor communities requires building their mental health competence. There are however limited community mental health competency studies in African context, to inform diagnosis of social realities of mental health in such communities and guide intervention planning. Integrating the social psychology of participation and community mental health competency models into a conceptual framework, this thesis conducted a critical social psychological analysis of the social realities of mental health probkems in Jamestown and Usshertown - two urban poor communities in Accra, Ghana. The conceptual framework explored three social psychological features of community mental health competency; i) symbolic competency – social representations which provides insight into lay mental health knowledge in the communities, ii) material competency – access to concrete material conditions such as money food, shelter and mental healthcare which structure mental illness experience in community context, and iii) relational competency – access to bonding, bridging and linking social capital which provides material and symbolic resources for addressing mental health problems. Mixed-method data were gathered, combining survey, focus group discussion, key informant interviews and situated conversations. Data was gathered from 384 survey respondents and 77 qualitative participants. The qualitative data was analysed using theoretically-driven thematic analysis. The survey data was analysed using chi square, multiple regression and structural equation modelling.

Three key insights emerged, in line with the conceptual framework. First, the communities exhibited relatively high symbolic mental health competency, compared to their material and relational competencies. There was general awareness that the prevalent mental health disorders in the communities were depression, anxiety, ‘madness’, epilepsy, substance

addiction, suicide, psychosocial stress, excessive anger, worry and frustration. There was also high awareness of the multilevel factors that expose them to these mental health disorders. Mental illness stigma and empathy co-existed simultaneously. Representations of the mental illness were cognitive-emotional, which informed legitimization and illegitimization of some mental health disorders depending on severity of conditions and identity of the sufferers. Second, the communities were extremely low on material mental health competency. Structural poverty and joblessness exposed healthy community members to recurring psychosocial struggles, and also undermined quality of care for individuals and families affected by mental health disorders. Finally, relational mental health competency of the communities was also low. While their bonding social capital was relatively high, there are limited existing bridging and linking social capital targeted at addressing mental health problems within the communities. Nevertheless, there are existing partnerships that offer opportunities for strategic alliances in transforming mental health within the communities. The implications of the insights in the development of participatory mental health interventions to build mental health competency in the research communities are discussed.

Keywords: community mental health competence, social psychology of participation, urban poor communities, Ghana

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Globally, the burden of mental disorders - prevalence, morbidity, mortality and disability - is rising. One in every four persons globally experience mental ill-health, including neurological and substance use problems (Canady, 2020). Mental disorders is recognized as a significant contributor to disability-adjusted life years (defined as total years lost due to ill-health), gradually becoming leading cause of mortality and morbidity (Patel & Farmer, 2020). Low- and middle-income countries (LMICs) are the worst affected (Petersen, van Rensburg, Gigaba, Luvuno & Fairall, 2020). In Sub-saharan Africa for instance, even though large epidemiological mental health surveillance studies are scarce, the burden of mental disorders is reported to be rising, with prevalence rates between 12 – 22% (WAHO, 2018; WHO, 2015). In Ghana, an estimated 2 – 3% of the population live with severe mental and neurological disorders such as dementia, bipolar disorders and schizophrenia, while 5 – 15% live with common mental disorders like anxiety, depression and psychological distress (Canavan et al., 2016; WAHO, 2018). The rise in global mental disorders burden has led to a widening treatment gap in LMICs, where an estimated 80 - 90% of individuals living with mental disorders remain untreated (Herrera-Ferrá, 2020).

Individuals in poor and deprived communities bear the greatest burden of mental disorders in LMICs (Burgess, Jain, Petersen & Lund, 2020). The reason is attributed to the presence of several social and structural-level stressors in these communities that compromise well-being (Burgess et al., 2020). Poor communities experience complex social realities of extreme material deprivation and psychosocial struggles. Health systems within such communities are also weak

and compromised (de-Graft Aikins & Agyemang, 2017). The configuration of these complex psychosocial, material, and structural factors predisposes individuals in poor communities to elevated risks of mental ill-health (de-Graft Aikins & Agyemang, 2017). Poor communities also experience significant mental disorders treatment gap (Mathias, Mathias, Goicolea & Kermode, 2018; Saxena, 2019).

Mainstream mental health research and institutionalized practice have been found to be unable to address the multilevel drivers of poor mental health in poor and deprived communities (Burgess et al., 2020). The mainstream approach is criticized as overly medicalizing mental health problems (Campbell & Burgess, 2012), and ignores the complex social and structural factors that compromise mental health in these communities (de-Graft Aikins, 2015). By so doing, mainstream mental health practice and research uncritically transports 'westernized' biomedical mental health concepts and interventions (Burgess et al., 2020; Petersen et al., 2020), in ways that marginalise traditional systems of mental health in poor communities, particularly those in non-western countries (Burgess & Mathias, 2017; Campbell & Cornish, 2014).

In order to holistically address the burden of mental health problems in poor and deprived communities, there have been calls to focus on communities in addressing global mental health problems. Different groups within global mental health research have provided different approaches on how the focus on communities should be done. There is the mainstream group who calls for delivering institutional mental healthcare to poor and under-served communities (Patel et al., 2018; Patterson & Edwards, 2018; Saxena et al., 2019), and a critical group who calls for a 'whole-of-community' approach to addressing mental health needs of such communities (Campbell & Burgess, 2012; Burgess et al., 2020; Mathias et al. 2018). The critical approach is informed by empirical studies from critical social and health psychologists, working

in poor communities in Africa, Latin America and Asia, who have witnessed, at first hand, the disappointing outcomes of mainstream mental health interventions in these communities (Campbell & Jovchelovitch, 2000).

The critical group therefore conceptualizes the 'whole-of-community' approach as moving beyond just providing institutional mental healthcare in poor communities, to creating mental health-enabling communities by strengthening their broader community mental health systems (Campbell, 2014; Howarth et al. 2013; Mathias et al., 2018). Critical approach empowers poor communities to competently take part in transforming the social realities of their mental health inequalities (Campbell & Jovchelovitch, 2000; Howarth et al. 2013). In line with this has, there has been the development of a new 'community mental health competence' line of research, which aims to create social contexts that support sustainable and transformative social change in mental health in poor communities (Campbell & Burgess, 2012; Mathias et al. 2018).

The current thesis draws on the critical approach to explore pathways to building mental health competence in Jamestown and Usshertown, two twin urban poor communities, collectively referred to as Ga Mashie in Accra, Ghana. Both communities are listed among the urban poor communities in a multi-cultural global city of Accra, based on several indicators such as high population density, poor housing infrastructures, low levels of income, and poor environmental sanitation (de-Graft Aikins et al, 2020; GSS, 2012). Prevous longitudinal research project within the two communities, which spans research on infectious diseases, maternal and reporductive health and NCDs inclduing mental health highlight poor physical and mental health status in both communities (de-Graft Aikins et al, 2020).

The project has involved; i) two Edulink surveys (in 2010 and 2013), which have led to articles on food system and practices (Boatemaa, Badasu& de-Graft Aikins, 2018), infectious disease burden (Awuah et al., 2018), mental health (Greif & Dodoo, 2015; Kushitor et al., 2018; Kyei-Arthur, 2013); ii) a decade longitudinal cardiovascular disease (CVD) study which has led to articles on diabetes (de-Graft Aikins et al., 2015, 2019), hypertension (Awual et al., 2014, 2018), stroke and risk factors (Sanuade, Dodoo, Koram & de-Graft Aikins, 2019), and iii) an establishment of Jamestown Health Club (JTHC), a support group for community members living with hypertension, diabetes, asthma and post-stroke conditions (de-Graft Aikins et al, 2020). Empirical evidence from these projects have highlighted high burden of chronic physical conditions and associated high prevalence of mental disorders (de-Graft Aikins et al., 2015; Sakyi, 2015; Teye, 2013), and community-level mental health stressors, high level of both severe and common mental disorders like anxiety, depression and psychological distress (Grief & Dodoo, 2015; Kushitor et al. 2018).

The next phase of the project uses social psychology of participation model to build health competence in the communities, specifically, CVD competence. The project has mapped different elements of social contexts and identity groups within the community that are theoretically and practically relevant to CVD health within the communities (de-Graft Aikins et al, 2020). The current thesis therefore builds on the project by focusing on mental health competence in the communities. The thesis applies the 'social psychology of participation' approach to conduct social psychological assessment of mental health needs and resources within the communities. This approach provides a multilevel framework for analysing participation of communities in health development at the individual, interpersonal, group and macro-social levels (Campbell & Jovchelovitch, 2000). The goals of this thesis are therefore to diagnose the

social realities of mental health problems within the communities, and also to assess existing and potential social capital for developing mental health competence of the communities.

According to Guareschi and Jovchelovitch (2004), diagnosing social realities of health needs of communities requires assessing three social psychological features; social representations, social identities and power. Social representations involve exploring local knowledge surrounding mental disorders and mental health in the communities (Campbell & Jovchelovitch, 2000; Guareschi & Jovchelovitch, 2004). Social identity involves assessing individuals and groups who are affected and how they are affected by mental disorders burden (Campbell & Jovchelovitch, 2000; Guareschi & Jovchelovitch, 2004). Power involves examining social capital that the communities can draw on to transform the social realities of their mental health inequalities (Campbell, 2019; Campbell & Jovchelovitch, 2000). Detailed explanations of these three features are discussed under the theoretical and conceptual framework in chapter two.

1.2 Statement of Problem

Poor communities are disproportionately affected by global mental disorders burden. The same is true for Ghana. Mental health research from colonial era to present have highlighted the existence and high prevalence of both severe and common mental disorders in poor communities in Ghana (Read & Doku, 2012). Formal responses to mental health problems, both at the national and community level in Ghana have been very weak and underfunded (Ofori-Atta et al., 2015). This is witnessed in the high treatment gap for mental health in poor communities, undermining quality of care for individuals with mental disorders in poor community contexts (Canavan et al., 2016). The decade of multidisciplinary health development research in both Jamestown and Usshertown for example shows not only high burden of both chronic physical and mental health conditions, but also highly compromised national and community mental health response

systems (de-Graft Aikins et al., 2014). The mental health conditions in both communities therefore highlights how pre-existing gaps in mental health responses national level intersects with pre-existing weak mental health systems at the community level to compromise mental health in poor communities.

Despite the call for whole-of-community approach in addressing the complexities of the social and structural determinants of mental health burden in poor communities (Burgess et al. 2017; Campbell & Burgess, 2012; Mathias et al. 2018) including in Ghana (Read, Adiibokah & Nyame, 2009), and despite the launch of a right-based mental health policy [Mental Health Act 846, 2012], there are still gaps in community mental health research in Ghana. Early community-based mental health studies have been predominantly mainstream, which privileged individual-level determinants of mental illness, and socio-cognitive models of mental health education at best (Osei, 2003). Ghana is trying to change community mental health delivery, moving into right-based approach (Read, 2017, 2019, 2020). However, recent studies that draw on critical frameworks have been more institutional in approach (Canavan et al., 2016; Ofori-Attah et al., 2010). These approaches are inadequate for poor communities like Jamestown and Usshertown whose poor mental health are largely driven by complex social and structural drivers. This creates difficulties when it comes to developing actionable, evidence-based and contextual interventions to build mental health competence within such community contexts.

This thesis conducts a social psychological assessment of mental health needs of Jamestown and Usshertown. Social psychology of participation is used to examine complex drivers of poor mental health and mental illness experiences and responses in the communities. This helps to unearth individual-society interface in mental health problems in communities, integrating individual, interpersonal, group, community and structural levels of understanding mental health

realities, and what it will take to build mental health competence in poor communities like Jamestown and Usshertown (de-Graft Aikins et al., 2020). Both communities are therefore well-suited for a critical 'whole-of-community' research approach to inform mental health competence interventions for poor communities within the Ghanaian context.

1.3 Aim and Objectives

To use social psychology of participation approach to conduct social psychological assessment of mental health problems in Jamestown and Usshertown, and examine existing and potential resources for building mental health competence in the communities. The study had four objectives:

1. Examine the prevalence of mental health problems in the communities
2. Explore social representations of mental illnesses and mental health problems within the communities
3. Understand how social identities shape who is affected by mental disorders within the communities
4. Explore the communities' social capital that can be used to build their mental health competence.

1.4 Research Questions

Four research questions were explored:

1. What is the prevalence of symptoms of common mental health disorders, what mental health problems do community members list as prevalent?

2. How do community members make sense of mental disorders (broadly as a concept) and the specific conditions that they describe as prevalent, and how do they respond to mental illness?
3. Which groups of people are affected and how are they affected by mental disorders within the communities?
4. What are the available social capital that can be drawn on to build mental health competence in the communities?

1.5 Significance of the Study

The significance of this thesis lies both in its conceptual, practical and methodological implications for community mental health research and practice. The current study is the first to use social psychology of participation approach to conduct assessment of mental health needs of communities in Ghana. The thesis is therefore conceptually, practically and methodologically significant to researching mental health in community context in Ghana. The study therefore provides evidence-based insights into using 'whole-of-community' approach to guide the development of targeted interventions to build mental health-competence in poor communities in Ghana.

Through critically merging social, community and health psychologies, the thesis broadens the theoretical understanding of the multi-level context of individual-society interface community mental health systems. This would inform policy strengthening in community mental health delivery in Ghana, to sustainable ways of building transformative mental health-competence in poor communities. This contributes to the theoretical and conceptual development in community mental health competence research.

1.6 Organization of chapters

The thesis is structured into eight chapters. Chapter One is the introduction. It provides the background of the study, problem statement, aim and objectives, research questions underlying the study and then outlines the significance of the study.

Chapter Two discusses the literature review. The chapter begins with review of concepts, followed by theoretical framework which informed the study. After that, empirical studies are then reviewed based on the objectives of the study, and then a summary of the review is provided.

Chapter Three discusses the methodology. The sections discussed are research setting, paradigm, approach, design, selection of participants, procedures and tools for data collection, ethics and data analysis.

The findings of the study are presented in four chapters (chapters 4 – 7), each chapter addressing specific objectives; objective 1 - prevalent mental health problems in the communities (Chapter 4); objective 2 - social representations of mental health within the communities (Chapter 5); objective 3 – social identities and its mental health implications (Chapter 6); and objective 4 - community social capital and participation in mental health promotion (Chapter 7).

Chapter Eight provides synthesis and discussion of the findings. It presents general synthesis and discussion of findings, and also discusses the implications and recommendations from the study, limitations, suggestions for future research, and conclusion.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

The discussion of theoretical and empirical literature is presented in this chapter. The literature review situates the current study within the context of diagnosing social realities of mental health problems in poor communities. Further, opportunities for building community mental health competence are also discussed. The theoretical and conceptual framework is discussed first. After that, empirical studies are discussed to elaborate and illustrate key concepts, and the interconnections between them.

2.2 Theoretical and Conceptual Framework

This thesis draws on critical approach to mental health competence in poor communities. Specifically, two models – social psychology of participation model (Campbell & Jovchelovitch, 2000), and community mental health competency model (Campbell & Burgess, 2012), are used as the framework. The social psychology of participation model is used as the overarching framework, and the community mental health competency model is integrated within it. Integration of these two models allows for critical analysis of the three social psychological features (i.e. social representations, social identities and power) of mental health competence at the community level.

2.2.1 Social Psychology of Participation (SPP) Model

The Social Psychology of Participation (SPP) model was developed by Campbell and Jovchelovitch (2000), to theorize multilevel analysis in community health participation. Critical psychologists argue that both societal power and individual agency shape realities of individuals,

including their mental health outcomes (Gough, 2016; Howarth et al., 2013; Nelson & Evans, 2014). Campbell and Jovchelovitch (2000) focused on understanding health outcomes and experiences as shaped at the individual-society interface, in ways that allows for integrating a multi-level - individual, interpersonal, group and community - analysis in community-based research and interventions. The SPP model proposes three social psychological features that are central for community participation in improving health and wellbeing –social representations, social identities and 'structured ecologies of power' (Campbell & Jovchelovitch, 2000).

Social Representations: defined as practical social knowledge which guide attitudes and behaviours (Campbell & Jovchelovitch, 2000). Social representations help to understand how individuals and groups familiarize unfamiliar or new phenomena they encounter in their every day lives (Sammut, Andreouli, Gaskell & Valsiner, 2015). Social representations provide insights into the content, source and functions of local knowledge which guide communities' worldviews and interpretations of social realities and every day lives (de-Graft Aikins, 2012). The content of representations helps to understand what communities know and how they make sense of social realities. The source of representations provides insights into where individuals draw their knowledge on social realities from.

Social representations, as a concept, was developed within the social representations theory, and Moscovici is credited as being the founding theorist. In his seminal research on social representations of psychoanalysis, Muscovici (1961) used the concept of cognitive polyphasia to describe how individuals draw on diverse and often incompatible sources of knowledge to make sense of social realities. When individuals draw on diverse sources of knowledge that are sometimes incompatible, it can help them to gain new knowledge of social realities they hitherto not familiar to them (de-Graft Aikins, 2012). The functions of social representations inform

every day practices, and provide insights into how communities respond to their social realities (Campbell & Jovchelovitch, 2000).

Social Identities: members of a community conceive of and articulate themselves through their social identity (Campbell & Jovchelovitch, 2000). Social identities within communities are heterogenous, manifest in hierarchies and shape complex social relationships and practices that impact on health and wellbeing in every day life (Campbell & Jovchelovitch, 2000). The SPP model therefore argues that social identities are constantly being constructed, contested and reconstructed within range of symbolic and structural constraints. The constraints limit the extent to which individuals construct images of themselves in ways that adequately reflect their interests and potentials. Thus, social identities may constitute a tool for social change when marginalized groups come together to reconstruct an empowered identity that challenge marginalized status, and then use the empowered identity to improve their social realities and well-being through collective action (Campbell & Jovchelovitch, 2000; Phoenix et al., 2017). Social identity therefore becomes an arena of struggle for marginalized groups and participation becomes the processes through which these are enacted and realized in public sphere (Campbell & Jovchelovitch, 2000)

Power: the SSP model defines 'structured ecologies of power' as the conditions that structure community life, by promoting or constraining access to material resources (e.g. food, shelter, money or employment) and symbolic resources (e.g. self-esteem, respect, dignity) that are critical to health and wellbeing (Campbell & Jovchelovitch, 2000). The power element draws on Paulo Freire's concept of conscientisation and Pierre Bourdieu's notion of social capital in understanding how power is structured and contested in communities. Campbell (2019) applying Bourdieu's social capital, elucidated three critical forms of social capital in community context –

bonding social capital, bridging social capital and linking social capital. She defined bonding social capital as networks of solidarities within and between community members and social groups. Bridging social capital encompasses networks that unite poor communities with other marginalized communities. Linking social capital encompasses networks that unite marginalized communities with powerful external actors. These forms of social capital provide communties access to appropriate and adequate material and symbolic resources to improve their health and wellbeing.

2.2.2 Community Mental Health Competency (CMHC) Model

The community mental health competency (CMHC) model was developed by Campbell and Burgess (2012) to highlight the psychosocial pathways that shape the competence of communities to address their mental wellbeing. Community mental health competence is defined as the ability of individuals in communities to collectively facilitate effective prevention, care, treatment of mental disorders and advocacy for mental health (Campbell & Burgess, 2012). Building mental health competence of communities requires addressing multi-level social contexts that frame mental health problems in communities. The CMHC model thus characterises mental health-competent communities in terms of three core dimensions; sound knowledge, safe social spaces and productive partnerships (Campbell & Burgess, 2012). Based on these three dimensions, the model proposed three psychosocial drivers of community mental health competencies; sound community knowledge, safe social spaces and dialogue, and partnerships for action (Burgess & Mathias, 2017).

Sound Community Knowledge: First, individuals in communities should have sound knowledge of mental health. They should be able to; identify risk factors for poor mental health, recognise symptoms of mental distress at an early stage, refer serious cases of mental illness,

know how to access mental health services and support systems and use them in ways that are culturally appropriate.

Safe social spaces: local knowledge should be shared and debated within a supportive social space that allows for integration and incorporation of (often) unfamiliar knowledge with local worldviews or frames of reference (Campbell & Burgess, 2012). Social representation is critical here as it provides understanding of how the unfamiliar gets familiarized within communities. Safe social spaces thus help to translate unfamiliar mental health information into concepts and practices that make sense to them within their socio-cultural context and then brainstorm to devise locally appropriate responses to their mental health problems. Safe social spaces for dialogue also inspire a sense of local solidarity, which can be leveraged around collective efforts to promote positive mental health in adverse conditions.

Partnerships for action: resources for addressing mental health problems often lie outside the boundaries of poor communities. Community mental health competence therefore requires building productive alliances and partnerships that allow local communities access (material and symbolic) resources from external agencies to promote mental health. These outside agencies may include government agencies, research institutions and universities, NGOs, INGOs, charitable organizations and other social and political groups. This is in line with the argument of social capital as a starting point for building community competence (Campbell & Jovchelovitch, 2000). This is because, often, vulnerable communities do not have the power and resources to tackle their mental health problems without external support. Having powerful external agents to partner with, provides access to power and resources that are critical to addressing their social realities.

2.2.3 Conceptual Framework

The three concepts of the SPP model (i.e. social representations, social identities and power) and the three psychosocial pathways (i.e. community knowledge, social spaces and partnerships for action) were integrated to develop the conceptual framework (Figure 2.1) for this study. These concepts are organized into three overarching themes, addressing three critical elements of social contexts of community mental health; symbolic context, relational context and the material context (Campbell & Cornish, 2010). These three dimensions of social context offers opportunities for developing actionable conceptualizations of social contexts to inform research and practice of community mental health.

These social psychological features have been applied for researching health development within poor communities in Ghana (de-Graft Aikins et al., 2020; de-Graft Aikins et al., submitted), in other African countries (Campbell et al., 2013; Mahr & Campbell, 2016; Mannell et al., 2018) and Asian countries (Aveling & Jovchelovitch, 2014). These features are used as a framework in this thesis to diagnose the social realities of mental health problems in the communities, and explore possibilities of building mental health competence of the communities.

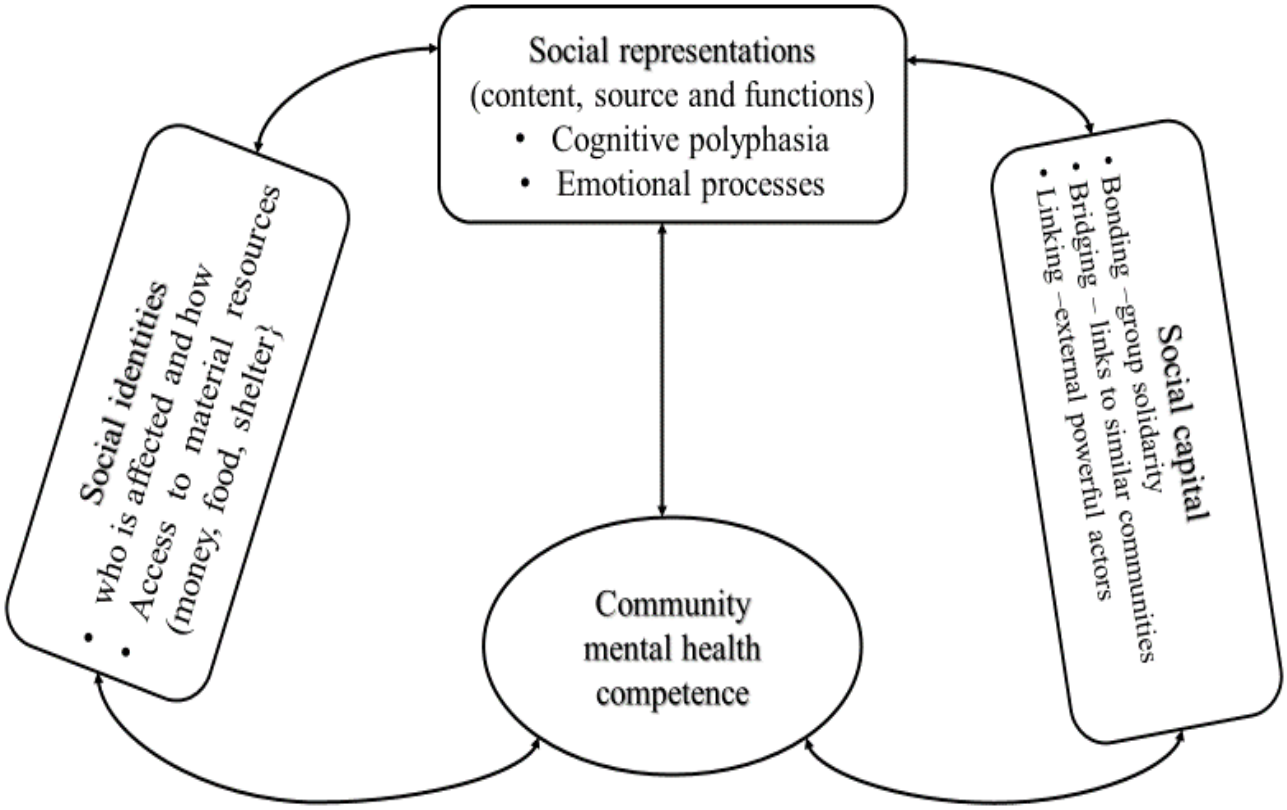

Figure 2. 1: Conceptual model of social context of community mental health competence

Symbolic context of Mental Health in Communities

The symbolic context encompasses the social representations and social identities within the communities. In this thesis, social representation of mental disorders was examined as the practical local knowledge of mental disorders (i.e. content, source and functions) in the community. Social representations of mental illnesses opens the way for understanding the socio-cultural drivers of distress and poor mental health, obstacles to effective responses and how the impact might be predicted and ameliorated. Content of representations is about understanding what community members know and how they make sense of mental disorders broadly, and how they make sense of the specific mental health problems that are prevalent within the communities. The sources where community members draw knowledge from in their

representations are also examined. Cognitive polyphasia is used as an analytical tool to explore the heterogeneity of sources of knowledge stocks on mental disorders within the communities. Functions of representations are analysed as how the communities respond to mental illness.

Poor communities have long developed coping strategies and invented resources to deal with their stress-laden social realities in the absence of expert information, state support and aid (Jovchelovitch, 2007). In this sense, social representations provide (practical and symbolic) resources that equip local communities to cope with their social realities. On the other hand, local knowledge could be detrimental to health and well-being of local people. There may also be some ideological mechanisms that conspire to obscure and distort mental health (Jovchelovitch, 2007). In this way, social representations become a (symbolic) risk factor for poor mental health. There is therefore the need to establish a constructive dialogue between local knowledge (i.e. what communities know) and expert knowledge (i.e. what researchers and practitioners know) as a necessarily precondition for addressing mental health needs of communities. Recognition of local knowledge systems as an asset in mental health development at the community level is therefore critical to establishing productive partnerships between communities and mental health development practitioners (Jovchelovitch, 2007). As dominant knowledge systems meet local knowledge systems, it becomes critical to establish dialogue that bring on board local understandings with understandings of mental health researchers and practitioners (Campbell & Jovchelovitch, 2000). Without this constructive dialogue, mental health interventions will be met with mistrust, resistance and failure.

Material Context of Mental Health in Communities

Material context encompasses concrete resources such as money, food, shelter, healthcare, and thow these structure mental illness experience in community context. For instance, how individuals living with mental disorders and their families get access to material resources such as money and shelter to help them to better cope with poverty that cripple or undermine their well-being. Social identities shape how individuals and social groups get access to these concrete material resources that are needed for propoer mental healthcare for individuals and families affect by mental disorders.

Social identities are inherently heterogenous. What defines who individuals are encompass complex interactions of lived, embodied, material, as well as symbolic (how others define them). Therefore, the symbolic, relational, material and embodies are intricately linked and mutually influential in defining social identities. Lived experience and the subjective and embodied aspects of mental health and mental disorders within the communities are critical. For instance, the symbolic context shapes various forms of stigma in the communities, which in turn affect how individuals living with mental disorders and their families feel about themselves, are seen by members and cared for in the communities.

Social identities provide insights into how every day lives of individuals who are differentially affected by mental disorders are structured (de-Graft Aikins, 2015), and whether or not these individuals benefit from community interventions (Mannell et al., 2018). For example, de-Graft Aikins (2015) shows that in Ghana, individuals living with schizophrenia or psychosis, epilepsy, young men with substance abuse disorders, elderly people with dementia, and old women with witchcraft-related depression risk choosing life of destitution or having it imposed on them.

Mannell et al., (2018) have also showed in Rwanda that, unmarried women who experience physical violence from their intimate partners also experience psychological violence when accessing community resources available to victims of intimate partner violence. Understanding social identities therefore helps to uncover how heterogeneity of community identities structure mental disorders experiences, and why it is important to factor this in segmentation, data gathering and development of interventions.

Relational Context of Mental Health in Communities

The relational context provides insights into access to power and resources in the communities. Power is operationalized as social capital in this study. Social capital was examined using Campbell's (2019) conceptualization of bonding, bridging and linking social capital. Bonding social capital was assessed as the wider community relationships among individuals and groups within the communities, and how these relationships engineer sense of community, social cohesion, interpersonal trust and collective responsibility and collective action. Bridging social capital assessed the existing and potential interconnections between the communities and other marginalized communities that can offer opportunities for mental health advocacy. For example, there is vibrant right-based research in Kintampo and Nkoranza communities in the Brong Ahafo region (Read, 2019; Read, Sakyi & Abbey, 2020, Read & Nyame, 2019), which provides forms of bridging social capital. Linking social capital was assessed in terms existing and potential productive alliances between the communities and supportive external actors, who have both symbolic and material power to help communities address their mental health. There are also plans underway for implementing the mental health policy in Ghana (Anum et al., 2020), which provides opportunities for linking social capital for the study communities. The three elements of

the conceptual framework – social representations, social identity and social capital guide the review and presentation of the empirical literature.

2.3 Community mental health research in Ghana

This section discusses community mental health research in Ghana. The historical context of community mental health in Ghana is discussed first. After that, social groups at risk of mental health challenges, determinants of mental health challenges, representations and responses to mental health problems in communities in Ghana are discussed. A focus on mental health research in the Ga Mashie community where the current study is conducted is then discussed.

2.3.1 Historical context of community mental health research in Ghana

Community-based mental health research in Ghana has gone through an interesting historical trajectory, particularly in relation to multidisciplinary perspectives and identities of researchers. In the 1930s and 1970s, mental health research in Ghana was dominated by Euro-American psychiatrists and anthropologists (de-Graft Aikins, 2018). During this era, community-based mental health research in Ghana focused on drivers of psychosis in Tallensi communities (Fortes & Mayer, 1960), and mental disorders in Ga and Asante communities (Field, 1959,1960). These studies highlighted the existence and prevalence of severe mental disorders such as depression, suicide, schizophrenic and psychotic disorders in the communities. These insights challenged the notions of non-existence of severe mental disorders (e.g. depression, suicide) in African populations in colonial psychiatry and mental health research (de-Graft Aikins, 2018).

In the 1980s and 1990s, Ghanaian researchers, predominantly clinical psychologists, emerged in mental health in Ghana. Community-based mental health research in this era focused on delivering clinical mental healthcare to under-served communities (de-Graft Aikins, 2018). The

2000s saw a turning point in mental health, with the Mental Health and Poverty Project (MHaPP) which advocated for the integration of clinical and social psychology into formal healthcare delivery (Ofori-Attah et al., 2010; Ofori-Atta et al., 2015). The advocacy from the project contributed to the development and passage of Mental Health Act of 2012 (Act 846), establishment of Mental Health Authority (MHA) to implement the Act, and formation of Ghana Psychological Council (GPC) to oversee psychological practice in Ghana. These structural changes are meant to contribute to strengthening mental health system in Ghana (MHA, 2012).

The era also saw increasing use of community participants, but with mainstream approach, particularly in examining predictors of mental disorders symptoms. Some studies have reported community-level prevalence of mental illness using mean scores (Atuoye & Luginaah 2017) and frequencies (Dzator, 2013; Kyeremanteng, 2012). Atuoye and Luginaah (2017) in a study of food insecurity as a determinant of mental distress in selected communities in the Northern region of Ghana, also reported mean score of 1.3 (SD = 1.32), estimated from 5 items on 3-point Likert scale (ranging from 0 – 2), among a sample of 1,438 household heads within the communities. Dzator (2013) also reported in urban Ga communities that 12.7% of respondents reported depressive disorders within the last 30 days, 12.2% reported experiencing depressive symptoms in the last 3 months, and 29.88% experiencing some form of mental distress in more than 3 months preceding the study. Kyeremanteng (2012), in a study of mental well-being of 218 community-sample women in Ashanti region, reported high levels of depression (25% moderate, 9.6% severe), anxiety (28.07% moderate, 9.64% severe) and stress (21% moderate, 7.02% severe).

The post 2000s era has seen increasing emergence of some critical perspectives in community mental health research, with some studies focusing on migrant squatters in Greater Accra Region

(de-Graft Aikins & Ofori-Atta, 2007), suicide (Osafo, 2012; Osafo et al. 2015), disadvantaged children in Ga communities in Greater Accra Region (Asante, 2015), cultural explanations of mental disorders in Asante communities in Ashanti region (Opare-Henaku & Utsey, 2017), community responses to mental disorders in Northern region (Quinn & Evans, 2010; Ofori-Dua, 2014). There are also ongoing ethnographic-based research studies, which focus on delivering right-based approached to mental health care in rural communities in Brong Ahafo region (Read, 2017, 2019, 2020; Read et al, 2009).

2.3.2 Social groups at-risk of mental health problems at the community level

Social groups at-risk of mental health problems which have featured in community mental health researchers include family caregivers (Kyei-Arthur, 2013; Kyei-Arthur, 2017; Quinn & Evans, 2010), individuals living with chronic health conditionsi in (Teye, 2013), siblings of people living with mental disorders (Cooper, 2016), suicide/self-harm attempters and their families (Asare-Doku, Osafo & Akotia, 2017; Osafo, Akotia, Andoh-Arthur & Quarshie, 2015), self-help groups (Cohen et al., 2012; Sakyi, 2013), teenage girls in mining communities (Doh, Aryeetey, Ahadzie & Lawson, 2016), aged and elderly in communities (Akorful, 2015; Ofori-Dua, 2014), children with disability (Agbolosoo, 2014), children affected by HIV/AIDS (Doku, 2010), migrant squatters in wealthy urban communities (de-Graft Aikins & Ofori-Atta, 2017) and migrants in poor urban communities (Asafu-Adjaye, 2015; Dzator, 2013).

These studies have basically focused on the psychosocial stresses that come with the every day lived experiences of these at-risk social groups and their coping strategies. There is consistent evidence of high psychosocial stress among these at-risk social groups. Caregivers for instance are found to report high psychosocial stress, such as depression and social exclusion (Quinn & Evan, 2010). Low psychosocial well-being (in the form of excessive thinking, loneliness) and

negative emotional functioning (fear, excessive worry, anxiety) have also been reported among chronically ill patients in poor urban communities (Teye, 2013). Cooper et al., (2016) have also reported that siblings of individuals with mental disorders in poor communities' experience intrapersonal stresses (e.g. concealing identity, forgoing personal plans and ruined opportunities), interpersonal stress (e.g. family division and failed romantic relationships), and social stress (e.g. stigma, discrimination, fighting). Doh et al., (2016) have also reported that teenage girls in mining communities experience limited psychosocial wellbeing. Children with disability also experience discrimination and social exclusion (Agbolosoo, 2014). Psychological stresses (worry, excessive thinking and anxiety) and psychosomatic disorders are found to be common among squatters in wealthy urban communities (de-Graft Aikins & Ofori-Atta, 2007). The dominant coping strategies for these at-risk social groups include; religious coping (faith, hope, prayers), family support (Agbolosoo, 2014; Cooper, 2016), finding the positivity in the situation and "sheer bravery" – is largely one of the ways poor and marginalized groups navigate multi-layered disadvantages (de-Graft Aikins & Ofori-Atta, 2007, p.768). de-Graft Aikins and Ofori-Atta (2007) have also shown that social relationships are sites of high psychosocial distress among squatters in a wealthy urban neighbourhood in Ghana. Social relationships developed within the community dwellers are characterized by complexities of support and conflicting tensions.

2.3.3 Determinants of mental health problems in communities

Community members are observed to face physical, sociocultural and structural mental health stressors, which are both material and symbolic. The material determinants of mental health disorders are mainly poverty indicators such as food insecurity, employment status and low income (Atuoye & Luginaah, 2017; Boyce, Raja, Patranabish, Bekoe, Deme-der & Gallupe,

2009; de-Graft Aikins & Ofori-Atta, 2007). For instance, Atuoye and Luginaah (2017) have reported a strong association between food insecurity and psychological distress among household heads in rural communities in the Northern region.

Living far away from health facilities has also been found to be associated with elevated mental distress among household heads in rural communities (Atuoye & Luginaah, 2017). Employment status is also associated with mental health in communities. Employment stability after the onset of mental disorders is found to stabilize and improve mental disorders recovery in communities (Boyce et al., 2009). Contrary to Atuoye and Luginaah (2017), a positive association between income and mental distress has been observed in low income urban communities (Boyce et al., 2009).

There have been inconsistent findings reported between social participation and well-being in poor communities. On one hand, the odds of elevated mental distress are reported to be lower among individuals who belong to social groups in rural communities (Atuoye & Luginaah, 2017). On the other hand, a negative association is reported between social participation (religious participation, volunteer activity and group membership) and self-rated well-being (Amoah, 2018).

2.3.4 Community representations of mental illness

Some of the community studies have examined the beliefs, attitudes, knowledge and perceptions towards mental disorders and mental health. The representations entailed both beliefs regarding mental disorders presentations, descriptions, manifestations and socio-cultural terminologies, and beliefs regarding perceived causes or explanatory models for mental illness. The studies showed that there are fundamentally negative beliefs and attitudes towards mental disorders at the

community level (Adombiri-Naba, 2013; Adeeku, 2015; Adjei, Akpalu, Laryea, Nkromah, Scottie, Ohene & Osei, 2013; Opare-Henaku & Utsey, 2017).

Community members draw mainly on common sense or social observations in making sense of mental illness. These are reflected in the descriptions of symptomatology and classifications of mental health disorders (Adombiri-Naba, 2013; Opare-Henaku & Utsey, 2017). Adombiri-Naba (2013) for instance reported among rural communities in Northern region of Ghana that physical appearance (e.g. nakedness, dirtiness, unkempt, shabby dressing), abnormal behavioural patterns (e.g. talking to oneself, shouting, laughing for no reason) and bizarre emotions (e.g. moodiness) are used to determine mental illness.

Opare-Henaku and Utsey (2017) also reported among urban communities in Ashanti region that mental disorders are classified based on cultural frames regarding level of severity, behavioural features, onset of condition, persistence of symptoms and curability or incurability of condition. They identified five culturally-based labels of mental illnesses, describing different forms, severity and symptoms. Most severe mental disorders is labelled as 'Abɔdam' (literally mean madness), characterized by violence and unpredictability, unintelligible speech, unkempt physical appearance, eating from dumpsters and self-talk. This is followed by 'adwenmuka' (possible onset of mental illness), characterized by fluctuating abnormal behaviours. There are also socially inappropriate behaviours which they include in the classifications of mental disorders. For instance, 'bɔdamaniateɛ' (i.e. cunning), which is a mental disorders label used for individuals with high level of awareness and functioning despite suffering from mental disorder, or individuals who have recovered from mental disorders but still exhibit residual symptoms. 'Bɔdamaniateɛ' individuals were therefore thought to oscillate between normality and abnormality. The last label is 'gyimigyimii' (which literally translates 'stupid, stupid' or double

stupid), usually reserved for children with some form of mental deficit or cognitive impairment, speech impairment, inappropriate affect and social behaviours.

The dominant perceived caused of mental disorders at the community level is spiritual (Adombiri-Naba, 2013; Adeeku, 2015; Adjei et al., 2013; Bampoe, 2017; Opare-Henaku & Utsey, 2017). However, there are other biopsychosocial models that are used alongside the spiritual model for explaining the causes of mental illness. For instance, some community members in northern Ghana allude that family history (genetics), drug abuse, stress from relationship problems, having dubious character and psychological trauma can lead to mental disorders (Adombiri-Naba, 2013; Adeeku, 2015). More severe forms of mental disorders are also sometimes attributed to biological or genetic facts, even though spiritual and retributive causation (such as a curse or bad spirits) are predominantly used (Opare-Henaku & Utsey, 2017; Quinn, 2007). The explanatory model and onset of condition are drawn on to determine the curability or otherwise of mental disorders. For instance, mental disorders are seen to be chronic and incurable when they; have onset in childhood (Opare-Henaku & Utsey, 2017) and are believed to be are caused by biological factors such as genetics (Adombiri-Naba, 2013; Adjei et al., 2013). However, mental disorders that are caused by psychosocial factors (such as stress from daily hassles, drug abuse, psychological trauma) are believed to be curable (Adombiri-Naba, 2013; Adjei et al., 2013; Quin, 2007) because there will always be residual symptoms (Opare-Henaku & Utsey, 2017).

The representations of mental illnesses were similar across the communities, particularly with regards to causes and symptoms of mental illness. The representations however differed across settings based on the classifications and unification of mental disorders conditions. Mental disorders in the communities in the Northern Ghana were more unified into single condition of

'madness' (Adombiri-Naba, 2013; Quin, 2007). Representations in communities in the Ashanti region were more nuanced with variations of mental disorders of different forms, severity and symptoms (Adjei et al., 2013; Opare-Henaku & Utsey, 2017).

2.3.5 Community responses to mental illness

The community response to mental disorders theme synthesized evidence of how individuals in communities in Ghana responded to mental illness. Two forms of community responses are discussed; (i) treatment and care response, and (ii) relational response (how individuals relate to mentally ill patients and their families, including response to reintegration of individuals recovering from mental illness). Treatment and care of mentally ill patients in communities takes place within a vibrant pluralistic health system (de-Graft Aikins, Boynton & Atanga, 2010), characterized by orthodox psychiatric treatment, spiritual and faith healing system, and traditional and herbal treatment (de-Graft Aikins, 2015; Opare-Henaku & Utsey, 2017). Treatment for mental disorders are sought from a combination of biomedical hospitals, prayer camps, herbalists and traditional healing (Adeeku, 2015; Adjei et al., 2013; Kyei, Dueck, Kyei, Dueck, Indart & Nyarko, 2014; Opare-Henaku & Utsey, 2017; Read, Adiibokah & Nyame, 2009).

However, the dominant treatment response to mental disorders in communities is spiritual or faith healing (Adeeku, 2015; Kyei, Dueck, Kyei et al., 2014; Opare-Henaku & Utsey, 2017). In rural communities, families discontinue with antipsychotic drugs for their mentally ill patients for variety of reasons, mostly cohering around; unpleasant side effect, perceived failure of antipsychotic drugs to achieve permanent cure, especially when the family caregivers consider local resources and concepts to be more effective in maximizing treatment (Read, 2012). Care for mentally ill patients is also found to be characterized by human right abuses of the patients in

poor urban and rural communities. Cases of chaining, diet restriction, isolation and beating are very common in communities such as Kintampo and Nkoranza in Brong Ahafo region (Ae-Ngibise et al., 2015; Read et al., 2009), and Zuarungu and Sumbrugu communities in Norther region (Naba, 2014)

Some studies have documented positive relational family response towards mentally ill patients. For instance, Adeeku (2015) reported that some individuals indicate that they are willing to provide material and emotional support, if family members developed mental illness. Similar findings have been reported by other community-based studies both in Northern and Greater Accra regions (Quinn, 2007; Quinn & Evans, 2010). However, community-level relational response to mental disorders in Ghana is largely negative. Evidence show that individuals in both rural and urban communities respond to mental disorders in ways that undermine the psychosocial support needed for improvement. Individuals with mental disorders and their family caregivers experience high levels of stigma and shame (Adeeku, 2015; Adjei et al., 2013; Barke, Nyarko & Klecha, 2011). There are also high levels of stigma, authoritarian and socially restrictive attitudes towards mental disorders in urban Ashanti communities (Barke et al., 2011). Majority of respondents surveyed in Pantang community in Accra believe that mentally ill patients should be kept away from society, in psychiatric hospitals permanently for the protection of communities (Adeeku, 2015). Mentally ill patients are seen as inferior, contagious, social deviants and bad omens in rural communities (Adjei et al., 2013). Also, majority of individuals in rural communities would; end their marriages if partners developed mental illness, not permit a relative to marry a person with history of mental illness, and not employ individuals with history of mental disorders (Adombiri-Naba, 2013).

Two studies have explored community responses to reintegrating individuals with mental disorders into their communities (Bampoe, 2017; Sahl, 2017). The studies show how poverty and stigma undermine reintegration of individuals recovering from mental disorders into their communities. Symbolically, there is a dynamic coexistence of high levels of positive and negative attitudes towards mental disorders (Bampoe, 2017). Reintegration attempts are undermined by high levels of stigmatization and discrimination towards individuals with mental illness, both at the family and community levels (Bampoe, 2017; Sahl, 2017). Sahl (2017) for instance reported that adolescents recovering from mental disorders who have been reintegrated into their communities still experience social exclusion and discrimination both within the family and in their community. Materially, poor and inadequate housing facilities undermine reintegration. Sahl (2017) found that lack of independent living arrangements, overcrowded compounded houses made families less willing to agree to bringing home their relatives recovering from mental illness.

2.3.6 Community mental health research in Ga Mashie

The current study is situated in Jamestown and Usshertown, two twin communities in Greater Accra region, jointly referred to as Ga Mashie. Research in these communities demonstrate high prevalence of common mental health disorders. Grief and Dodoo (2015), in a study of community-level determinants of mental health problems in Ga Mashie, used a single item estimation for depression ("How often in the past one month did you feel depressed?"; on 5-point Likert scale) and perceived powerlessness ("I feel that what happens in my life is often determined by factors beyond my control", on 5-point Likert scale). The respondents were found to report higher mean levels of perceived powerlessness (M = 3.54, SD = 1.24) than depression (M = 1.74, SD = 1.08). Kushitor et al., (2018) also reported a mean of 25.5 (SD = 5.5)

psychological distress score (estimated from 9 out 10 items of Kessler's Psychological Distress Scale, K-10) among a sample 782 residents in three urban poor communities in Accra, Ghana. A mean score of 25 – 29, on the K-10 shows moderate psychological disorder. Therefore, the mean score reported in Kushitor et al., (2018) study show at least the presence of moderate psychological distress among the respondents. Teye (2013) in a study of psychosocial well-being of chronically ill patients in the communities also reported that approximately 21% reported poor mental health and 12% reported poor emotional functioning. Kyei-Arthur (2013) in a study of mental health outcomes among caregivers in the communities, also reported that 16.1% of the caregivers reported poor mental health, while 2.3% reported extremely poor mental health.

Drivers of mental disorders in Ga Mashie are both material and symbolic. In terms of material drivers of mental ill-health, difficulty paying bills and local economic disadvantage are associated with high depression and powerlessness, while external economic assistance is associated with lower depression (Grief & Dodoo, 2015). In terms of symbolic drivers, Grief and Dodoo (2015) also reported a positive association between depression and perceived community stressors. Asante (2016) also found a positive association between sense of community and psychological distress in two urban poor communities in Accra. Social capital has been found to show double-edged effect on mental health in the communities (Grief & Dodoo, 2015; Kushitor et al., 2018). Social capital is beneficial to individuals facing extreme economic disadvantage, but becomes emotionally burdensome among those who are relatively economically advantaged (Grief & Dodoo, 2015). Interpersonal trust is reported to provide a good buffer for psychological distress for individuals in urban poor communities (Kushitor et al., 2018).

2.4 Social representations of mental health

Social representations of mental health provide insights into practical social knowledge of mental health in the communities. In terms of knowledge, there is poor mental health knowledge in rural and poor communities. Similar findings have been reported among communities in Tanzania, where majority were found to have poor knowledge about mental disorders and unable to identify any type of mental disorders (Benedicto, Mudeme, Mwakagile & Mwansisya 2016). Within poor and marginalized communities, poor knowledge of mental health is found to be higher among males, individuals with low education and income (Gibbons, Thorsteinsson & Loi, 2015; Yu et al., 2018). It is however worthy to note that poor mental health knowledge is not a rural/poor communities problems. Poor mental health knowledge exist in urban and wealthy communities as well. Community mental health research tend to focus on rural, poor and marginalized communities. Also, not every resident in communities labelled poor, is poor. There are some wealthy individuals in poor communities.

Low mental health literacy among communities is reflected in largely negative perceptions about mental disorders in communities. Community members identify mental disorders based on complex competing factors such as spiritual rhetoric, psychosocial appropriateness, behavioural disturbances, adaptive functioning, substance use, social difficulties and biomedical impairment (Monteiro & Balogun, 2014). The predominant perceptions of mental disorders in communities include unpredictability, aggression and violence (Benedicto et al., 2016; Adjei et al., 2013; Opare-Henaku & Utsey, 2017). Spiritual causal theories (e.g. evil spirits, witchcraft, punishment from God) remains dominant explanatory model for mental disorders overriding competing biomedical, psychosocial and substance use explanatory models (Benti et al., 2016; Gibbons et al., 2015; Opare-Henaku & Utsey, 2017). These shape a largely negative relational response,

characterized by stigmatization, social distancing, social exclusion and dehumanizing treatment often received by mentally ill patients (Benedicto et al., 2016; Benti et al., 2016; Kyei et al., 2014; Adjei et al., 2013; Opare-Henaku & Utsey, 2017; Read et al., 2009).

There is the need to understand deeper socio-cultural assumptions surrounding mental disorders and mental health in order to better make sense of these surface level basic perceptions and attitudes towards mental disorders in communities. Some studies (e.g. Foster, 2001; Morant, 2006) have explored local knowledge in mental disorders to provide insight into how social groups in communities make sense of mental disorders and mental health. Foster (2001) for instance undergraduate students in London tend to cluster all mental disorders together as one based on characteristics of being unpredictable and violence. The articipants unified mental disorders by squarely locating all mental disorders in the brain, portraying mental disorders as visually inaccessible, impenetrable and highly sensitive condition to unravel, thus sustaining a somewhat mysterious nature of mental disorders (Foster, 2001). In this way, all mental disorders are seen as internal tendencies, and social conditions only become like triggers.

The students at the same time differentiate between different mental disorders based on its severity and curability. The Participants also differentiated between mental disorders to aid identification and categorization. The participants used medical differentiation for instance helped in differentiating between severe (e.g. schizophrenia, manic depression and autism) and less severe (e.g. anxiety and depression) forms of mental illnesses. The differentiation helped in further classifying mental disorders beyond biomedical lines, to include *normality* (i.e. placing symptoms on normality – mental disorders continuum), *severity* (i.e. not harmful to harmful either to self or to society), *temporality* (e.g. symptoms lasting short time to long time), and *treatment* (i.e. whether condition has treatment or not) (Foster, 2001).

de-Graft Aikins (2015) shows how mental disorders are distinguished based on differentiation and legitimization. In some African countries (such as Ghana, Kenya, Uganda and Uganda) and Britain, depression and neurosis for instance are classified as mild, while psychosis and schizophrenia are classified as severe (de-Graft Aikins, 2015). Mental disorders classified as severe (e.g. schizophrenia and epilepsy) are deemed illegitimate and therefore have high risk of destitution, those with medium severity (e.g. postpartum depression, post-traumatic stress disorder) are granted conditional legitimacy and therefore medium risk of destitution, and those classified as least severe (e.g. dementia, Alzheimer's) are grant unconditional legitimacy and therefore have lower risk of destitution (de-Graft Aikins, 2015).

In a related study, Morant (2006) explored social representations of mental illnesses among community-based mental health professionals in the United Kingdom. Findings showed a complex representation of mental illness, characterized by uncertainty and ambivalence. The mental health professionals made sense of mental disorders through medical and functional (i.e. inability to cope and function) representations. Otherness (i.e. different and un-understandable experiences of individuals with mental illness) and sameness (i.e. similar experiences) coexisted simultaneously. The professionals were found to use psychoses as reflection of primarily otherness and neuroses as reflection of primarily sameness. The findings of Foster (2001) and Morant (2006) reflect findings from a related study in Ghana on cultural conceptualizations of mental disorders (Opare-Henaku &Utsey 2017).

The co-existence of othering and sameness of mental disorders are shaped by the processes involved in the formation of social representations of mental illness. de-Graft Aikins (2012), drawing on anthropological evidence from African communities, showed how cognitive and emotional processes underlined representations of unfamiliar, and informed categorization and

stigmatization of unfamiliar health conditions based on strangeness and severity. de-Graft Aikins (2012) argues that emotions are fundamental in forming social representations, because emotions constitute valid knowledge, informs how individuals and communities think and reflect, and also informs what individuals and communities do and how they act. She therefore advanced a cognitive-emotional process of social representations informs othering of individuals who live with mental disorders that are perceived to be threatening and fearful. She argued that a "mixed, often opposing, emotions directed at both self and the other: contempt versus respect, fear versus desire, disappointment versus hope" mediate social representations (de-Graft Aikins, 2012, p.14).

Lu, Chauhan and Campbell (2015) explored men's account of how they handle their every day socio-political and family demands in urban communities in China. Findings showed that the men defined psychosocial strength and mental health in four main ways; control over emotions, adherence to Confucian philosophy (of a 'perfect man' motivated by moral and social considerations, rather than the ideas of autonomy, independence, and worldly success), cherishing family relationships and discharging familial obligations, and demonstration of social obedience and conformity (Lu et al., 2015). The findings suggest a fundamental socio-culturally prescribed mental health, characterized by emotional control, selflessness, interdependence, family obligation and social conformity. Thus, acts of emotional expression, self-interest, autonomy and independence become signs of mental weakness (Lu et al., 2015). Also, factors such as pressures from modernity, anxieties of aging, and stereotypical constructs of patriarchy, were seen as disruptive to mental health (Lu et al., 2015).

Some studies have also focused on exploring dialogue surrounding mental health within community social spaces, as avenues for creating and challenging socio-cultural assumptions that

compromise well-being. Mental health in communities are underpinned by both explicit and implicit stigma that shape not only treatment and care seeking, but also more importantly, recovery among mental ill patients (Stull, McConnell, McGrew & Salyers, 2017) and expectations of community mental health professionals (Biringer, Davidson Sundfor, Ruud & Borg, 2017). For instance, Mestdagh and Hansen (2014) in a systematic review, have reported that individuals living with schizophrenia experience stigma and discrimination in community health centres. They observed that while community mental health professionals demonstrate considerable awareness of the structural problems in mental health care, their relational and behavioural encounters with individuals living with schizophrenia are still characterized by stigmatization, neglect and subtle abuses.

Morral and Morral (2016) have also reported among community pharmacists in England Wales that even though they have relatively positive attitudes towards mental illness, they nevertheless feel less comfortable providing services to patients taking psychotropic medications, compared to patients taking cardiovascular medications. They were also found to perceive lower prevalence of physical health conditions among mentally ill patients (Morral & Morral, 2016). The findings from Mestdagh and Hansen (2014), and Morral and Morral (2016) show how despite explicit positive attitudes towards mental illness, pharmaceutical care and service provision in community contexts are undermined by unexamined assumptions, implicitly undermining mental disorders recovery.

Mathias, Mathias, Goicolea and Kermode (2018) have also provided critical insight into how community mental health competence can be strengthened through safe social spaces. In a study that examined the association between context, interventions, mechanisms and outcomes of community mental health project in India, Mathias et al., (2018) showed that safe social spaces

allow communities develop new knowledge and absorb and incorporate new understanding of mental health issues within their existing explanatory frameworks. Informal community conversations about mental health for instance were found to promote knowledge sharing through non-hierarchal means. Safe social spaces therefore allowed integration of unfamiliar biomedical mental health knowledge into local knowledge systems about mental disorders and mental health (de-Graft Aikins, 2012). Safe social spaces were thus found to increase social support for mentally ill patients and their families (Mathias et al., 2018).

Deeply rooted implicit assumptions that undermine mental health call for safe social spaces for critical dialogue that exposes such implicit mental health-damaging assumptions that lie beyond surface display of compassion and understanding. Dialogue in communities surrounding mental health can promote or undermine such implicit mental health-damaging assumptions. Community conversations for instance have been found to strengthen positive responses to well-being in various ways including; enabling members to brainstorm for practical action plans to respond to health problems, means for challenging and reducing silence and stigma, providing forum for developing a sense of common purpose, and encouraging community members to see themselves as active problem solvers (Campbell, Nhamo, Scott, Madanhire, Nyamukapa, Skovdal & Gregson, 2013).

Social spaces within communities also provide contexts which can either support or undermine the success of community mental health interventions in very insidious ways. Mahr and Campbell (2016) show how safe social spaces promote mental health, even in communities that are dealing with aftermath of mass genocide. After evaluating a small-scale community-based mental health intervention in Rwanda, Mahr and Campbell (2016) observed that community engagement workshops enhanced mental health competence by creating a safe social space

where community members simultaneously opened up on their problems and also developed critical understanding of processes of pain and potentials for healing. Three elements were identified in how the community engagement workshops facilitated safe social spaces. First, workshop participants were divided into smaller groups to overcome the intimidating nature of large groups, thereby encouraging people to talk (Mahr & Campbell, 2016). Secondly, privacy and confidentiality were assured, through the workshops' 'rules of protection'. The third element was that the moderators of the workshops were perceived as both professional and sensitive. These three elements encouraged community members to open up freely and engage in critical dialogues of rebuilding their post-genocide lives and communities. Through the dialogues, the community members developed critical consciousness that provided deeper understanding of themselves and others, and developed practical ways of rebuilding their lives. For example, the community members understood their pain and the needed process of healing, formed bonding social capitals and developed income generating activities.

Synthesizing the findings from the studies reviewed, social representations impact mental health in communities in significant ways. At the basic level, social representations provide insight into knowledge of, beliefs about and attitudes towards mental disorders and mental health in communities, all of which are underlying factors for stigmatization and discrimination, as well as informing quality of care individuals living with mental disorders and their families. Social spaces allow for competing knowledge encounters (especially between lay and professional knowledge systems) and also provide insight into how symbolic resources are created and contested within communities to address mental health challenges.

2.5 Social identities and mental health research

Social identities also provide insight into understanding the multilevel drivers of mental illness. The role of social identities in mental health research has been approached differently in mainstream and critical psychologies.

2.5.1 Mainstream approach to social identities and mental health

The mainstream approach to social identities and mental health has focused on how social groups affect mental health of individuals. Originating from mainstream applied social and health psychologies, this approach has sought to quantitatively explain how membership of and identifications to social groups influenced mental disorders of individual members. Social identity is argued to constitute a 'social cure' in times of ill health and therefore there is a fundamental research agenda to advance social group membership and social relationships as cure to ill health (Haslam, Cruwys & Haslam, 2014; Haslam, Jetten, Postmes & Haslam, 2009). Within the mainstream literature, there is recognition that social relationships have double-edged effect on well-being, which can constitute a cure or a curse (Jetten et al., 2017). For instance, social relationships are argued to be health-enhancing to the extent that social groups provide individuals with a positive sense of identity (characterized by meaning, support and agency), and health-damaging when social groups challenge a sense of identity (Jetten et al., 2017). The mainstream research has therefore focused on understanding the psychosocial mechanisms underlying social groups as essential determinants of health and well-being.

Social identification is reported to; reduce depression in elderly individuals with diseases (Cameron et al., 2018), improve recovery from depressive symptoms (Cruwys et al., 2014), be both curative of existing depression and protective against the development of future depression (Cruwys et al., 2013). Social identification also reduces stress among students experiencing

social isolation and affective disturbance (Haslam et al., 2016) and psychiatric distress among students (Miller, Wakefield & Sani, 2015). Social identification is also reported to reduce general and social anxiety (Cruwys et al., 2014; Haslam et al., 2016), associated with lower paranoia (Greenaway, Haslam & Bingley, 2018) and promote general and psychological well-being (Cruwys et al.,2014; Haslam et al., 2016; Lam et al., 2018).

The way social identification is conceptualized and measured is fundamental to understanding social relationships as a psychosocial resource (Cameron 2004; Leach et al., 2008). Following this argument, Cameron (2004) proposed a three-factor model of social identity to explain three dimensions of social identification that are critical to health and well-being; *centrality* (individuals' subjective evaluation of the importance of group to self-definition), *ingroup affect* (quality of emotions associated with social group membership) and *ingroup ties* (the extent of psychological ties that bind individuals to groups). Leach et al. (2008) also proposed a hierarchical multicomponent model of social identification, consisting of five components; *individual self-stereotyping* (perceiving self as similar to other group members), *ingroup homogeneity* (extent of perceiving group as sharing commonality that makes group homogenous, which establishes the group as a coherent social identity), *perceived solidarity* (perceived sense of belonging and psychological and emotional bond with and commitment to group), *satisfaction with group* (positive feelings of group membership) and *centrality* (perceiving group as central aspect of self-concept). These five components are organized within two-dimensional model; model of group-level self-definition (i.e. individual stereotyping and in-group homogeneity) and model of self-investment in group activities (i.e. solidarity, satisfaction with group and centrality).

The impact of social identity on mental health depends on the kind of social group that individuals belong to or identifies with (Postmes, Wichmann, van Valkengoed & van der Hoef, 2018). In a meta-analysis examining association between social identification and depression, Postmes et al., (2018) identified four social groups on two continua, as fundamental to depression, cohering around *group type* (social categories vs interactive groups) and *group stigma* (stigmatized groups vs non-stigmatized groups). It was observed that the studies that focused on identification with interactive groups (such as friends, therapy groups and family) had larger effect sizes in depressive symptom reduction than those that focused on social categories (such as ethnic identity, gender). Also, studies that examined non-stigmatized groups found larger effect size in depressive symptom reduction than on stigmatized groups (e.g. LGBTQIA and immigrants). The way social identification was measured also made substantial difference to the average effect size. Studies that used self-evaluation of collective identity reported larger effect size compared to those who used identity sub-scale of collective self-esteem scale and multi-ethnic identity scales.

Stigmatized social groups (36.1%) and non-stigmatized social groups (32.8%) have featured strongly in the literature (see Appendix F). Interactive social groups (8.3%) and social categories (1.7%) are least featured in the literature. The main stigmatized social groups researched include; elderly group, mental health patients, mental health support groups, refugee groups, groups with physical deformities, racial minorities and sexual minorities (e.g. Ai et al. 2015; Arbona & Jimenez, 2013; Arbona & Jimenez, 2014; Bogart, 2015; Branscombe et al. 1999; Cameron et al., 2018; Cruwys et al., 2016; Cooper et al., 2017). For instance, Cameron et al., (2018) reported that higher identification with a chronic disease management self-help group was associated with lower depression in elderly people, health distress and higher psychological well-being. Cruwys

et al., (2016) also reported that identification with clinical psychotherapy group predicted recovery from depressive symptoms among adults diagnosed with depression.

The effect of identification with severely stigmatized social group is however not all positive. Crabtree, Haslam, Postmes and Haslam (2010) for instance showed that identification with mental health support groups has a direct negative effect on mental health by reducing self-esteem. Support group identification was only found to have a positive impact on self-esteem through the provision of stress-buffering resources. Crabtree et al (2010) therefore argued that social identification with a stigmatized group has, simultaneously, both direct negative and indirect positive consequences for self-esteem.

The non-stigmatized groups researched are students, dominant religious groups, professional and political groups (e.g. Arbona & Jimenez, 2013; Bizumic et al., 2009; Cruwys et al., 2013; Cruwys et al., 2015; McIntyre et al., 2018; Miller et al., 2015; Sani, 2012; Van Dick et al., 2017). For instance, Bizumic et al. (2009) reported that high identification is associated with psychological well-being among undergraduate students and staff. Similar findings have also been reported by Hunt and Burns (2017) with regards to alcohol consumption and mental health among undergraduate students. The interactive social groups featured in research include sports groups, community recreation groups, social clubs, family and friends (Branscombe & Wann, 1991; Cruwys et al., 2014; Greenaway et al., 2018; Sani et al., 2010; Sani, 2012). Cruwys et al. (2014) for instance have reported that adults at risk of depression who joined community recreation groups experienced significant recovery from depressive symptoms. Branscombe and Wann (1991) also reported among students that high identification with their sports team was associated with high self-esteem and lower depression, anxiety and feeling of alienation.

Social identity has also been conceptualized and measured differently within mainstream mental health research (see Appendix F). Multiple social group membership and multiple identities came up top as assessment of social identity (23%), followed by identity centrality (18%), satisfaction with groups (16.4%), individual stereotyping (14.8%), solidarity (11.5%), ingroup homogeneity (8.2%), social engagement (6.6%) and one item identification with social groups (1.6%). However, some studies (e.g. Cooper et al., 2018; Crabtree et al., 2010; Cruwys & Gunaseelan, 2016; Kearns et al., 2018; Latrofa et al., 2009) overlap because they assess multiple components (i.e. centrality, satisfaction with ingroup, solidarity, ingroup homogeneity and or individual stereotyping) of social identification. These components have been reported to have positive effect on mental health (Ai et al., 2015; Cooper et al., 2018; Crabtree et al., 2010; Cruwys & Gunaseelan, 2016; McIntyre et al., 2018). However, a gap identified among the studies that examined multicomponent of social identification is that they do not examine the differential effect of the dimensions. The studies usually examine composite social identification and so there is limited knowledge which component causes the effect that is usually observed.

Conceptualization of social identification as multiple group membership, have been found to have inconsistent impact on mental health. Some studies show that membership in multiple groups is protective of mental health (Lam et al., 2018; Miller, Wakefield & Sani, 2015; Sani et al., 2015). For instance, Miller et al., (2015) have reported an additive effect of multiple social group identification, to the effect that the odds of psychiatric distress decreased with additional group with which participants identified strongly. Lam et al., (2018) have also reported that belonging to multiple groups positively predicted retirees' health and well-being in both Western and non-Western cultural contexts. Sani et al. (2015) have also shown among Scottish community participants that (even after controlling for gender, age, education and number of

contact-intensive groups), identification with multiple social groups was associated with both lower self-rated depression and lower odds of having received a prescription for antidepressants.

However, other studies (e.g. Cruwys, Dingle, Haslam, Haslam, Jetten & Morton, 2013; Iyer et al. 2009; Settles, 2004) show a more complex association of multiple social groups on mental health. Settles (2004) for instance show that multiple identities lead to identity interferences which reduces psychological well-being. Iyer et al., (2009) have also shown that multiple groups only have positive effect on mental health to the extent that the multiple identities are compatible, and that incompatible identities undermine mental health among students adjusting to college transition. In a 2-wave longitudinal study, Cruwys et al., (2013) also showed that while belonging to multiple groups was associated with lower depression, multiple social group nonetheless was a significant predictor of future depressive symptoms among individuals with a history of depression. This suggest that for individuals with history of mental illness, multiple social groups can cause relapse.

The link between social identity and mental health has been explained by four psychosocial mechanisms in the mainstream literature. These are; *self enhancement* (Cameron et al., 2018; Cooper et al., 2017; Greenaway et al., 2018; Haslam et al., 2016; Miller et al., 2015), *cognitive appraisal* (Branscombe, Schmitt & Harvey, 1999; Cruwys, South, Greenaway & Haslam, 2015), *stress-buffering* (Carbtree et al. (2010 et al., 2010; Crane, Louist, Phillips, Amiot & Steffens, 2018; Haslam et al., 2016) and *adaptive social functioning* (Greenaway et al., 2018; Haslam et al., 2016). These four psychosocial factors are argued to simultaneously alleviate psychosocial symptoms and enhance psychosocial functioning.

First, social identification lead to self-enhancement, which in turn improves mental health. The self-enhancement happens through various psychosocial means such as enhanced self-esteem (Cooper et al., 2017), self-efficacy (Cameron et al., 2018), increased sense of self-control (Greenaway et al., 2018) and identity stability (Miller et al., 2015). For instance, Cooper et al., (2017) observed that social identification with autism self-help group leads to enhancement in personal self-esteem, which in turn reduces depression. Cameroon et al., (2018) also reported that self-efficacy mediates social identification and mental health outcomes among chronic disease patients. Greenaway et al., (2018) have also found that enhanced self-control explains the underlying mechanism between social group identification and mental health among individuals diagnosed with paranoia. Miller et al., (2015) also argue that school provides a stable and reliable social groupfor adolescents and therefore, high school identification leads to stable identity, which then improves mental health of students. Thus, when mental health is threatened or disrupted, social identification provides platform for self-enhancement that rehabilitates and restores mental health.

Secondly, social identity and social identification reduces psychosocial stresses, in three explicit ways; enhancing stressor acceptance (Crane et al., 2018), providing stress-buffering resources (Crabtree et al., 2010) and providing access to health-enhancing social support (Haslam et al., 2016). Crabtree et al. (2010) for instance have reported that group identification is associated with increased social support, stereotype rejection and stigma resistance, which act as self-protective mechanisms in improving self-esteem among mental health support groups in England. Haslam et al., (2016) have also reported among undergraduate students in Australia that social group memberships provides basis for effective social support. In a related study, Crane et al., (2018) found that stressor acceptance significantly moderates the negative association

between stressors and burnout among undergraduate students in Australia. This suggests that that in times of high frequency and intensity of stress, stressor acceptance significantly reduces the devastating effect of stress on burnout. They found further that identity centrality enhances the effectiveness of stressor acceptance. Crane et al. (ibid) therefore concluded from their two-wave studies that identity centrality enhances the effectiveness of stressor acceptance in the face of group-based stressors. These findings suggest that the positive effect of social identification with stigmatized or marginalized groups in improving mental health depends on the effectiveness of stressor acceptance. These findings thus suggest that social identification constitutes a foundation for providing stress-buffering resources for improving mental health.

Thirdly, social identification affects mental health through cognitive appraisal such as positive attributions (Branscombe et al., 1999; Cruwys et al., 2015). In a study of prejudice and discrimination among African Americans, Branscombe et al., (1999) observed that minority group identification had significant protective effect on mental health. However, the effect was moderated by their prejudice attributions. Specifically, perceiving prejudice as pervasive produced positive effect on well-being that are fundamentally different from those that may arise from an unstable attribution to prejudice for a single negative outcome. Cruwys et al. (2015) have also reported that social identity negatively predicted depressive attribution style, which in turn positively predicted negative moods among undergraduate students in Australia. This means that cognitive appraisal mediates the protective effect of social group identification on depressive symptoms. Evidence from the Branscombe et al., (1999) and Cruwys et al. (2015) studies suggest that social identity is protective of mental health largely to the extent that it fosters positive attribution styles.

Lastly, social identification is found to improve mental health through adaptive social function (Greenaway et al., 2018; Haslam et al., 2016). Greenaway et al., (2018) for instance have reported that social identification enhances interpersonal trust, which in turn alleviate symptoms of paranoia. Haslam et al. (2016) also argue that because social identification provides social support and means of active social engagement and participation, social identity becomes a conduit for interpersonal trust and social functioning. These elements improve mental health outcomes that have perceived disrupted social and interpersonal relations as underlying factor. This suggests that, through adaptive social function, social identification restores interpersonal trust and social participation, which alleviate symptoms of negative mental health.

2.5.2 Critical approach to social identities and mental health

While the mainstream approach focuses on membership of and identification with social groups reduce or mental disorders symptoms, the critical approach to social identities and mental health research focuses on understanding the multiple and multilevel factors that shape lived experiences of mental disorders at the community level (Campbell & Burgess, 2012; Campbell & Jovchelovitch, 2000). The critical approach focuses on qualitatively understanding the complex interactions of material, symbolic and embodied factors that define who individuals are (Campbell & Jovchelovitch, 2000; Mahr & Campbell, 2016), to unearthing the heterogeneities of identities, and how these identities shape mental disorders experience in communities (Campbell & Jovchelovitch, 2000; Mannell, Seyed-Reaisy, Burgess & Campbell, 2018).

Social identities structure lived experiences in community context, and matters in segmentation, data gathering and interventions. Mannell et al., (2018) for example have showed how social identities mattered in community-based intimate partner violence (IPV) interventions in Rwanda, meant to promote well-being of women. Findings showed that the community members

responded to intimate partner violence in three ways; providing interpersonal support for victims of IPV (in the form of couple counselling and reconciling couples experiencing violence), engaging community support by raising cases of IPV during community discussions, and using public spaces as means of putting pressure on men to stop their violent behaviours (especially when attempts to reconcile the couple failed). Two main kinds of public spaces were identified and used. The first is 'umuganda' which was a government-mandated community engagement (with high level government officials) meant for discussing local community issues of concern. Raising issues of IPV during *umuganda* provided opportunities for both gaining public witnesses and soliciting public interventions (Mannell et al., 2018). The second public space used is 'umugoroba w'ababyeyi', which is seen as parents' evenings when couples usually meet to deliberate on domestic issues within the community.

Mannell et al. (2018) found further that the use of public spaces for raising IPV issues was strongly contested, usually by the men, which also undermine the effectiveness of using public spaces to address domestic violence against women in the community. However, in cases where public spaces failed, public institutions such as local police and the court systems were used as last resort to address situations of violence. Notable absences were identified in the access of resources. First, the community resources available to victims of IPV were more directed exclusively towards physical violence (Mannell et al., 2018). This means that women who experience psychological and or emotional forms of violence had no help. Secondly, the community responses and support were usually directed towards married women, by helping them access available resources and providing them opportunities to be part of community (Mannell et al., 2018). The findings showed that gendered identities structured lived experiences

of both physical and psychological violence, and explain what the social spaces were not supportive of unmarried women who experienced violence from their intimate partners.

The material context of social identities also matters, in understanding access to resources for addressing mental health challenges. Material context matters because poverty still remains fundamental structural problem that undermine well-being of individuals in resource-poor communities. Poverty also undermine efforts at addressing mental health problems in deprived communities and neighbourhoods. Material deprivation (such as food insecurity and non-ownership of household asset) for instance has been associated with higher psychological distress among HIV positive adults in India (Kang et al., 2015), household heads in rural communities in Northern Ghana (Atuoye & Luginaah, 2017) and severe mental disorders in rural China (Ran et al., 2018). Material deprivation, in the form of housing problems, financial problems, food and transportation, is associated with poor mental health in European countries (Dreger, Buck & Bolte, 2014; Durbin, Sirotich, Lunsky & Durbin, 2017), particularly with migrant and minority ethnic communities (Awuah et al., 2020).

At the community-level, poverty and material deprivation undermine community mobilization efforts to address health and well-being problems. Gibbs et al., (2015) for instance show how poverty undermines community mobilization efforts by compromising ability to develop and sustain social capital, and hinders treatment and care for mentally ill patients. Campbell et al., (2013) also report of how poverty and poor harvest undermine the development of local community competence to address endemic HIV problem in rural Zimbabwe. Poverty and poor harvest (coupled with political instability) frustrated and limited community members' efforts in implementing actionable plans. Material support from outside the community, in the form of

antiretroviral drugs and treatment played a vital role in improving the health of people living with HIV/AIDS within the community.

Understanding the material context therefore provides critical insights into what and how resources (both material and symbolic) shape identities and how that could be drawn upon or leveraged to mitigate the devastating effect of endemic poverty on mental health in deprived communities. The material context therefore encompasses the practical and useful resources for coping with the conditions that undermine mental health. For instance, how individuals with mental disorders and their families are supported to better cope with poverty that cripple or undermine their well-being. Within community contexts, these include economic empowerment, community-based facilities for providing mental health services, human resources and institutional provisions or constraints that promote or undermine mental health. (Mannell et al., 2018)

Even though the material context is well theorized to shape health and well-being in communities, there are limited empirical studies when it comes to mental health in poor and deprived communities and neighbourhoods. The few studies available show how supportive material context can enhance well-being in deprived communities. Mahr and Campbell (2016) for instance report how the material context played a key role in creating mental health competence in post-genocide Rwandan survivors in Mageragere community. The material needs of the community members were mainly expressed in homelessness, food insecurity and inability to pay children's school fees. Through community-based healing workshops, support-networks were created of which variety of support structures were generated. The government and church groups also provided material support to the community members, in the form of food, clothes and some educational supports. The workshop also provided skill training to the community

members which helped some of them to start small businesses to improve their financial situation. Thus, on economic level, mental health competence in the Mageragere community was created through workshops on entrepreneurship and skills training, which led to the establishment of small income-generating activities.

2.6 Social capital and mental health research

Several scholars (e.g. Campbell, 2019; Lippman et al., 2018) allude that there may be some minimum threshold of social capital needed in communities for community-based interventions to improve health and well-being succeed. Given the complex effect of social capital on mental health, it is imperative to examine how social capital emerges in poor community contexts. This is critical due to empirical evidence that shows that poor communities and neighbourhoods have limited power to transform their social realities (Campbell, 2019; Portinga, 2012; Lippman et al., 2018). Poor neighbourhoods have low civic participation, political activism and limited external ties with powerful social actors (Portinga, 2012). This section presents discussion of empirical literature on social capital, along three dimensions; bonding social capital, bridging social capital and linking social capital, as conceptualized by Campbell (2019).

2.6.1 Bonding social capital in community context

Empirical studies linking bonding social capital to health and well-being in community context have largely been examined quantitatively. Some of the studies have measured bonding social capital in cognitive terms, assessing perceived community/neighbourhood cohesion (Bassett & Moore, 2013; Haseda, Kondo, Takagi & Kondo 2018; Lippman et al., 2018; Murayama et al., 2015; Portinga, 2012). Some of the studies also conceptualized social capital in relational terms

by measuring generalized trust (Bassett & Moore, 2013; Giordano, Bjork & Lindstrom, 2012; Portinga, 2012) and interpersonal trust (Han et al., 2018). Third group of studies also conceptualized social capital in terms of socio-political participation (in line with Bourdieu's conceptualization) by measuring social participation (Bassett & Moore, 2013; Giordano et al., 2012; Iwase et al., 2012), community participation (Wickrama & Wickrama, 2011) political activism, civic participation, political participation, political efficacy and political trust (Haseda, Kondo, Takagi & Kondo 2018; Portinga, 2012).

These varied conceptualizations of social capital have been linked to various aspects of health and well-being. Health in these empirical studies has been conceptualized largely in terms of self-rated health (Chen & Meng 2015; Elgar et al., 2011; Giordano et al., 2012; Kim et al., 2005; Kishimoto et al., 2013; Maass, Kloeckner, Lindstrom & Lillefjell, 2016; Murayama et al., 2013; Portinga, 2012) and HIV-related behaviours (Lippman et al., 2018). Well-being on the other hand has been conceptualized in terms of different poor mental health indicators such as depression (An, Jung & Lee, 2019; Bassett & Moore, 2013; Han et al., 2018; Murayama et al., 2013; Murayama et al., 2015; Wickrama & Wickrama, 2011), psychological distress (Kobayashi, Suzuki, Noguchi, Kawachi & Takao, 2015), post-traumatic stress risk (Wickrama & Wickrama, 2011), cognitive decline (Murayama et al., 2013) and dementia symptoms (Murayama et al., 2018). Others have also looked at positive mental health indicators such as life satisfaction (Elgar et al., 2011; Maass et al., 2016) and quality of life (Hamdan, Yusof, Marzukhi & Abdullah, 2018).

These associations have been examined among different social groups such as elderly populations in Japan (An et al., 2019; Han et al., 2018; Haseda, et al., 2018; Kobayashi et al., 2015; Murayama et al., 2013; Murayama et al., 2015a, Murayama et al., 2015b; Murayama et al.,

2018), tsunami-affected mothers in Sri-Lanka (Wickrama & Wickrama, 2011), urban dwelling adults in Canada and China (Bassett & Moore, 2013; Chen & Meng, 2015), minority ethic groups in UK (Heim et al., 2011), and general populations in national surveys (An et al., 2019; Bassett & Moore, 2013; Elgar et al., 2011; Giordano et al., 2012; Kim et al., 2005; Maass et al., 2016; Portinga, 2012).

High community-level bonding and bridging social capital is found to be; negatively associated with self-rated poor health in communities in United States (Kim et al., 2005) and Japan (Iwase et al., 2012), increases quality of life in Malaysia (Hamdan et al., 2018), inversely associated with psychological distress among Japanese elderly people (Kobayashi et al., 2015); has both direct effect on late-life depression and a buffering effect on the association between stress and late-life depression in Korea (An et al., 2019). Generalized trust has also been reported to be positively associated with self-rated health (Giordano et al., 2012), reduced depressive symptoms among urban dwelling adults (Bassett & Moore, 2013). Perceived neighbourhood cohesion is found to partially offset devastating effect of daily stressors on depressive mood among aged in Japan (Murayama et al., 2015) and a significant predictor of life satisfaction but not self-rated health in Norway (Maass et al., 2016). Low interpersonal trust and reciprocity levels are also found to be associated with high depressive symptoms among Korean elderly people (Han et al., 2018). However, some studies also report no significant association between social capital and health and well-being. For instance, Bassett and Moore (2013) found no significant association between network ties and depressive symptoms in Canada. Murayama et al. (2013) also found neither bonding nor bridging social capital to have significant effect with cognitive decline among aged population in Japan. Haseda et al. (2018) also reported that social capital failed to attenuate the effect of income on depressive symptoms among older adults in Japan. In a two-

wave study among aged people in Japan, Murayama et al. (2015) also reported no significant association between perceived neighbourhood cohesion and depressive mood at baseline. Community participation also significantly reduces mental health risk among tsunami-affected mothers in Sri Lanka (Wickrama & Wickrama, 2011).

Some studies have also reported counter evidence to show more deleterious effect of socio-political participation on health and well-being, largely in low-income groups and neighbourhoods. For instance, individuals in poor neighbourhoods who are more politically active are found to report poor self-rated health (Portinga, 2012). Also, higher community-level civic participation is found to be associated with high prevalence of depressive symptoms among older adults in low-income groups in Japan (Haseda et al., 2018). In urban poor communities in Ghana, social capital and community-level social cohesion also show unhealthy association with mental health by increasing depression and perceived powerlessness (Greif & Dodoo, 2015).

The effect of social capital on health and well-being is found to be moderated by different factors such as gender (Elgar et al., 2011; Iwase et al., 2012; Murayama et al., 2015), age (Elgar et al., 2011), length of stay/residency (Murayama et al., 2015), rural-urban divide (Chen & Meng, 2015) and whether social capital is assessed at the group or individual level (Lippman et al., 2018). For instance, the when it comes to gender, the benefit of social capital is greater for women than for men (Elgar et al., 2011; Iwase et al., 2012; Murayama et al., 2015). High bonding and bridging social capital are positively associated with poor self-rated health among men in Japan (Kishimoto et al., 2013); no association between social capital and subjective dementia symptoms among men in Japan (Murayama et al., 2018). In terms of age, the benefit of social capital is greater for older adults than for younger adults (Elgar et al., 2011). Also, in terms of length of stay, the effect of neighbourhood cohesion on reducing effect of stress on

depression stronger on long-term residents (Murayama et al., 2015). For rural-urban divide, Chen and Meng (2015) have reported that individuals living in communities with higher bonding social capital tended to report poorer adjusted self-rated health in urban areas while the opposite tendency held for rural areas.

Understanding the mechanisms would provide insight into when and why social capital becomes a protective factor or risk factor and when and how to intervene. However, there have been limited studies examining the intervening psychosocial processes or mechanisms that link social capital to health and well-being. The few available studies show that social capital affect well-being through maintenance of sense of coherence (Maass et al., 2016) and conservation of individual psychosocial resource (Wind & Kmoproe, 2012). For examples, Wind and Kmoproe (2012) argued that high community social capital provides platform for individuals to confide in their social context to address their collective demands, and by so doing, employ less individual psychosocial resources for coping. This conservation of psychosocial resource is argued to stabilized mental health (when disaster strikes) and sets individuals on the road to recovery and well-being.

2.6.2 Bridging social capital in community context

Bridging social capital within community context encompass relationships that exist between social groups in different communities with similar interests. Research that examine bridging social capital in community context usually come from critical psychologists working in deprived communities. For example, in a comparative study of the effect of community mobilization on HIV-related behaviours in two communities (i.e. Mpumalanga and North West) in South Africa, Lippman et al., (2018) found that group-level cohesion was protective in Mpumalanga (where social cohesion was higher) than North West (where social cohesion was

lower). This suggests that the protective effect individual level psychosocial capital might be dependent on some minimum level of community-level social capital. It is therefore important to assess how social capital emerge and shaped at the community level.

In a related study that evaluated community-based approach to addressing mental health after genocide in Rwanda, Mahr and Campbell (2016) reported how different community social groups defined roles for themselves in partnership with external agencies. For instance, churches in the community saw themselves as better provision of space for meetings that encouraged reconciliation and forgiveness, families were seen as spaces for instrumental support and inheritance of properties. Emotional support was seen to emanate from family members, neighbours, friends and orphans who were adopted after genocide. The community members saw the role of NGOs as offering counselling, and the role of government agencies as mainly providing access to structures to aid community groups carry out their activities smoothly. These self-other representations shaped which activities the community members were drawn to and how they actively participated in.

Bridging social capital emerges in communities through safe social spaces that create opportunities for critical dialogue and collective identity (Burgess & Campbell, 2014; Campbell et al., 2013; Gibbs et al., 2015; Mannell, Seyed-Reaisy, Burgess & Campbell, 2018; Mahr & Campbell, 2016; Nhamoa, Campbell & Gregson, 2010). Mahr and Campbell (2016) for instance show how community-based healing workshops that provided opportunities to speak publicly about traumatic e3xperiences enabled the development of emotional support and empathy in post-genocide communities in Rwanda, leading to the creation of bonding social capital through improved relationships among families and community members. Campbell et al. (2013) also shows how community conversations enabled rural community members in Zimbabwe develop

critical awareness of their potential capacities and strengths in responding to HIV/AIDS epidemic within their community. The community conversations also allowed them to uncover and challenge stigma that undermine HIV care and prevention within the community.

Gibbs et al., (2015) in three case study analysis showed how safe social spaces allow communities to engage in technical communication about community problems which increased community knowledge and awareness levels. Mannell et al., (2018) also provided evidence of how opportunities for dialogue allow unfamiliar knowledge to be shared and debated in fighting against intimate partner violence in poor communities in Rwanda. Cornish et al., (2014) in a systematic review of how community mobilisation impact on HIV prevention in LMICs, also observed that safe spaces for critical dialogue allows social groups to build strong collective identity to address their social circumstances that undermine their well-being. Other studies have also shown that safe social spaces within communities uncover and challenge all forms of taken-for-granted socio-cultural assumptions that create marginalization of young people by adults (Nhamoa et al., 2010) and women by men (Burgess & Campbell, 2014) undermine the development of social capital in communities.

2.6.3 Linking social capital in community context

This subsection presents discussion on partnerships between poor communities and external powerful social actors in addressing (mental) health challenges. The external partnerships can be developed with government agencies, national and international NGOs and research institutions such as national and foreign universities and researchers (Campbell, 2019; Gibbs et al., 2015; Mahr & Campbell, 2016; Nhamoa et al., 2010). Such supportive external links to powerful social actors builds linking social capital by providing access to symbolic resources such as power that

are needed to make socio-political and structural changes to circumstances that compromise well-being in poor communities.

Partnerships are increasingly recognized to play significant role in improving global mental health, based on the recognition that the challenge of mental health defies sector boundaries and therefore cannot be effectively addressed by any single sector alone (Corbin, Jones & Barry, 2016; Skovdal, Magutshwa-Zitha, Campbell, Nyamukapa & Gregson, 2017). Since mid-1990s, partnerships have become ubiquitous in interventions for improving local and global health (Aveling & Jovchelovitch, 2014). These partnerships often involve multiple independent social actors such as aid agencies, international donors, international NGOs (INGOs), universities, civil society organizations, local NGOs, government agencies, healers (biomedical professionals, faith healers, ethnomedical) and local communities (Cornish & Ghosh, 2007; Kirwan, Lambe & Carroll, 2013).

When external actors work sensitively with communities, the community members are able to participate meaningfully in interventions meant to improve their wellbeing. Campbell et al., (2013) have reported how consensual communicative strategies are instrumental when working with communities. In a study that explored how community conversations strengthen positive responses to health problems, Campbell et al., (2013) showed how engaging in and encouraging open and consensual communication with local communities facilitated local HIV competence among rural communities in Zimbabwe. Through encouraging community conversations by outside facilitators (foreign NGOs), the community members felt valued, motivated and inspired, were encouraged and challenged by involvement of outside facilitators to think of new ways about HIV issues that were locally seen as normal or unchangeable. With the consensual style of communication, the community members felt sense of honour at having opportunity to

participate in stakeholder groups, encouraging critical thinking, challenging normative worldviews, limiting behavioural repertoires and development of feasible actionable plans to address HIV problems in their communities.

External links are vital for sustainable and transformative change because poor communities do not have the power to generate the needed social capital from below without the support from about. In essence, building capacities of local communities with shout from below without opening the ears of powerful social actors to hear and listen to the voices of the marginalized does not lead to real transformational change. Gibbs et al., (2015) therefore argued that the assumption that local communities can generate social capital from the ground up is unreasonable, but rather they need the support of powerful social actors to enable social capital to emerge. At the same time, attention needs to be paid to working on the below with regards to the need for quality internal community relations among community social groups and organizations to heed the push from below. Quality interpersonal relations in communities create avenue for both emotional and instrumental support during adversity which further strengthen bonding social capital (Burgess & Campbell, 2014; Gibbs et al., 2015)

2.7 Synthesis of Literature Review

In synthesizing the empirical literature, there is a lack of studies that operationalize certain aspects of the mental health competence framework. For example, with respect to representations of mental illnesses in community context, the cognitive and emotional processes that inform the formation of Mental illness stigma in urban poor communities have been underexplored. This poses a challenge to operationalizing and assessing mental health knowledge in urban poor communities and how safe social spaces can be created to facilitate mental health dialogue in such communities. There is also limited understanding of how heterogenous social identities

shape mental illness experiences, and how it informs how interventions are planned to target at-risk groups within urban poor communities. Social capital in community contexts has also received limited attention in community mental health research. These gaps undermine deeper and critical understanding and tackling mental health challenges, especially in poor communities, where poverty remains major structural risk factor undermining efforts at addressing mental health problems. A critical approach is therefore needed in community mental health research in poor communities. The current study applies the social psychology of participation approach to address the gaps in community mental health research in urban poor communities, to facilitate developing mental health competence of such communities.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

The methodological processes and procedures undertaken in gathering and analysing data are discussed in this chapter. The chapter begins with a description of the communities where the study was conducted. This is followed by a discussion of the philosophical basis of the study. The research design and approach are discussed next, after which the qualitative component is discussed followed by the quantitative component. The inclusion and exclusion criteria are described and the ethical considerations of the study discussed.

3.2 Research Setting

The study was conducted in two indigenous urban communities (i.e. Jamestown and Usshertown), shown on Figure 5. The two communities were chosen for the study due to their socio-historical significance and the high physical and mental health burden, which make them good context for community mental health research. They are located along the Atlantic Coast, historically at the heart of Ghana's Capital City of Accra, on latitude 5°32'28.32" and longitude -0°12'33.12", covering about 100 hectares of land along the southwest coast of Accra (Mahama et al., 2011; Razzu, 2005). The communities, often regarded as twin communities and referred to as Ga-Mashie (Nortey, 2012).

Ga-Mashie is often referred to as the 'Old Accra' because it is regarded as the oldest communities in Accra due to the fact that, that is where the original Ga-Adangbe ethnic group were believed to have settled (Boakye & Beland, 2018; Nortey, 2012). The Ga-Adangbe consist of seven quarters (Nortey, 2012). The Usshertown community is made up of four quarters (i.e.

Abola, Gbese, Asere and Otublohum) and James Town is made up of three (i.e. Akanmaadzen, Sempe and Ngleshie) (Patterson, 1979). The major local language spoken in both communities is Ga language. There are other ethnic groups in the communities such as the Akans who speak Twi, the Ewes who speak Ewe, the Mole-Dagbani who speak Hausa and the Guans who speak Guan. The major source of livelihood in the communities is fishing for the men and fish mongering for the women. However, other economic activities (e.g. petty trading, food vending, hair dressing, carpentry, butchery, electrician) are also very popular in the communities, gradually becoming dominant source of livelihoods (Wrigley-Asante & Mensah, 2017).

Ga-Mashie is situated in the central business district of Accra. However, the communities lack adequate public infrastructures and social amenities such as playgrounds, parks and gardens (de-Graft Aikins et al., 2020). There are also few schools, poor water and power supply and sanitation is a major health concern in both communities. There is poor management of solid and liquid waste; and the systems do not function as the few existing drains are always chronically choked with plastic and other solid waste (Atiglo et al., 2018; Patterson, 1979; Silver et al., 2017). The communities offer good context of exploring realities and opportunities for mental health competence in poor communities in the Ghanaian context.

3.3 Research Paradigm

The current thesis was underpinned by critical social science paradigm, a constituent of interpenetrating body of work which is shaped by critical theory of the Frankfurt School (Watts & Hodgson, 2019), recent developments in the sociological study and analysis of science (Adams, Hollenberg, Lui & Broom, 2009) and global public health (Mykhalovskiy et al.,2018). Critical theory, fundamentally problematizes social structures and power relations as determinants of health and well-being (Watts & Hodgson, 2019). In a related but different path,

recent sociological studies of science and professions have sought to examine (medical) scientific inquiry as a social activity, by situating the practice of science within a wider sociohistorical and structural context to unearth intersections, segmentations and rivalries within the scientific community (Adams et al., 2009). Similar approach has been applied to examine the social, historical and political context of global health to problematize poverty and power relations as strong determinants of health (Broom & Adams, 2016; Mykhalovskiy et al.,2018).

Critical social science places emphases on contextualizing health within the macro-structural and historical context, in order to understand the social and political parameters that shape health and well-being (Adams et al., 2009; Watts & Hodgson, 2019). Drawing on critical social science enabled the researcher to delve deeper into the complex structural and community-level factors that shape mental health at the individual level in the communities. More specifically, the study drew on critical social psychology approach to inform practical and transformative social change interventions for mental health development in the communities (Day, Rickett & Woolhouse, 2017; Gough, 2017; Howarth et al. 2013; Martinussen, 2019; Nelson & Evans, 2014).

3.4 Research Approach and Design

Within critical psychology subfields - social, community, health - there has been methodological debate regarding the best methods (qualities, quantitative, mixed, cross-sectional or longitudinal) for researching and transforming realities of poor communities (Gough, 2017). Most critical psychology studies in communities have privileged qualitative methods because of its ability to delve deeper into the heterogeneities of knowledge and identities in communities (Martinussen, 2019). However, recent developments in critical psychology subfields have embraced combining methodological approaches to unearth all depth and breadth of marginalization in communities

and embark on a social justice approach to wellbeing in community context (Martinussen, 2019; Nelson &Evans, 2014).

In the current study, mixed-method approach was chosen to allow for examining depth and breadth of mental health realities in the communities. Specifically, the concurrent triangulation mixed-method design was used adopted. The concurrent triangulation design allows for both qualitative and quantitative to me gathered and analysed simultaneously, and then results compared or combined (Creswell & Clark, 2017; Saunders & Townsend, 2018; Tashakkori & Teddlie, 2011). This design allowed the researcher to draw intersections, convergence and divergence from both the qualitative and quantitative data, in order to get holistic insights into the social realities of mental health in the communities. The qualitative data was gathered using combination of key informant interviews, focus group discussions, observation and situated conversations. The quantitative data was gathered using survey. The detailed processes, procedures and tools involved in the data gathering are described in section 3.6.

3.5 Selection of Participants

In this section, the population of the study and the processes in selecting the participants of the study are discussed. Subsections discussed here are population, number of participants and sampling techniques.

3.5.1 Population of the study

The target population of the study encompassed all members of the two communities. The last census in 2010 by the Ghana Statistical Service (GSS, 2012) indicates that the total number of populations in these two communities was 43,845; with the population of Usshertown (= 27,624) being higher than that of James Town (= 16,221). The population comprises the indigenous Ga-

Adangme who make up the majority (estimated 64 – 70%), and other ethnic groups such as the Akan, Ewe, Mole-Dagbani and the Guan, who make up between 25 – 30% (de-Graft Aikins et al., 2020; Grief & Dodoo, 2015; Kushitor et al., 2018)

3.5.2 Study Participants

This section presents the study participants. The socio-demographic characteristics of the survey respondents are presented first. After that, the socio-demographic profiles of the participants for the qualitative component are presented.

3.5.2.1 Survey respondents

For the survey, a sample size of 384 respondents (Jamestown = 144, Usshertown = 240) was used. This sample size was determined using power analysis; $\alpha = .01$, Power = .80, effect size = medium (Cohen, 1992). The sociodemographic information of the respondents are provided on Table 3.1.

In the sample, there were more females (55.7%) than males (44.3%). Their ages ranged between 18 – 85 years, with a mean age of 34.38 years (SD = 14.37 years). The communities are predominantly indigenous Ga-Adangme, but there are other ethnic representations, which reflected in majority of respondents being Ga (64.8%), a quarter of them being Akan (25.9%), and others such as Ewe, Guan and Mole-Dagbani. A majority of them indicated being Christians (89.1%), and more than half of them indicated being unemployed (42.1%). Educational levels were low, with majority of them attaining up to basic school.

Table 3. 1: Sociodemographic profiles of survey respondents

Demographics	Categories	f (%) /M (SD)
Community	Jamestown	148 (35.5)
	Usshertown	236 (61.5)
Gender	Male	170 (44.3)
	Female	214 (55.7)
Educational level	No education	31 (8.1)
	Primary	102 (26.6)
	Middle/JHS	114 (29.7)
	Secondary/SHS	115 (29.9)
	Tertiary	22 (5.7)
Ethnicity	Ga-Adangme	249 (64.8)
	Akan	99 (25.8)
	Ewe	19 (4.9)
	Mole-Dagbani	14 (3.6)
	Guan	3 (0.8)
Marital status	Single	181 (47.1)
	Married	87 (22.7)
	Co-habiting	98 (25.5)
	Divorced	6 (1.6)
	Widowed	12 (3.1)
Religion	Christian	342 (89.1)
	Traditional religion	32 (8.3)
	Muslim	10 (2.6)
Employment status	Unemployed	200 (52.1)
	Employed	184 (47.9)
Age		34.38 (14.37)

Source: Fieldwork (2018 – 2019)

3.5.2.2 Qualitative participants

A total of seventy-seven (77) participants were involved in the qualitative study. The sociodemographic profiles of the participants are provided on Table 3.2.

Table 3. 2: Sociodemographic profile of qualitative participants (= 77)

Characteristics	Categories	f (%)
Community	Jamestown	44 (57.1)
	Usshertown	33 (42.9)
Gender	Male	30 (39.0)
	Female	47 (61.0)
Ethnicity	Ga-Adangme	60 (77.9)
	Akan	12 (15.6)
	Ewe	5 (6.5)
Age	20 – 29 years	9 (11.7)
	30 – 39 years	26 (37.8)
	40 – 49 years	11 (14.3)
	50 – 59 years	17 (22.1)
	60+ years	14 (18.2)
Key informants	Lay community members	33 (42.9)
	Self-help group members	27 (35.1)
	Biomedical mental health practitioners	4 (5.2)
	Traditional and faith-based practitioners	4 (5.2)
	Caregivers	4 (5.2)
	Patients with history of mental	3 (3.9)
	Local community leaders	2 (2.6)
Educational level	No education	35 (45.5)
	Basic/Middle School	30 (39.0)
	Secondary/SHS	5 (6.5)
	Tertiary	7 (9.1)

Source: Fieldwork (2018 – 2019)

As shown in Table 3.2, slightly more than half were females (61%), majority were Ga-Adangme (77.9%), and educational levels were low. The identities of the participants included; lay community members, JTHC members, biomedical mental health practitioners, traditional and faith-based practitioners, caregivers of people living with mental illnesses, patients with history of mental illness, and local community leaders. The detailed information of each of the participants are provided in Appendix IV.

The participants were purposively selected with segmentations based on interviewing key informants, engaging lay community members in focus group discussions, engaging members of the JHTC, and conversations with random members of the communities in situated conversations. Engagement with these segments of the communities was guided by meaning saturation in the data gathering process.

3.5.3 Selection Criteria

The survey respondents were selected using multi-staged sampling techniques. The communities are demarcated into enumeration areas by Ghana Statistical Services for census purposes. The first stage therefore involved randomly selecting enumeration areas within the communities. Within each of the selected enumeration areas, housing structures were conveniently selected, and respondents within each house were conveniently selected for the survey.

The qualitative participants were selected using combination of different selection approaches. The lay community members used for the FGDs were conveniently selected, based on their availability and willingness to be part of group discussions at schedule date and venue. The participants for the situated conversations were conversations held with random members of the

communities. The key informants were purposively selected, based on the practical and theoretical relevance of their identities to mental health within the communities.

The inclusion criteria were individuals above the age of 18 years, who are residents within the selected communities and who are not in any apparent distress (both physical and mental) to hold discussions. For these criteria, individuals below the age of 18 years, non-residents within the communities and residents who are not fit to hold discussions were excluded from the study.

3.6 Data collection procedures and tools

Ethical approval was first sought for the study (Appendix A). A pilot was first conducted before the main data collection began. The detailed processes and tools involved in the data gathering are described below.

3.6.1 Qualitative data gathering procedures and tools

Data for the qualitative component was gathered combining individual interviews, focus group discussions, and situated conversations. For the individual interviews and the focus group discussions, semi-structured interview guides were developed (Appendix D), informed by social psychology of participation model and the community mental health competency model. The guides covered different elements of the social contexts; (i) knowledge of mental illness, (ii) common mental health problems in the community, (iii) representations of mental illness, (iv) social group memberships, (v) responses to mental disorders within the communities, and (vi) social actors whose work bothers on mental health within the communities. Some of the issues were drawn on for the situated conversations. Sample questions in the semi-structured interview guide posed to interviewees are provided in Table 3.3.

Table 3. 3: Sample questions in semi-structure interview guide

Sample questions for key informants
i. What can you say about mental health within this community? (Probe into how serious it is within the community)
ii. What are the common mental health problems you have observed in this community? (Probe into severe, mild mental health problems or behaviours)
iii. What do you think exposes individuals to the likelihood of developing mental health problems? (Probe general and community-specific risk factors)
iv. In your opinion, who do you think is responsible for mental health promotion in this community? ***Prompts***: role of government, local community leaders, identified social groups, family/household and individuals
v. What groups/institutions/organizations are involved in mental health promotion in this community? Generate list and probe into who these groups are and what they do within the community
vi. How would you describe this community's ability to access external help in efforts to promote mental health?

Individual interviews with key informants

The individual interviews were conducted among key informants in the communities whose position and identity make them able to see the social conditions of the community, and therefore can speak on mental health issues at the community level. Some of the individuals interviewed were; local community leaders, biomedical practitioners in the community (e.g. community mental health nurses and over the counter medicine sellers), faith-based healers (e.g. traditional priestess and prophets), herbal and traditional medicine practitioners and leaders of social groups.

Focus Group Discussions

The focus group discussions were held with both lay community members and other identified social groups. The discussions with the lay community members meant to explore the members'

perspectives of the mental health issues within the communities. The discussions with the identified social groups explored mental health issues as related to the members of their groups and others with similar identities within the communities. The groups included in these separate discussions were members of JTHC, male-only groups and female-only groups in each of the communities. The discussions with these groups were held separately for each of the groups.

Situated Conversations

The situated conversations were opportunistic conversations held with some of the community members during the period of fieldwork. A number of these conversations were conducted during the transact walk data gathering process. Others were conducted during field visits for other activities related to ongoing community health development research within the communities. These conversations were usually impromptu, informal and unstructured short conversations that was held, as and when the opportunity presented itself, sometimes with one person, and other times with groups of two or three members of the community. A total of 10 community members were engaged this way, comprising five males and five females, six in Usshertown and four in Jamestown, with ages between 25 – 39 years.

3.6.2 Quantitative data: Survey

The survey data was gathered by administering questionnaire to a cross-section of the community members. The administration of the questionnaire took the form of both self-administered (for community members who could read and write) and researcher-administered (for community members who could not read and write). The survey data gathered information regarding mental disorders symptoms, social identification, community social capital and willingness to participate in mental health promotion within the communities.

Mental illness symptoms: was measured with the WHO's Self-Reported Questionnaire 20 (SRQ-20; 1994) which has been validated in Ghana (Weobong et al. 2009). The WHO's SRQ-20 was used to screen for common mental disorders symptoms. The SRQ-20 was chosen because it has relatively high proportion of somatic items and so it has been found to work well within the Ghanaian context (Weobong et al. 2009; Dzokoto, Opare-Henaku & Kpobi, 2013). Depressive and anxiety symptoms were estimated from the participants responses. The SRQ-20 has high reliability cohering around $\alpha = .79 - .88$ (Weobong et al. 2009). In the current study, $\alpha = .83$ for depressive symptoms, and $\alpha = .82$ for anxiety symptoms (Table 3.4). Scored for both depressive and anxiety symptoms ranged between 0 – 12, and classified as normal symptoms (0 – 3), mild symptoms (4 – 5), moderate suymptoms (6 – 8) and severe symptoms (9+).

Social identification: measured with Social Identity Mapping (SIM) Questionnaire (Cruwys et al. 2016). The original SIM was developed to provide visual representation for assessing individuals subjective networks of social group memberships. The SIM requires participants to list the social groups they belong to on sorted cards, and then answer series of questions on their identifications with each of the groups on a scale of 1 - 10, in a nominal group technique style (Cruwys et al. 2016). From the visual representations, different elements of social identification such as number of group memberships, frequency of contacts, satisfaction with groups, group homogeneity and others can be estimated. By its nature and procedure, the SIM is well suited for small groups of individuals, who can read and write. In a survey involving a large sample size, in communities with low literacy levels, the nominal group technique was impractical. In the current study therefore, the SIM was adapted in a questionnaire form (SIM-Q), where individuals were required to list the social groups they belonged to and then rated the groups. From the responses, eight elements of social identification were estimated; number of social group

membership, frequency of contact, perceived group stigma, self-stereotyping, ingroup homogeneity, identity centrality, satisfaction with group and perceived ingroup solidarity.

Bonding social capital: this was adapted from the Community Mobilisation Measure (CMM), developed by Lippman et al. (2016) to measure social psychological features that help to mobilize members of a community for health promotion. The features measured are; social cohesion (5 items which measured connectedness in the community), shared concern (5 items which measured how concerned that community members are about mental health problem), leadership trust (5 items which measured how well members trust their local community leaders to help them address their mental problem), critical consciousness (5 items which measured awareness and understanding of the realities of their mental health problem) and interpersonal trust (5 items which measured how well community members trust themselves). The reliability levels in the original scale ranged between $\alpha = .81$ - .93. In the current study, $\alpha = .84$ for social cohesion, $\alpha = .82$ for interpersonal trust, $\alpha = .93$ for shared concern, $\alpha = .94$ for critical consciousness, and $\alpha = .94$ local leadership trust.

Participation in mental health promotion: assessed the extent to which members of the community are willing to participate in interventions to promote mental health in the community. It was measured by adapting Community and Socio-Political Participation Scale (CSPP) developed by Moreno-Jimez, Rodriguez and Martin (2013). The instrument is a 10-item scale that assesses community participation (CP = 5 items) and socio-political participation (SPP = 5 items). The SCAP is highly reliable, $\alpha = .815$ for the CP sub-scale and $\alpha = .81$ for the SPP sub-scale. The community participation was adapted to measure participation in mental health promotion. In the current study, $\alpha = .75$ for mental health participation.

3.7 Ethical consideration

Ethical clearance for the study was obtained from the Ethics Committee for Humanities of the University of Ghana (Appendix A). Informed consent was sought from all individuals who were approached for the study. During the consent seeking process, the aims of the study and their rights, risks and benefits were all explained to them. Consent for the study were obtained both orally and in writing. Those who agreed to take part in the study were given informed consent form to sign/thumbprint. Privacy and confidentiality were assured throughout the process of the study to protect identity of the participants. There are plans underway to feed the findings of the study back to the communities.

3.8 Data Analysis

3.8.1 Qualitative data analysis

The interviews from the key informant interviews, focus group discussions, and situated conversations were audio recorded and transcribed verbatim. The qualitative data was analysed with the help of Atlas Ti. Before and during the analytical procedure, quality checks of the transcripts and trustworthiness of the data was analysed. After that, three analytical techniques were used – theory-driven thematic analysis, social representation analysis, and stakeholder analysis.

Quality checks of the transcripts

The first stage involved doing comprehensive quality check on all the transcripts. The process involved reading the transcripts to familiarize myself with the transcripts, and among other things, make summary notes and also not any discrepancies and/or absences within the context of the interview guide. Some minor methodological absences were identified, mainly in the form

of some interviews failing to capture detailed demographic information of three of the participants in focus group interviews in Usshertown. Also, two of the key informant interviews, particularly with the traditional and faith-based practitioners did not strictly follow the questions in the interview guide in chronological order, but all key issues in the guide were addressed. These discrepancies were noted and to inform the coding of the transcripts.

Trustworthiness of the qualitative data

There are different approaches and strategies that are employed to ensure trustworthiness in the analysis and presentations of the qualitative data (Gervais, Morant & Penn, 1999; Lincoln & Guba, 1986). In the current study, I chose the typology of absences framework by Gervais et al., (1999) in strengthening the trustworthiness of the data, analysis and interpretations. Gervais et al., (1999) identified three kinds of absences in social representations research in particular, which in principle apply all social enquiries in general. These are theoretical absences, methodological absences, and analytical and interpretive absences (Gervais et al., 1999). They delineate the scope and nature of these absences, as well as suggestions for avoiding them to strengthen the trustworthiness, reliability and credibility of a qualitative research.

Gervais et al., (1999) conceptualized theoretical absence as either inadequate theory, partial conceptualizations and inevitable outcomes. These were guarded against by ensuring that the theoretical framework chosen for the study was adequate in explaining the social contexts in community context. The social psychology of participation model (Campbell & Jovchelovitch, 2000) and the community mental health competence model (Campbell & Burgess, 2012) chosen for the study are the two current models both for research and practice of communities in participation and community mental health competence. Integrating both models provided a

framework that adequately conceptualized social context of the communities in symbolic, material and relational terms.

Methodological absence is conceptualized as insufficiently sensitive methods, inadequate sampling, unskilled interviewers, limited time frame and/or low response rate (Gervais et al., 1999). These were guarded against by ensuring that appropriate methodological processes and procedures were used. The plurality of methods (i.e. key informant interviews, focus group discussions, situated conversations) combined in gathering the qualitative data ensured sufficient data gathering on the complexities of the social contexts within the communities. Adequate participants across different groups were sampled, and the response rates were high, particularly with the survey respondents and interview participants. The interviews were conducted by the researcher, with assistance from two social psychology PhD students (who are all highly skilled interviewers), and two research assistants (who were well trained in interviewing skills and questionnaire administration).

Analytical absence is conceptualized as interpretive inadequacy, which manifests in ignoring, taken-for-granted and subjugation of perspectives and experiences (Gervais et al., 1999). Analytical absence was guarded against by eliminating subjectivities and lone researcher biases (Braun, Clarke, Hayfield & Terry, 2019; Lawless & Chen 2019). The coding of the transcripts was done with two other independent analysts who are all highly skilled in thematic analysis (Braun et al., 2019). After the quality checking, the transcripts were sent to the two independent analysts (both PhD students; one with in-depth knowledge of the communities and the other with no knowledge of the communities) to code both deductively and inductively, and then compared with the researcher's own coding. Inter-rater reliability for the deductive codes was near universal, and that for the inductive codes was also high (Lawless & Chen 2019). The

perspectives of the independent analysts were also sought after deriving the basic and organizing themes.

The final process in guarding against analytical absences involved presenting the quotes and themes to my supervisors at different stages of the analysis. My supervisory committee then audited and reviewed the codes and themes to ensure they reflect the realities of the communities. These processes reduced subjective lone researcher biases that are mostly inherent in thematic analysis (Braun et al., 2019; Lawless et al., 2019).

Theory-driven thematic analysis

The individual interviews, focus group discussions and the situated conversations were integrated, and a theory-driven thematic analysis was conducted, following the steps outlined by Attride-Stirling (2001). However, in answering some of the specific research questions, further analytical techniques such as social representation analysis and social group analysis were conducted on the initial general thematic analysis.

The first stage of the thematic analysis, which involved reading the transcripts to familiarize myself with the transcripts was achieved, during the stage of checking the quality of the transcripts. The first stage ended with the development of a coding framework to guide the coding of the transcripts.

The second stage of the analysis involved coding all the transcripts using the coding framework as a guide. Coding was done both deductively and inductively. The deductive codes derived from the key elements of the models that informed the theoretical framework (Campbell & Burgess, 2012; Campbell & Jovechelovitch, 2000), and insights from existing Ghanaian and global mental health literature (Campbell & Burgess, 2012; de-Graft Aikins, 2015; Mathias et al., 2018). The

inductive codes were derived from context-specific issues within the social contexts of the communities studied. The coding process made the coding framework iterative, with new inductive codes from the transcripts being added to the framework as the coding progressed.

The next stage involved developing the codes into themes. Attride-Stirling (2001) identified three kinds of themes in thematic analysis, to guide the construction of thematic network; basic themes, organizing themes, and global themes. She defined basic theme as the lowest-order theme derived from textual data (Attride-Stirling, 2001). In the current study, basic themes were derived by drawing basic similarities and linkages between the (deductive and inductive) codes generated. Therefore, all the codes were refined into basic themes. At this points, associations and similarities were drawn between the codes to guide their groupings into basic themes. For instance, on the knowledge of mental illnesses, codes such as *worry, excessive thing, thinking too much and frustrations* were grouped together into one basic theme called 'psychological struggles'.

From the basic themes, the next stage involved deriving organizing themes. Attride-Stirling (2001) defined organizing themes as "the middle-order theme that organizes basic themes into cluster of similar issues" (p.389). In the current study, the basic themes were defined as groups of basic themes that provide mid-level insight into the study objectives. For instance, basic themes (such as single parenting, childlessness, divorce, impotence, being unmarried at certain age) that spoke to causes of mental disorders were grouped under objective 2 of the study were grouped together to form an organizing theme called *psychosocial pressures.* Also, basic themes (such as frustration, sleeplessness, excessive thinking, worry and hopelessness) that spoke to knowledge of mental health problems were grouped together to form an organizing theme called *psychological struggles.*

Social representations analysis

Social representations analysis was also drawn on to subject the codes and themes to further analysis. At this level, the focus was on analysing the content of knowledge, sources of knowledge and functions of knowledge. The content of knowledge focused on what the participants knew about mental disorders (broadly as a concept) and specific conditions they considered serious. Communities are heterogenous, with multiplicities of identities which comes with competing and often opposing opinions, worldviews and interests (Campbell & Jovchelovitch, 2000; Campbell & Murray, 2004; Howarth, 2001; Howarth et al., 2013; Stephens, 2007).

Therefore, in analysing the content of knowledge, attention was paid, not only to consensus and agreements, but also to dissenting and conflicting views and opinions or disagreement. This ensured that the complexities of the social contexts of the communities were adequately captured and revealed in the analysis process. Specifically, the content of knowledge was subjected to consensus – conflict – absence (C-C-A) approach by de-Graft Aikins (2005).

Consensus was judged to have been reached on a theme if and when all the participants spoke to and agreed on a particular mental health problem. For consensual themes, sample quotes that capture the shared meaning are presented to reflect the consensus. A theme was judged to be conflictual when the theme was characterized by conflicts, dissents or disagreements concerning some mental health problems within the communities. For conflictual themes, a range of quotes that are presented to capture the conflict or variations in views. Absence is used for community-based mental health problems that are predominantly reported in literature (including previous studies in Ga Mashie) but did not reflect the situation in Jamestown and Usshertown.

Sources of knowledge was also analysed to focus on the stocks of knowledge where participants drew their ideas from, using cognitive polyphasia as an analytical tool. An interpretive representational framework was developed by adapting a stock of knowledge framework by de-Graft Aikins, Dzokoto and Yevak (2015) to organize the themes into sources of knowledge that participants drew on for their representations of mental illnesses. de-Graft Aikins et al (2015) identified three stocks of knowledge which were drawn on in making sense of socio-psychological epidemics. The stock of knowledge framework has been used to study lay knowledge of type 2 diabetes in rural and urban Ghana and Ghanaian migrants in Europe (de-Graft Aikins et al., 2019). Cultural stock of knowledge constitutes core representations which are stable and rooted in cultural heritage, which common sense and scientific stocks of knowledge constitutes peripheral representations which are shaped by access to credible information (de-Graft Aikins, 2019). Box 1 shows the characteristics of the 3 stocks of knowledge.

Box 1: Three stocks of Knowledge

Cultural knowledge: cultural stock of knowledge is characterised by deep seated core cultural beliefs that organizes individuals' life around misfortunes and crisis. This stock of knowledge operates at the level of the collective.

Common-sense knowledge: this stock of knowledge is characterized by social observations and every day knowledge of inter-group relations in the public sphere, including the micro and macro politics of social life. This stock of knowledge operates at the level of inter-group relations.

Scientific knowledge: encompasses ideas derived from scientific fields such as medicine, psychiatry, and psychology in making sense of mental disorders. This stock of knowledge operates at the level of the individual.

Stakeholder analysis: partnerships and alliances

As part of answering the objective 4, on existing and potential partnerships and alliances, a stakeholder analysis was conducted. Data for the stakeholder analysis cam from three sources; i) the qualitative data set on group memberships, as well as narratives that speak to help of any kind within and outside the community; ii) the quantitative data where respondents were asked to list membership groups; and iii) the literature review on mental healthcare and policy in Ghana which provided names of institutions, research groups working on mental health.

3.8.2 Quantitative data analysis

All statistical analyses of the survey data were performed using IBM's Statistical Package for Social Sciences (SPSS) version 23, and AMOS 21. Preliminary analyses were first conducted in establishing necessary conditions for multivariate analysis. The preliminary analyses included missing data, normality and outliers, multicollinearity (including singularity), linearity and homoscedasticity.

Analysis and treatment of missing data

Missing data was analysed by focusing on amount and pattern using SPSS Missing Value Analysis (MVA). Amount of missing data analysis indicate how much of the data is missing, while pattern analysis indicates the nature of the missing data (Tabachnick & Fidell, 2019). As shown on Table 3.4, the amount of missing data ranged between 1% and 4.2% across all the variables.

The missing observations were deemed to be missing completely at random (MCAR) since no major systematic order was identified in relation to specific variables (Tabachnick & Fidell,

2019). Missing values were therefore calculated for participants with missing observations for all variables using the expectation maximization (EM) method. It is worth mentioning that in cases where missing data is less than 5% in a large dataset, any method of procedure or method of handling missing observations yields the same results because the problem is less serious (Tabachnick & Fidell, 2019). Nonetheless, the EM method is recommended over the other common methods of dealing with missing data (when data is considered to be MCAR) such as pairwise and listwise deletion, and mean substitution (Tabachnick & Fidell, 2019). With the EM method, all the missing observations were substituted through the iterative process.

Table 3. 4: Amount of missing data on the variables in the study

Variables	No. of items	N	% Missing
Mental illness symptoms			
Depressive symptoms	12	384	-
Anxiety symptoms	10	384	
Community social capital			
Community social cohesion	6	373	2.9
Interpersonal trust	3	378	1.6
Shared community concern	10	372	3.1
Critical consciousness	9	371	3.4
Trust in community leadership	9	370	3.6
Participation in mental health promotion	6	380	1.0
Social identification			
Number of group membership	1	368	4.2
Perceived group stigma	1	368	4.2
Self-stereotyping	1	368	4.2
Ingroup homogeneity	1	370	3.6
Identity centrality	1	368	4.2
Satisfaction with group	1	368	4.2
Solidarity	1	368	4.2

Normality, homoscedasticity, linearity and multicollinearity

Normality test examines the extent to which residuals of regression (i.e. error terms or difference between observed and predicted values of dependent variables) follow normal distribution (Tabachnick & Fidell, 2019). It was tested using the Probability Predicted (P-P) plot, to confirm the diagonal normality line. Homoscedasticity tests the extent to which the residuals are equally distributed or cluster together. Linearity tests the extent to which predictor variables have a straigt-line relationship with criterion variable so that they fit a linear regression line. When residuals are normally distributed and homoscedastic, linearity assumption is achieved or not violated (Tabachnick & Fidell, 2019). Multicollinearity tests the extent of relationships or correlations that exist between predictor variables, for models that have multiple predictors (Tabachnick & Fidell, 2019). The multicollinearity assumption was tested using correlation coefficient and variance inflation factor (VIF) and tolerance values. Multicollinearity assumption is not violated if correlation coefficients are < .70, VIF values are < 10 and tolerance values lie 0 and 1 (Tabachnick & Fidell, 2019).

All the P-P plots showed diagonal normality line (Appendix F) indicating linearity assumption met. The scatter plots also showed that the regression standardized residuals for the dependent variables were evenly distributed (Appendix F), suggesting homoscedasticity assumption met. The VIF values ranged between 1.113 – 3.220, the tolerance values ranged between .311 and .898, and correlation coefficients ranged between -.19 to .68, suggesting that multicollinearity assumption was met.

Descriptive statistics, data distribution and reliability

The descriptive statistics, including test of normality and reliability of the variables on Table 3.5. Skewness and kurtosis values were used to assess normality of the data and presence of

univariate outliers. Cronbach alpha (α) values were computed for reliability. For the normality and test of outliers, skewness values range between +1.00 and -1.00, while the kurtosis values range between +2.00 and -2.00 (Tabachnick & Fidell, 2019). For reliability, α should be ≥ 0.7.

Table 3. 5: Descriptive statistics, distribution and reliability

Variables	M	SD	Skewness	Kurtosis	α
Mental illness symptoms					
Depressive symptoms	4.77	3.80	.32	-1.38	.83
Anxiety symptoms	3.67	2.72	.51	-.63	.82
Community social capital					
Community social cohesion	14.91	5.19	.39	-.96	.84
Interpersonal trust	8.63	3.01	-.19	-.88	.82
Shared community concern	22.32	5.81	.78	1.89	.93
Critical consciousness	23.71	8.99	.11	-1.31	.94
Trust in community leadership	21.48	9.13	.44	-1.03	.94
Participation in mental health promotion	8.59	8.79	.79	-.59	.75
Social identification					
Number of group membership	1.52	1.14	.88	.38	-
Perceived group stigma	4.37	2.05	1.32	1.34	-
Self-stereotyping	7.54	2.44	-.66	-.78	-
Ingroup homogeneity	5.37	2.32	.09	-.53	-
Identity centrality	5.16	3.02	.27	-1.43	-
Satisfaction with group	6.16	3.15	-.25	-1.43	-
Solidarity	6.66	2.63	-.54	-.85	-

As shown on Table 3.5, all the variables were found to be reliable, with reliability levels ranging from α = .73 and .93. The data was also found to be normally distributed; skewness values ranged between -.54 and 1.32, and kurtosis values ranged between -1.38 and 1.54.

Estimation of prevalence of mental illness symptoms

In objective 1, as part of examining the prevalent of mental health problems in the communities, prevalence of depressive and anxiety symptoms was examined among the survey respondents. The data was drawn from the depressive symptoms and anxiety symptoms. As per the WHO's SRQ, scores on depressive symptoms were categorized as; normal (0 -3), mild (4 – 5), moderate (6 – 8) and severe (9+). Similarly, scores for anxiety symptoms were categorized as; normal (0 - 3), mild (4 – 5), moderate (6 – 7) and severe (8+).

Hierarchical multiple regression analysis

As part of assessing social groups and mental health within the communities (in objective 3), effects of social identification on depressive and symptoms were examined. Depressive and anxiety symptoms were each regressed on the dimensions of social identities. Two series of hierarchical multiple regressions were run to estimate how the dimensions of social identities are associated with depressive and mental disorders symptoms, after controlling for age, gender, ethnicity and educational level. Gender (female = 1, male = 0), ethnicity (1 = minority ethnic group, 0 = indigenous Ga) and educational level (tertiary = 1, other = 0) were first dummy coded. Age was measured as a continuous variable.

A zero-order correlation was run among the variables. After the correlation, two regression models were estimated, each explaining how social identities predict depressive symptoms

(Model 1) and anxiety symptoms (Model 2) respectively. For each of the models, the demographic factors were entered into the model at step 1, and then the dimensions of social identities entered at step 2.

Structural equation modelling (SEM)

As part of assessing bonding social capital in objective 4, a structural model was estimated to test how these social psychological features at community level (social cohesion, shared concern, leadership trust) interpersonal level (such as interpersonal trust) and individual level (such as critical consciousness) impacted on participation in mental health promotion. Structural Equation Modelling (SEM) was used for the analysis.

It was hypothesized that the three community level predictors (i.e. community social cohesion, shared community concern and community leadership trust) will be related to community mental health participation, and the association will be mediated by interpersonal trust and critical consciousness. The SEM was conducted to test; i) the confirmatory factor analysis for each of the latent factors, ii) the structural model, and iii) the hypothesized model.

A CFA was first conducted to assess the six-factor measurement model for the underlying constructs in the study (i.e. community social cohesion, shared community concerning, community leadership trust, interpersonal trust, critical consciousness and community mental health participation). After that, the hypothesized model was compared with other competing models However, the sample size was relatively small, (compared with the number of measurement items) for mediation model. So, item parcelling was used to create the observed variables for the purposes of enhancing the adequacy of item-to-parameter ratio (Bandalos, 2002; Wu & Wen, 2011).

Next, step 2 involved estimating the proposed structural model, and comparing it with alternative theoretically plausible models nested in the data, in order to determine the best fitting model for testing the hypotheses in the study. Model fit indices used in assessing the models were; root mean square error of approximation (RMSEA), comparative fit index (CFI), Tucker-Lewis index (TLI) and standardized root mean square residual (SRMR). Chi square difference test was then used to determine the best fitting model (Shi et al., 2019).

The mediation effects were then analysed. A 5000 bootstrap samples were created to assess the confidence intervals (CI) for the indirect effects (Shrout & Bolger, 2002). An indirect effect is deemed to be significant when its associated intervals do not include zero. However, in AMOS, indirect effects for multiple mediators are not reported. Therefore, the specific mediating effects of interpersonal trusts and critical consciousness were probed using Sobel's test (Sobel, 1982).

3.9 Summary of methodology

In this chapter, the research approach (i.e. mixed-method) and design (i.e. concurrent transformative QUAL + QUAN) have been discussed. The processes undertaken in analysing the data, and strategies for ensuring trustworthiness of the qualitative data and reliability of the quantitative data have been discussed. In the proceeding chapters, the findings are presented, based on the objectives of the study and discussed. Each chapter addresses one objective, and then a final chapter provided to synthesis and discuss findings from the study as a whole.

CHAPTER FOUR

PREVALENT MENTAL HEALTH PROBLEMS IN THE COMMUNITIES

4.1 Introduction

The first objective of the study explored prevalent mental health problems in the communities. The research question asked was - what is the prevalence of mental health disorders, what mental health problems do community members list as prevalent? Both the survey data and the qualitative data were drawn on to answer this question. The survey data was used to estimate the prevalence of depressive and anxiety symptoms in the communities. The qualitative data was drawn to find out whether indeed, depression and anxiety are major mental health problems in the communities, and also to explore the full range of mental health problems that are common in the communities. Drawing on both the survey and qualitative data this way helped to unearth intersections and interconnections that the community members make in exploring prevalent mental health problems in the communities.

4.2 Prevalence of depressive and anxiety symptoms

Depressive and anxiety symptoms were measured using the WHO's well-being scale. Scores are classified into normal, mild, moderate and severe symptoms. The prevalence levels are represented on Figure 4.1. Overall, the findings showed a total prevalence of 11.5% severe depressive to 28.1% moderate symptoms. More men (19%) than women (11.7%) were in the severe depressive symptom category. Overall prevalence of anxiety symptoms ranged between 6.5% severe t0 14.6% moderate symptoms. Here too, there were more men (17.6%) than women (11.5%) in the severe symptoms' category, but more women (17.8%) than men (10.6%) in the moderate symptoms category.

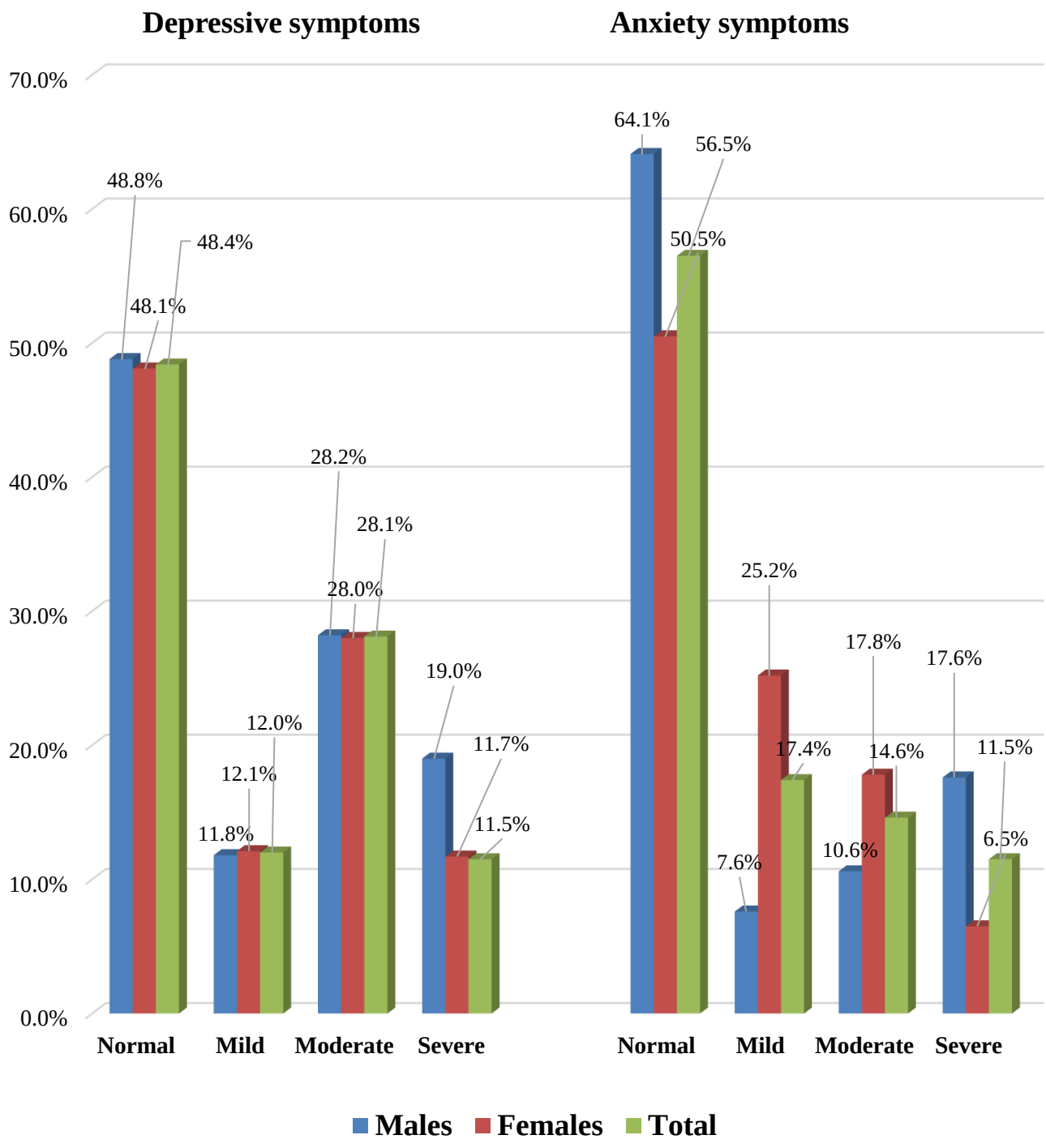

Figure 4. 1: Prevalence of depressive and anxiety symptoms

After assessing the prevalence, multiple regression analysis was used to assess sociodemographic factors that are associated with depressive and anxiety symptoms. The sociodemographic factors assessed were gender, age, educational level, ethnicity, employment status and community of residence. The findings are presented on Table 4.1.

Table 4. 1: Sociodemographic predictors of depressive and anxiety symptoms

	Depressive symptoms			**Anxiety symptoms**		
Demographics	**B**	**SE**	**β**	**B**	**SE**	**β**
Usshertown	-.778	.390	-.100*	-.258	.293	-.046
Females	.003	.014	.010	.373	.108	.218**
Age	.020	.347	.003	.034	.010	.179**
Tertiary education	-3.065	.379	-.387***	-2.196	.285	-.387***
Minority ethnic groups	1.799	.405	.226***	.332	.025	.430
Employed	.378	.360	.050	.291	.060	1.12

* p < .05; ** p < .01; *** p < .001

The sociodemographic factors predicted depressive symptoms [$F = 21.439$, $p < .001$], accounting for 25.4% variance ($R^2 = .254$). Depressive symptoms were found to be lower among respondents in Usshertown ($\beta = -.100$, $p < .05$), those with tertiary education ($\beta = -.387$, $p < .001$), but higher among migrant ethnic groups ($\beta = .226$, $p < .001$).

The demographic factors also anxiety symptoms [$F = 13.432$, $p < .001$], but accounted for 17.6% variance ($R^2 = .176$). Anxiety symptoms was higher among females ($\beta = .218$, $p < .01$), with increasing age ($\beta = .179$, $p < .01$) but lower among those with tertiary education ($\beta = -.387$, $p < .001$).

4.3 Qualitative insights into prevalent mental health problems in the communities

After the quantitative data suggested a high prevalence of depression and anxiety symptoms, the qualitative data was drawn on to ascertain; i) whether the community members considered depression and anxiety to be major mental health problems in the communities, ii) other more serious mental health problems within the communities, and iii) the full range of mental health problems that are common in the communities.

Community members' perspectives on depression and anxiety as major mental health problem

The qualitative data showed that depression and anxiety are considered to be major and widespread mental health problems in the communities. Participants from self-help groups, traditional and faith-based practitioners, caregivers and individuals with history of mental disorders mentioned depression as very common within the communities. The biomedical practitioners also mentioned depression and anxiety as common in the communities.

For instance, a 30-year old female mental health nurse who has been working in the communities for 4 years indicated that:

> *We also see people with depression and anxiety (*KII-10*)*

The view was shared by a 35-year old man, who is an over-the-counter medicine practitioner in Jamestown, who also indicated that:

> *Some people keep coming to buy sleeping pills. You can clearly see they are depressed. When you tell them to go to Ussher, they refuse (*KII-12*)*

The community members linked the depression problems to suicide attempts, which they indicated are common in the communities. The community members mentioned either knowing someone, or hearing about someone within the communities who either have attempted or completed suicide.

A 65-year-old Traditional Priestess in Usshertown for instance recounted an incident brought to her, where a young lady with suspected depression tried to commit suicide:

> *Yesterday, they brought a lady to me who tried to kill herself. She told me that she is tired of being alive and just wanted to go. I get such cases sometimes [*KII-14]

A 41-year-old Pastor in Jamestown also indicated that three of his church members who confided in him about having suicidal thoughts

> *At the moment, I have about 3 people who confided in me that they wish to take their lives. I have a friend who is a psychologist so I called on him to help. He indicated that they had depression so he is helping them, and I am also supporting with counselling and prayers [*KII-17]

A 39-year-old woman in Jamestown also recounted a situation where a young man tried to commit suicide in her neighbourhood:

> *Sometimes, some people here when they cannot handle the pressure, then they decide to kill themselves to end it all. There is this man in our neighbourhood whose wife has been cheating on him because he doesn't have money. Last month or so, he tried to kill himself. If not the fact that his friend was going to visit him and saw him hanging, he would have died.*

*The friend shouted for people to come and help and they saved him. So, there are people here who try to kill themselves [*SC-P4]

A 45-year old man in Jamstown who attempted suicide in 2017 linked his suicide attempt to depression:

Depression has caught me before. That is what almost made me kill myself. At the time, I didn't know there is something call depression. Ah….at that time I was always sad, not knowing what to do with all my problems. It was like I was carrying a heavy load and I didn't want to go close to people. That my friend that I was talking about took me to see his friend at Korle-bu and there I got to know I have depression. Since then I have become careful about it. It is very dangerous. I never knew depression can catch my mind like that as a man [KII-8]

A 45-year-old woman who is taking care of her sister receiving care for depression at a Polyclinic in Usshertown also indicated that the sister has attempted suicide twice within a space of five months:

My sister, has tried to kill herself twice. She tried the first one in September. Her daughter found a concoction her handbag and brought to us. Then just this January she tried again. They say we should never leave her alone so now l sleep with her in her room. She is okay now and laughs sometimes [KII-6]

Other more serious mental health problems community members outline

Other more serious mental health problems in the communities were also explored among the members of the communities. The other serious problems the members listed included madness, epilepsy, substance addiction, and psychosocial stress.

Madness

Madness came up as one of the more serious mental health problems within the communities. The participants used the term 'madness' to describe individuals suffering from or living with schizophrenic and psychotic conditions in the communities. The participants indicated further that these individuals are seen wandering, sitting or sleeping along the streets, gutters and other odd places within the communities.

A 53-year-old woman in Jamestown for instance indicated that:

> *There are many mad people in this community. Every day you see them with dirty clothes passing by, with many loads they are carrying and you don't know where they are taking them to [*SHG-P14]

A 32-year-old woman in the situated conversations group in Usshertown also said:

> *We see a lot of mad people in this community every day. They will be walking around with dirty clothes and carrying lots of load of rubbish [*SC-P3]

A 40-year-old fisherman in the men's focus group in Jamestown also said that;

> *Oh….always I see some [mad people] passing by. Even if you stay here for long, you will see that some will come and pass by [* FGD-JTM2]

A 41-year-old Traditional Priest in Usshertown also indicated seeing many cases of individuals within the communities who are 'going mad':

> *Sometimes I get cases of someone who is going mad. They bring them here for me to cure them [KII-15]*

However, there was some dissent, mainly regarding the identity of these individuals. Even though there was consensus that 'madness' is common within the communities, there were dissenting views regarding whether the 'mad people' were members of the community members or not.

> *The mad people in this community come from other communities. The don't come from here [SHG-P6]*

> *It is not all the mad people you see in this community that are from Jamestown here. These people they just roam so many of them come from other communities around. Some even come from far places in Accra [*KII-2*]*

> *As for this place, I can say that we don't really have mad people here. I mean those here are usually from other communities and they just walk to come here…you know these people, they are always walking [SC-P4]*

Epilepsy

The participants also indicated that epilepsy and seizures are also very common within the communities. There was consensus on this by participants across the different identity groups.

We see a lot of cases on epilepsy. There are plenty of patients in the community like that. As a matter of fact, more than half of the cases we see here are people who have epilepsy and seizures (KII-10)

Sometimes they rush people who are having seizures here (KII-15)

*I know several people in this community who have convulsions often. Some are old and some are young, both men and women. It is very common in this community. You will be talking to them and the next thing you know, they are on the ground struggling. It is very sad [*SC-P6]

*Ohh I will say people who have epilepsy is also very common in this community. I don't know why that is the case but there are several people like that here [*SHG-P23]

Substance addiction

Substance use and abuse disorders also emerged as one of the serious mental health problems within the communities. This was alluded to by all the participants across all the groups. The participants spoke of how rampant drugs and other addictive substances were within the communities, making them more accessible. Some of the substances mentioned were hard liquor, local bitters (alcoholic spirits made from local herbs and roots) tobacco, marijuana, heroin, shisha, cocaine, tramadol (an opioid pain-relieving medication used in the treatment of moderate to severe pain) and codeine.

As for this community, the drug use is too much. There are drugs everywhere so they just use it anyhow [KII-1]

I visit some drug users to share the gospel with them in their ghettos. Every time I go there, my heart becomes heavy because if you see what drugs have done to them, it is very sad [KII-17]

The substance use and abuse were more pervasive among young people, particularly the young men. Nevertheless, participants indicated that several young ladies were also using drugs. Alcohol use for instance was found to be very common among the women, while more men used strong addictive substances like marijuana, cocaine and tramadol:

In this community, if you raise a young boy here, there is high chance that he will use drugs and other substances. If you raise a young girl here, she will use alcohol, the strong ones. These things are so common in this community that it has become a way of life [KII-12]

*If you come here in the evening, you see so many people smoking everywhere, you can't even breath. Even during the daytime like right now, there are several places here I can take you to and you will be shocked the number of drug users you will find. But in the evening, it is worse. They all come to the streets, and that is where there smoke and use the other drugs [*FGD-UTF4]

I see smoking all those marijuana and using cocaine all as mental illness. They are not mentally well….the young men who do that, they are mentally sick [FGD-JTM2]

Drug addiction is part of being mentally sick. Some people they are so addicted that even when they know the drugs are killing them, they can't stop. They are always walking around this community, addicted to drugs [SHG-P27]

Alcohol and local bitters were indicated to be used more by the young women, while the hard drugs like marijuana, cocaine and tramadol were indicated to be used by men

> *These days, even the women they drink more than the men. The men usually like to smoke the substances, but as for alcohol like the local bitters, you can't stand the women [FGD-UTM6]*
>
> *The way people drink alcohol and other bitters here is serious. Even the women. Every day they are drinking alcohol with the men here. When you come here, these young people, they don't have job so do so you see people drunk always, men and women, all drunk [KII-2]*
>
> *Me if you ask me to mention mental health problems that I know about, I will add drug addiction. I see many young men here like that. They are always using hard substances such as cocaine and marijuana. As for the tramadol, now it is even too common. It is like alcohol and they are constantly using it [KII-14]*

The participants linked substance use and abuse to the conditions of poverty and unemployment in the communities:

> *In this community, if am not afraid, I will say that the young ones who use drugs is due to frustration and hopelessness. I get angry when I see them smoking all those substances but sometimes, I understand them too. There are not jobs for them so frustration and aimlessness, they use the drugs to forget their troubles [KII-16]*
>
> *Me if you ask me to mention mental health problems that I know about, I will add drug addiction. I see many young men here like that. They are always using hard substances such as cocaine and marijuana. As for the tramadol, now it is even too common. It is like*

alcohol and they are constantly using it. Because they don't have jobs to do, the drugs have become what they do with their time [KII-14]

The way young people drink alcohol and other bitters here is serious. Even the women. Every day they are drinking alcohol with the men here. When you come here, these young people, they don't have job so do so you see people drunk always, men and women, all drunk. Due to the poverty here, they don't have jobs to do so the drugs they are using always [KII-2]

Psychosocial stress

Psychosocial stress also came up as a major mental health problem in the communities. Participants from 4 groups (i.e. lay community members, local community leaders, traditional and faith-based practitioners, and caregivers) indicated that the hardships in the communities put many people in severe distress. They used terminologies such as excessive thinking, anger, and frustrations to indicate the widespread nature of anxiety within the communities.

*Here, people think too much. Me for instance I will not be telling the truth if I tell you I don't think [*FGD-UTF5]

*In this community, we struggle too much. There are no jobs, no money, nothing. It makes life too difficult. So, there are so many people who are frustrated and hopeless here. Every little thing and people are angry. All these are illness in the mind [*FGD-UTM1]

*What I have observed in this community is that people become too angry. Little thing and they are shouting and fighting. Sometimes they can't handle the stress in their lives [*SC-P4]

*If you live in this community, you will always be angry. There are too much tensions in the community so many people struggle [*SHG-P25]

*Majority of people in this community think too much. There is too much thinking and worrying here, so many people are frustrated [*KII-17]

Full range of mental health problems community members outline

After assessing the major mental health problems in the communities, other common mental health problems at the community level were also examined, to get a picture of the full range of mental health problems, as outlined by the community members. The full range of mental health problems that came up are presented on Table 4.2, indicating which groups of participants mentioned the conditions.

Table 4. 2: Full range of mental health problems in the communities

Mental disorders	Interview groups						
	LCM	**LCL**	**SHGM**	**TFBP**	**BP**	**PHMI**	**Caregivers**
Depression	++	++	++	++	++	++	++
Madness	<++>	<++>	<++>	++	++	++	++
Epilepsy	++	++	++	++	++	++	++
Substance addiction	++	++	++	++	++	++	++
Suicide	++	++	++	++	n/a	++	++
Frustration	++	++	++	++	++	++	++
Excessive anger	++	++	++	++	++	++	++
Prostitution	++	++	n/a	n/a	n/a	n/a	n/a
Homosexuality (gays)	++	++	++	n/a	n/a	n/a	n/a
Dementia	n/a	++	n /a	n/a	++	n/a	++

LCM = Lay community members; LCL = Local community leaders; SHGM = self-help group members, TFBP = Traditional and faith-based practitioners; BP = biomedical practitioners, PHMI = people with history of mental illness

++ theme mentioned by participants in all groups

<++> theme mentioned but with conflict

n/a - absent or not mention by participants in groups

4.4 Discussion

This chapter has presented the prevalent mental health problems in the communities. The survey provides insights into prevalence of depressive and anxiety symptoms in the communities. The qualitative provides insights into the seriousness of depression and anxiety, as well as the full range of perceived mental health problems in the communities. The findings showed that the communities experience high mental health problems, which are reflected in high prevalence of mental disorders symptoms at the individual level, and common mental health disorders at the community level. At the individual level, there are high prevalence of depressive and anxiety symptoms among the respondents. The prevalence levels of depressive symptoms in the communities are higher (28.1% moderate and 11.5% severe) than anxiety symptoms (14.6% moderate and 11.5% severe). These prevalent rates (particularly for depressive symptoms) are higher than national level prevalence rates of 18 – 21% reported in Ghana (Canavan et al. 2016; WAHO, 2018) and the 12.1 – 22% reported in other African countries (WAHO, 2018; WHO, 2015).

Sociodemographic factors associated with mental disorders symptoms were sex, age, educational level and migrant status. Depressive symptoms were higher and protracted among females, old people, individuals with lower education and migrants. These sociodemographic factors reduce individuals' material and symbolic resources for dealing with daily life stressors, thereby predisposing them to the ravaging impact of the stresses associated with living in poor communities.

The findings are in line with findings from other studies conducted within the same communities (Grief & Dodoo, 2015; Kushitor et al., 2018) and other similar contexts in Ghana (Dzator, 2013; Kyeremanteng, 2012). For instance, Kushitor et al., (2018) reported that females, older people,

and individuals with low education experience higher psychosocial distress. Grief and Dodoo (2015) also reported that females experienced high depression than males within the same communities. Similar patterns have been reported among community members in general (Asante, 2016), individuals living with chronic conditions (Teye, 2013) and caregivers (Kyei-Arthur, 2013, 2017) within same communities. Similar findings have also been reported to be risk factors for mental disorders symptoms in general and urban populations in Ghana (Awuah, 2016; Dzator, 2013).

Ethnicity also emerge as a risk factor for depression. In an earlier study in the communities, Kushitor et al (2018) found no association between ethnicity and psychological distress. The current study has however found that migrant status was associated with higher depressive symptoms. The difference in the findings can be explained by difference in mental ill health assessed. Kushitor et al (2018) assessed psychological ill health (i.e. psychological distress) while the current study found significance in emotional ill health (i.e. depression). This suggests that migrants within the communities experience poorer emotional ill health.

At the community level, there are several mental health problems which confront the communities. Substance abuse disorders emerged as the most common mental health problems within the communities. The others included neurological, psychotic, mood disorders, psychosocial distress and suicide and harm. These mental health problems found to be common speak to the high mental health problems in these poor communities. Substance use and abuse disorders are for instance linked to conditions of poverty and unemployment within the communities. Both Jamestown and Usshertown are materially-disadvantaged urban communities. Poverty and unemployment drive negative cognitive and emotional states of the young people which lead to engage in substance, as a form of coping mechanisms against

poverty-induced frustration and hopelessness. This confirms the fact that poverty increases risks of mental illness, and that poverty constitutes both a causal factor and consequence of mental health problems (Jordans et al., 2019).

The qualitative component has shown that local mental health knowledge is complex in the communities. Local knowledge of mental health highlights a broader range of mental health conditions that the survey examined. Local knowledge was found to go beyond depression and anxiety. The participants mentioned specific mild and serious conditions, they mention moods and cognitive-emotional states that are common in the communities.

The findings from the current study underscore the recognition that poor communities experience disproportionately higher burden of global mental disorders (Campbell, 2014; Jordans et al., 2019; Mathias et al., 2018). Poor communities face complex realities of extreme material deprivation, coupled with several socio-structural stressors. The everyday struggles of navigating and living through these social and structural stressors put pressure on and depletes the psychosocial resources of individuals in these communities, predisposing them to mental disorders symptoms at the individual level, and several mental health problems at the community level.

CHAPTER FIVE

SOCIAL REPRESENTATIONS OF MENTAL HEALTH

5.1 Introduction

The second objective of the study explored social representations of mental illnesses within the communities. This was to explore how the community members make sense of how do community members make sense of mental disorders (broadly as a concept) and specific conditions they describe as prevalent and how do they respond to mental illness. Social representation was conceptualized based on content of mental disorders knowledge, sources of knowledge, and functions of knowledge. The qualitative data was drawn in meeting this objective.

5.2 Content of knowledge and perceptions of mental illness as a concept

The ways in which the community members made sense of mental illness broadly as a concept was first explored. Emergent themes showed that mental disorders is understood within the communities in seven thematic ways; i) spoilt mind, ii) bizarre behaviours, iii) psychological struggles, iv) emotional disruptions, v) social struggles, vi) socio-cultural deviations, and vii) substance addition. The themes of mental illness representations are represented on Figure 5.1. The spread of themes across the various groups interviewed are provided on Table 5.1.

Table 5. 1: Spread of themes of local understanding of mental illness

Themes	Key informants	Male FGDs	Female FGDs	JTHC	Situated Conversations
Spoilt mind	+++	+++	+++	+++	+++
Bizarre behaviours	+	+++	+++	+++	+++
Psychological struggles	+	n/a	+++	+	+
Emotional disruptions	+++	+++	+	+++	+
Social struggles	+	+++	+	+++	+
Sociocultural deviations	n/a	+	+++	+	+++
Substance addiction	+++	+++	+++	+++	+++

+++ theme mentioned agreed by at least half of participants of the group

+ theme mentioned by few members in the group

n/a theme did not emerge in the group

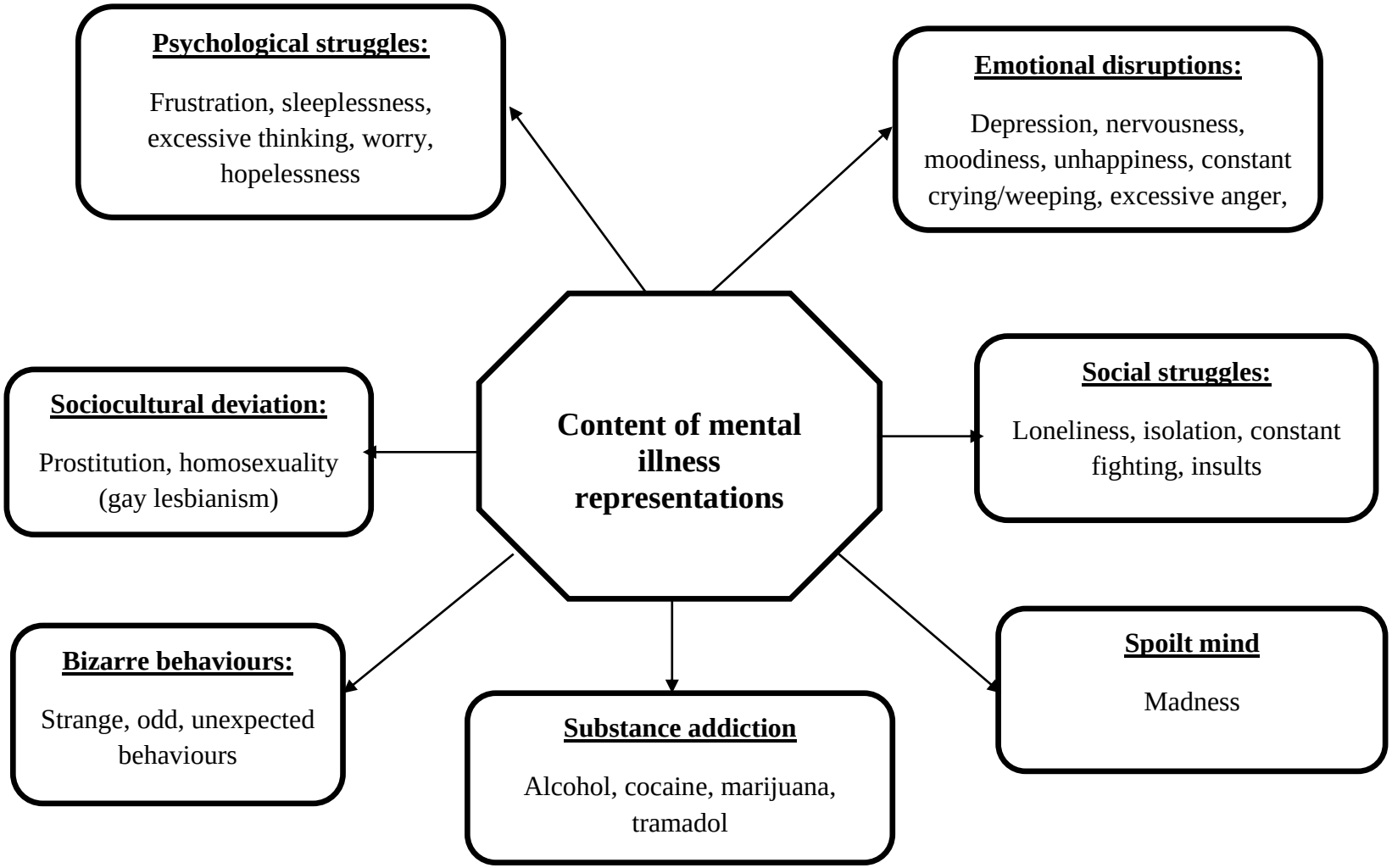

Figure 5. 1: Lay knowledge of mental health problems within the communities

Description of Themes

Spoilt Mind: A dominant narrative in the lay knowledge of mental illnesses included a sense of 'spoilt mind', particularly when talking about severe schizophrenic disorders. This theme emerged across all the five groups interviewed. They lay term used for this is translated as 'madness' to reflect a state of severe mental illness. This theme emerged in all four focus groups, self-help group discussions, and lay key informants in the communities. There was unanimous understanding that severe forms of mental illnesses meant that the mind or part of it is spoilt, which make individuals lose touch with reality. The participants used phrases such as 'something has gone wrong in the mind', 'the mind is spoilt', and 'mind no longer working' when representing particularly severe forms of mental illness, as reflected in the sample quotes below:

> *You see, the people we meet on the streets every day…they wear dirty clothes, carrying things and talking to themselves. They are all mental health problems. Their minds have spoilt, that is why [FGD-JTF2]*
>
> *Me I will say mad people….something has gone wrong in their minds, that is why they are mad like that [SHG-P12]*
>
> *Mental illness is when a person's mind has spoilt. The mad people who are on the streets, their minds do not work any longer, so they are not aware of anything going on around them. When the mind spoils like that, you get mental illnesses* [KII – 15]
>
> *….as for mental illness it is serious ooo. It is the mind is spoilt and so there is nothng you can do about it. All those people walking on the streets with dirty clothes, it is because their mind is not working again* [SC – P9]

Bizzarre Behaviours: another dominant theme that emerged in making sense of mental illnesses is bizarre behaviours. This theme emerged in all the groups interviewed. The participants indicated that mental illnesses are characterized by behaviours and actions that are strange and unusual to the community at large. They used phrases such as 'unexpected behaviours', 'strange

things', 'absurd things'. 'understandable' among others when describing behaviours or actions that people with mental illnesses exhibit, as reflected in the sample quotes below:

> *There is a guy here that every day people insult him that he is crazy. He is always dirty and the things he will do, you will know that he is mad. He does things that if you are standing there, you can't even imagine. He will just pick food on the ground and eat. He can just pick anything and throw at you if he stares at you and you stare back. Instead of the family to take him to a mental instittuion, they have just allowed him to roam in the community and be causing trouble all the time [KII – 1]*

> *Mental illness makes people do strange and understandable things. They don't know anything they do and so they just act anyhow. All these mad people we see every day on the streets, all the strange things they do, they don't even know [FGD – UTM1]*

> *When people get mental illness, you don't understand anything they do. They do things that are unexpected and you begin to wonder [SHG – P18]*

Psychological struggles: Psychological struggles also came up strongly in the participants' narratives of mental health problems. Across four of the five groups interviewed, participants made reference to the pressures on the mind that individuals experience as a result of daily. Narratives from the participants on psychological struggles cohered around; frustration, sleeplessness, excessive thinking, worry, and hopelessness. The participants attributed psychological struggles more to young people. These are exemplified with the quotes below:

> *For me I will say frustration. It is a serious problem that we the youth we face. You are living a life but nothing is working for you. No job, no money and family too is always calling for money. So, the pressure is high and you are always frustrated. If you noticed, when you came l almost didn't respond when you greeted. I am seriously frustrated now [SC-P7]*

> *I think thinking too much is part of the mental health problems. There are people who think too much. They worry a lot. Everything and they are worried and frustrated. They are all some of the problems of the mind [SHG-P11]*

> *In this community ah…in this Jamestown, hmm. The young people here, many of them are frustrated and hopeless. When you see them, you could see they have no hope and so they go about frustrated. All these things put too much pressure on the mind. I have many of them in my church. No hope [KII-17]*

You see, if I should tell you the truth, I don't remember the last time I slept very well that I felt ok inside. Like the way some people will say, oh as for today l have slept well. I don't remember the last time I had one. I get sleepless nights every day because am always thinking and worried about the next day [FGD-JTF5]

Emotional disruptions: Mood disruptions came up strongly in the participants' narratives of mental health problems. Across all the lay community groups interviewed, participants made reference to various emotional challenges that people go through which constitutes mental health problems, and therefore such people needed help. The basic themes of emotional problems that participants mentioned in their narratives were sadness, depression, grief and anger. These emotion states are translated in the Ga and Twi local languages as follows;

Emotions	**Ga Language**	**Twi language**
Sadness	Awerɛhoo	Awerɛhoɔ
Depression	Dwɛnmɔ	Awerɛhoɔ
Grief	Awerɛhoo	Awerɛhoɔ
Anger	Mlifu	Abufuo

These are exemplified by the sample quotes below:

You see, there are some people who are always unhappy. Every time you see them and you look straight into their eyes, you they are sadness, you don't see any sign of happiness in them. These are all illness of the mind that call for help [FGD-JTF2]

There are some people who are also always moody. You never see them laugh or being cheerful. A friend of mine is like that. Ever since I have known him, he is also moody. Even if we meet as friends and we are chatting and laughing, he will never laugh. Always moody with straight face. That guy needs help so you people should go and help him [SC-P7]

There is a lady who sells things at London market. Every time you see her she is crying. She will be sitting behind her things and be crying. I heard she lost her husband last year and she has been constantly crying since. There are some people like that. When they lose someone, they are not able to forget it and they share always crying. All of these things are some of the mental problems [KII-4]

There were some nuances with regards to the mood disorders. The participants' narratives suggested that mood disorders are preserve for women and the aged, except excessive anger, which were attributed to men. For instance, a 45-year-old man who had attempted suicide indicated that;

> *KII-8: Since then I have become careful about it. It is very dangerous. I never knew depression can catch my mind like that as a man [KII-8]*
>
> *Interviewer: why do you say you never knew depression can catch you as a man?*
>
> *KII-8: Ohh…..we all know that thing is for women. They like crying. But for a man to experience it, I was even embarrassed. Some of my friends even till now they tease me. They will ask you, has your depression come?*

One of the participants [FGD-UTF2] also indicated that

> *We women, you see the way we are, have emotions so things destroy our emotions easily. We can become moody for no reason within the next minute and we are cheerful again. The men are not like that. So, these crying and sadness and weeping that we have been talking about, we women experience them a lot. As for the men, theirs is anger. They are always angry [FGD-UTF2]*

One of the male participants in a focus group [FGD-JTM2] also indicated that

> *Oh the depression and other things they have mentioned are for women. For men, ours is anger. When you come here, men get angry a lot*

Social struggles: The participants across all the five groups identified social struggles as mental health problems. The social struggles they spoke to encompassed loneliness, isolation, constant fighting and insults. The participants described a continuum of social struggles, which ranged from from social isolation (being by oneself, not engaging with others) to social conflicts as a result of intense negative social engagement. Thus, the difficulty of good social life within the communities also constituted mental health problem:

> *I know some people who are constantly fighting. They are always fighting every day and fighting everyone in this community. Even strangers they fight them. There is this woman*

behind my house at Bukom like that. Every day she is fighting. All these are signs of mental health problems [SC-P5]

I also believe something being alone too much can be a sign that the person is not mentally well. There is a young lady I know at London market, she doesn't talk to anybody, she doesn't smile….she is always alone. If you see her talking, then it means someone is buying something from her. Apart from that, she is always alone [FGD-UTF4]

If you live in this community, one thing you will notice is that there are too much insults. People are always insulting themselves and fight. So, for some people, something small and they stand I nfront of their house insulting. Sometimes if you are passing, you may think you are the one the person is insulting. I see all these as not being mentally well…because if you are mentally well, you won't do that [KII-1]

Socio-cultural deviations: participants from four groups identified some ways of life that are contrary to their socio-cultural values as part of mental health problems. Specifically, they identified prostitution and homosexuality as mental health problems that need attention:

If you are to stay here for long, a certain guy will come and pass this street. He usually passes here at this time of the day. The way he walks, talks and do things shows he has mental problem. I grew up with him and now he is gay. You know the culture here does not tolerate these things. These things are all mental problems and he needs help [SC-P7]

All these young women who are selling their bodies for money, they all have mental problems. You know in Ghana our culture doesn't allow women to sell their bodies so those who do that have mental problems [FGD-UTF4]

In the evening, when you come here, you find so many young men who are gays. Some come from other communities to join those who are here and the way they do their things, I wonder how their parents feel. All these things are part of the mental health problems, because if something is not wrong with their minds, they wouldn't be doing that [FGD-JTF3]

5.3 Content of knowledge and perceptions of specific mental disorders

After exploring representations of mental illness as a broad concept, representations of specific mental disorders were also explored. Specifically, representations of top 4 mental health problems in the communities - depression, madness, epilepsy and substance addiction, were explored.

Representations of depression: was referred to as '*dwɛnmɔ*' in the indigenous Ga language, and as '*awerɛhoɔ*' in the Twi language (two most dominant languages spoken in the communities). Participants' representations of depression revolved around a mental disorder that catches. A 45-year-old man in Jamestown who had attempted suicide for instance indicated that:

> *Depression has caught me before. That is what almost made me kill myself….. I never knew depression can catch my mind like that as a man [KII-8]*

A 42-year-old women giving care to her sister receiving mental healthcare at a Polyclinic in Usshertown also indicated that:

> *…the husband left her [the sister] when she was pregnant with her second child. All we heard was that the man has gone to marry another woman at Nkawkaw. That is what made the depression catch her like that…* [KII – 3]

A 33-year-old man in Jamestown who lives with epilepsy also spoke of periods when he believes that he experienced depression:

> *..oh yes..I experience that [depression] often. When you have this thing [epilepsy], they way you are treated alone makes you sad always so depression catches you often. So, even though I am a man, there are times when I will feel depressed for weeks…[KII – 9]*

Another theme that featured strongly in their representations of depression was the fact that the participants attributed depression to women. A 53-year-old fisherman in Usshertown for instance indicated that:

> *Oh the depression and other things they have mentioned are for women. For men, ours is anger. When you come here, men get angry a lot* [FGD-UTM6]

The 45-year-old man in Jamestown who had attempted suicide, speaking about his experience also indicated that:

> *….. I never knew depression can catch my mind like that as a man [KII-8]*

The 33-year-old man in Jamestown living with epilepsy also said that:

…. So, even though I am a man, there are times when I will feel depressed for weeks…[KII – 9]

Narratives from some women in focus group discussions also indicated that depression is normal for women. A 42-year-old female care giver for instance said that;

…when the husband left her like that, that is when it [the depression] started. She is a woman and so when your husband does this to you, she wll experience it [KII – 3]

….as for a woman, feeling depressed is normal. There are a lot of things that we go through which make us emotional. Even when your husband treats you badly, you can be depressed. So, for women, I see depression to be normal [FGD-UTF4]

Representations of epilepsy: was referred to the participants as *Gbligbli* in the indigenous Ga language, and '*ɛtware'* in the Twi language. The dominant theme that emerged in their representation of epilepsy centered around a sense of *struggling on the ground.* The 33-year-old man in Jamestown who live with epilepsy for instance said:

….it [epilepsy] is very disgraceful. One minute you are fine and talking or walking. The next minute you are struggling on the ground [KII -9]

A 38-year-old woman in Usshertown who provides care to her 15-year-old broader also indicated that

Epilepsy is part of mental health problems. My brother experiences that sometimes and it not easy at all. When it comes, he just falls to the ground all of a sudden and be wobbling…hmm only God knows [KII-5]

Participants in the focus group discussions also made similar narratives:

*I know several people in this community who have convulsions often. Some are old and some are young, both men and women. It is very common in this community. You will be talking to them and the next thing you know, they are on the ground struggling. It is very sad [*FGD-JTF2]

There are some people who experience convulsion all the time. They will be going about their daily activities, and then all of a sudden you see them on the floor shaking and struggling. I see some in this community. I think these are all part of mental health problems [FGD-UTF1]

Representations of madness: was referred to as '*sɛkɛ'* in the indigenous Ga language and as *ɛdam* in the Twi language. Representations included dirty clothes, carrying loads, exhibition of bizzarre behaviours and losing touch with external reality:

There are many mad people in this community. Every day you see them with dirty clothes passing by, with many loads they are carrying and you don't know where they are taking them to [Woman, 45, Jamestorn]

All these mad people we see every day on the streets, all the strange things they do, they don't even know [FGD – UTM1]

He is always dirty and the things he will do, you will know that he is mad. He does things that if you are standing there, you can't even imagine [KII – 1]

5.4 Sources of knowledge and perceptions of mental illness representations

After exploring representations of mental illnesses within the communities, the sources of knowledge where participants drew from in their representations were analysed. As indicated in subsection 3.9.3, cognitive polyphasia was used as analytical tool to explore all stocks of knowledge that the participants drew on in making sense of mental illness broadly, and specific mental disorders. In analyzing the content of their representations and their lay explanations of what causes mental illnesses, five stocks of knowledge emerge: embodied knowledge, common sense, medical knowledge, cultural knowledge and religious knowledge. Each of these knowledge stocks are explained in Box 2, showing where individuals draw the knowledge from, and the level(s) where they operate.

Box 2: Stocks of knowledge of mental illness representations

Embodied Knowledge **-** participants drew on their lived experiences for making sense of mental illnesses. The embodied knowledge operated both at the individual and interpersonal levels. At the individual level, the participants drew on their personal experiences of suffering from some form of mental ill-health due to personal experiences of frustration, worry, aimlessness, hopelessness, which they as both a mental stressor and a precursor to mental illness. At the interpersonal level, the participants also drew either on their relational lives or their lived experiences as caregivers of individuals of individuals with history of or living with mental disorders to make sense of mental illnesses.

Common sense **-** participants depended on their social observation of people with history of or living with mental disorders in the communities, or the people in the community they encounter in their daily lives to make sense of mental illnesses. Through social observation, the participants identified poverty and unemployment as structural drivers of poor mental health in the communities.

Scientific/Medical Knowledge **-** participants drew on medical or scientific knowledge in making sense of mental illnesses. They made reference to medical diagnosis (from medical doctors and nurses), heredity, pregnancy and childbirth in their narratives of causes of mental disorders.

Cultural Knowledge participants drew knowledge from socio-cultural norms, beliefs and values about acceptable social life, in making sense of mental illnesses. This stock of knowledge operated at the structural level and was drawn on to identify some ways of life that are contrary to their socio-cultural values (e.g. gay, prostitution) as part of mental health problems.

Religious Knowledge **-** participants also drew from knowledge and beliefs about supernatural as possible narratives of causes of mental illnesses. Supernatural factors emerged strongly as one of the factors that cause mental health problems. The supernatural factors identified included witchcraft (evil magic powers that operate only at night), juju (using objects to charm others), curses (invoking supernatural power to inflict punishment), sakawa (combination of cyber fraud with traditional rituals like sacrifices) and other evil spirits. These factors were attributed to cause the more severe forms of mental disorders that either destroy lives (such as schizophrenia) or disgrace individuals (such as epilepsy). The supernatural causes are seen to be either bought or orchestrated by close associates, as a form of punishment, jealousy or sheer wickedness.

Embodied Knowledge

Here the participants drew on their individual experiences and their stress from giving care to individuals living with mental illness:

> *At least, I know depression is a mental health problem. Depression has caught me before. That is what almost made me kill myself. [KII – 8]*
>
> *I will add that frustration too is a factor. When you are frustrated, sometimes you don't even know what you are doing. The other time, I wore chalewote different colours to the market. It was at the market that someone told me. I didn't even know because of frustration. So, yes, frustration can make someone to be mentally ill [FGD-UTF1]*
> *If you see me, you think ohhh…. this guy like smoking or alcohol. You see we were not like that. When you are frustrated, we go to base to chat and also do [smoke] little you know, to reduce the worries [KII-7]*
> *I will say pregnancy can cause that too. Me for instance, when am sick I experience so much stress in my mind. It gets so intense that sometimes I feel like aborting it. But because I don't know how to describe it for people to understand, I don't talk about it [FGD-JTF2]*

In drawing on their caregiving experiences, some of the participants, all women caregivers, used their experiences of their loved ones suffering mental disorders to make sense of mental illnesses.

A 38-year-old caregiver in Usshertown who provides care to her 15-year-old broader said:

> *Epilepsy is part of mental health problems. My brother experiences that sometimes and it not easy at all. [KII-5]*

A 42-year-old caregiver in Usshertown also indicated that:

> *My sister, they say she has depression…... That is what made the depression catch her like that…* [KII – 3]

In drawing on their relational lives, some of the participants, particularly women, also identified reproductive and sexual health matters such as marriage, romantic relationships as sources of stress driving mental ill-health of themselves and other women in the communities:

…when the husband left her like that, that is when it [the depression] started. She is a woman and so when your husband does this to you, she will experience it [KII – 3]

The women here we are always stressed. Our husbands don't help at all. They leave all the burden of the children on you. If you complain, they will say they don't have jobs. So, every day the women are the ones going through all the stress [FGD-UTF1]

Me, I am always fighting with my husband every day. I don't remember the last time he gave me money for housekeeping. Yet he expects food when he comes home. I go through so much stress every day just to get food for the children. If you are a woman and your husband doesn't help you eh…the stress you go through, it is only God. You can breakdown anytime [SC-P4]

I will say that for some women, their relationships give them so much stress. They will stay with this guy, the guy will leave her, they will find another one, the same story. You men these days they don't want to marry but they want to have sex. So, many women experiences stress in their relationships because when you mention marriage, the men will find excuse to breakup with you. It put too much stress on use as women [FGD-JTF2]

In this community, so many women have mental health issues. They have given birth with men who didn't marry them and also not taking care of the children. You see so many who have given birth to children without husbands in this community. They are always frustrated because the pressure is too much for them. One lady in our house, she always directs her frustration to the children. She can beat them eh…hmmm. They all need help [SHG-P24]

I will also say divorce. Always people are divorcing. Here too, if you divorce, especially when you are a woman, nobody will marry you again ooo…..so the women who are divorce, there is so much pressure on them. That pressure can push you to do things that you don't want to do [FGD-UTF4]

Common sense

The participants made sense of mental disorders social observation, from which they identified poverty and unemployment as structural drivers of poor mental health in the communities.

Too much worry…..for me, too much worry is not good. In life sometimes you worry but the one I am talking about is worrying every day every time. There are some people I know in this community erh, you never see them smile. Anytime you see them, when you look at their face, you sense they are overburdened so they worry every day. One friend like this I always advise her but nothing. Constantly worrying. That can make a person get sickness in the mind [SHG-P13]

In this community, we the young ones we don't have jobs to do. Every day you see so many young guys roaming up and down in the community doing nothing. Joblessness everywhere, why won't they use drugs to reduce their frustration? [FGD-JTM6]

The unemployment here is too much. All the young men here, they don't have anything to do. All they are left with is to use drugs and do unnecessary things. It is not their fault. There are no jobs for them [FGD-UTF4]
Me, I will say poverty can make a person become sick in the mind. You see, when you are poor eh…hmmm. You don't have peace of mind, why won't you be sick in the mind. Poverty is very bad [FGD-UTM6]
Poverty…yes. Poverty too is a factor. In this community, poverty is high. So, many people, even what they will eat, they can't find. Sometimes can be talking to someone, you will talk ahh the person will not be responding. Sometimes you have to touch the person or shout….hey! before the person will come to awareness. Poverty is not good at all [KII-16]

Scientific/Medical Knowledge

The scientific stock came mainly from diagnosis from biomedical practictioners, and understanding of how some medical conditions can lead to mental ill-health. For instance, in making reference to medical doctors or medical diagnosis as source of knowledge, the 45-year old man in Jamstown who attempted suicide indicated getting to know about his depression when he was diagnosed in Korle-bu Teaching Hospital:

.....That my friend that I was talking about took me to see his friend at Korle-bu and there I got to know I have depression [KII-8]

A 42-year-old woman who provides care for her father living with mild stroke also drew on knowledge from medical doctors in linking the stroke to depression experiences of her father:

Sometimes, some diseases too can cause mental illness. You see if you are one person and you live with soo many chronic diseases like diabetes, stroke, hypertension and the rest, you will easily be depressed. My father for instance, he has mild stoke, Every time we go to Korle bu, the doctors say he is depressed [KII-3]

The 45-year-old woman providing care for her sister receiving care for depression at a Polyclinic in Usshertown also drew on the nurses as source of knowledge:

They [the nurses] *say we should never leave her alone so now l sleep with her in her room. She is okay now and laughs sometimes [KII-6]*

Some other participants also drew on biomedical factors such as hereditary and pregnancy in making sense of mental illnesses. For instance, a 31-year-old man in Usshertown drew on heredity in explaining causes of mental illnesses:

> *Ohhh…for me, I know that sometimes madness can run in a family. Sometimes it can be passed on to children in a family. Some families are like that SC-P2]*

A 53-year-old women in Jamestown also mentioned childbirth as possible cause of mental disorders:

> *Childbirth can cause mental health problems. Yes. I know someone, a friend of mine, who after delivery suffered a mental health problem but has now recovered [SHG-P15]*

A 35-year-old woman in Jamestown also linked pregnancy to her antenatal depression experience:

> *I will say pregnancy can cause that too. Me for instance, when am sick I experience so much stress in my mind. It gets so intense that sometimes I feel like aborting it. But because I don't know how to describe it for people to understand, I don't talk about it [FGD-JTF2]*

Cultural Knowledge

The participants drew on socio-cultural knowledge to identify prostitution and homosexuality, particularly gay as mental health problems that need attention:

> *You see how in Ghana our culture ensures that women should get married and give birth to childre and take care of family. But here, some of the women don't follow that….All these young women who are selling their bodies for money, they all have mental problems [FGD-UTF4]*

In the evening, when you come here, you find so many young men who are gays. Some come from other communities to join those who are here and the way they do their things, I wonder how their parents feel. It is as if they don't know that our culture is against it...All these things are part of the mental health problems, because if something is not wrong with their minds, they wouldn't be doing that [FGD-JTF3]

Religious Knowledge

The participants also drew on religious to make sense of severe forms of mental disorders with sudden or unexplained unset:

Oh…as for sickness in the mind, you can get it spiritually. Yes, it is very common…. through supernatural powers, one can be affected. Some people can throw all sort of diseases in the air and innocent people can catch it. So, madness can be thrown in the air too

If you offend somebody and the person has spiritual powers, they can give you some of these sicknesses in the mind as a way of punishing you [FGD-JTM6]

Some people who have witchcraft can give people mental disorders to destroy their future. There is a young girl I know who has epilepsy. They have taken her everywhere but the thing doesn't go. Recently, they took her to a certain church and the pastor told them that the problem is from his father's side and that there are some rituals that need to be done for him [FGD-UTF4]

Some people go to juju places and they will destroy your life for you. Yes, in this life eh, there is something there, so you need to be careful. All the mad people we see every day eh, most of them somebody destroyed their lives spiritually like that [KII-14]

Oh mental sickness, it can always be given spiritually. I deal with several cases like that. In fact most of them, if not all, have spiritual basis [KII-16]

5.5 Functions of lay mental health knowledge

Function of knowledge was explored at three levels –community level, relational level and individual level (self). At the community level, mental disorders representations shaped *categorization of mental illnesses, mental health dialogue* and *mental disorders stigma*. At the

relational level, mental disorders representations shaped *caregiving*. At the level of self, mental disorders representations were found to shape *self-diagnosis and self-care*.

Categorization of mental illnesses

Mental disorders representations shaped how mental disorders were classified in the communities. Predominantly, the participants distinguished between mental disorders based on a general observation of seriousness and severity of the disorders. Three categories emerged from the participants narratives – serious disorders, intermediate disorders and non-serious disorders. These are reflected on Figure 5.2.

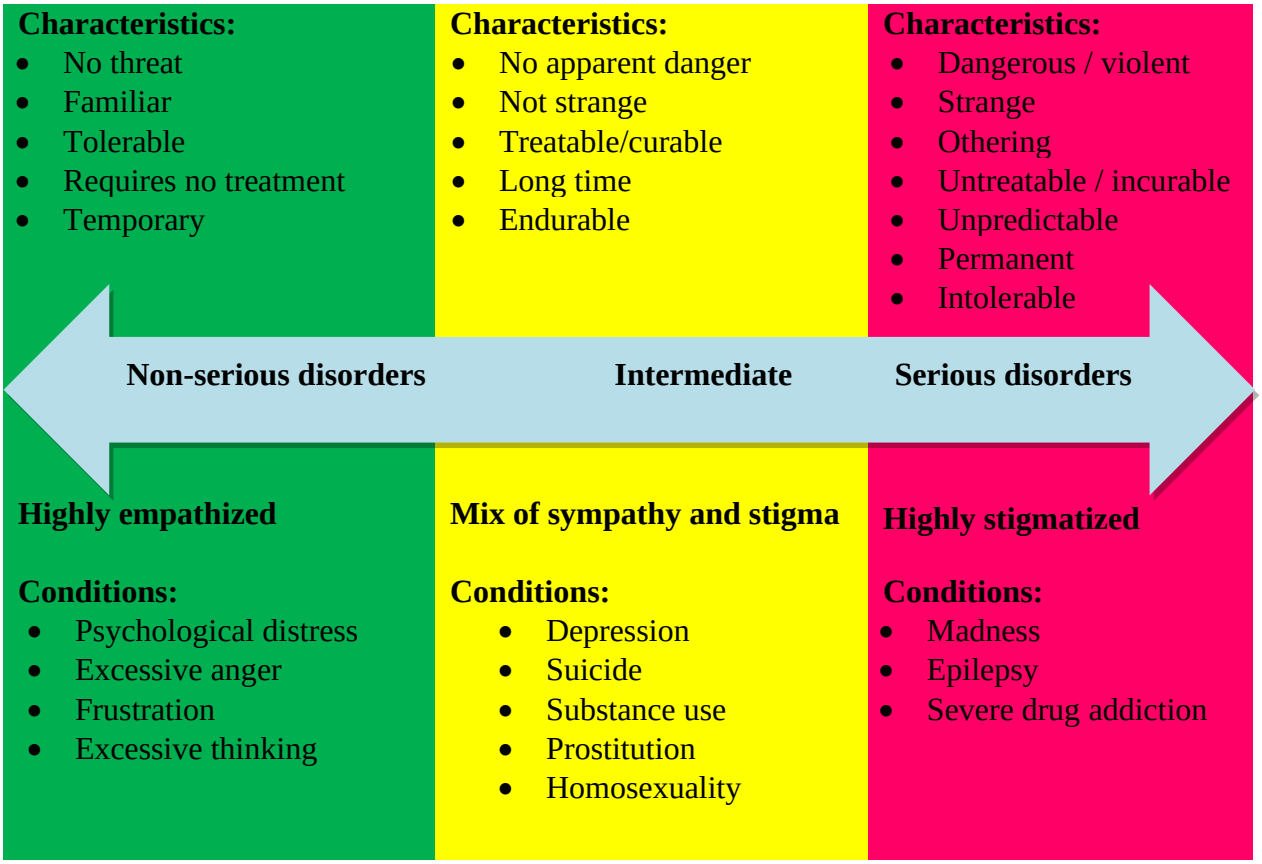

Figure 5. 2: Lay categorization of mental disorders based on severity and seriousness

Serious mental disorders: representations of severe mental disorders focused on characteristics of violence, strangeness, incurability and permanence. Conditions within these category included madness, epilepsy, severe forms of drug addiction which were associated with madness. These conditions suffered othering, were seen to be intolerable and therefore highly stigmatized.

> *….as for that sickness [madness], it is dangerous. You can never tell what maybe going through their mind. They can hurt you and there is nothing you can do, you can't beat them, you can't arrest them [FGD-JTF2]*
>
> *..me am always complaining to the Assemblyman to do something about such people [with severe drug addition]. They can do anything, like even hurt you or something [KII-17]*
>
> *….people like that [with severe drug addition]t, they are difficult to predict. Little chance they get, they can even kill themselves [KII-8]*
>
> *When the person is all dirty or exhibiting strange behaviours, then you have to be extra careful [SC-P4].*
>
> *Some of them, we don't even know where they come from or what caused their madness [KII-2].*
>
> *Oh as for me, if I don't know the person and he is mad, I can't tell what the person will do so I give distance [FGD-UTM1]*

Intermediate mental disorders: representations of this category focused on the fact that these conditions do not pose apparent danger to others, are not strange to the people, even though takes longer time but are relatively curable. Conditions within this category included depression, suicide, substance use, prostitution and homosexuality. These conditions seem endurable within the communities and as such elicited a mixed feeling of empathy and stigma.

> *…some of the mental sickness, when it comes it can be treated. Those one come for a short time and the person will be cured. Those ones are not dangerous. The ones that when it comes, it is for life, those ones are dangerous. No medicine can cure it, unless the person dies with it [ ]*

There are some people, they have mental disorders but you don't see it on them. They are not dirty or don't talk by heart. Those ones are ok. But the once that the person will be dirty and talking anyhow, those ones are serious

Non-serious mental disorders: representations of this category cohered around the fact that the conditions are no threat, but rather as a result of the stressors of life in general and the conditions of poverty in the community in particular. These conditions were seen to temporary and not needing any form of treatment. Conditions within this category included various forms of psychological distress such as anxiety, excessive anger, and frustrations. The conditions were seen as normal in the communities and therefore elicited empathy.

There are some people in the community like that. We know them. As for them, their conditions are not all that serious so we live with them. They don't harm anybody and they are not dirty too [FGD-JTF4]

Representations drive mental illness stigma

The representations were found to drive high level of stigmatization towards individuals and families affected by mental illnesses. The stigma manifested in terms of process of othering and hostile treatment of people with severe mental disorders. The attitude of othering was mainly directed towards people living with severe schizophrenic disorders. The indigenous community members for instance indicated that the 'mad people' in the communities were not from the communities, suggesting a sort of labelling individuals with such disorders as 'mad strangers':

The mad people in this community come from other communities. They don't come from here [SHG-P6]

*It is not all the mad people you see in this community that are from Jamestown here. These people they just roam so many of them come from other communities around. Some even come from far places in Accra [*KII-2*]*

As for this place, I can say that we don't really have mad people here. I mean those here are usually from other communities and they just walk to come here…you know these people, they are always walking [SC-P4]

Some of them, we don't even know where they come from or what caused their madness [KII-2].

Oh as for me, if I don't know the person and he is mad, I can't tell what the person will do so I give distance [FGD-UTM1]

High levels of hostility towards individuals with severe mental disorders were also observed from the participants' narratives. The participants indicated that acts of teasing and name calling are commonly experienced by adults with living severe forms of mental or neurological disorders. For example, a 33-year-old man living with epilepsy, which he describes as severe indicated that:

People can be very hostile to you if they know your condition. Me, mine is very serious. It comes often and it takes long before I am ok. Because of this, People keep teasing me and calling me names. Every small things then they refer you to the condition. It makes you feel as if you are less of a human being [KII-9]

Other community members also indicated that there are common instances of beating and other physical abuse from community members experienced by children with severe mental or neurological disorders.

The way some people treat mentally ill people is sad. Sometimes they beat the person. Sometimes they throw things like stones towards them just to drive them away [FGD-UTM1]

There is this boy in our area who has mental disorders [though specific condition not indicated], people beat him anyhow. Calling him names and teasing him and all that. Sometimes I fight some of them. It is sad but what can you do [SC-P9]

Representations drive mental health dialogue

The mental illness representations were also found to shape conversations around mental health in the communities. Participants indicated that mental health issues are rarely discussed at the community level. Narratives from across the different participant groups suggested that there no

structured community level conversations around mental health issues, and so people rarely talk about it:

> *Me, I have never heard of any program that they organize in this community that oh this day or this day there is a group coming to discuss mental health or anything like that. Me I haven't heard of anything like, apart from the last time you came here and today that we are talking [FGD-UTM1]*

> *In this community, I will say no. We don't usually talk about mental health issues, the way you are suggesting like we talk about health and sanitation or money issues. We don't really discuss mental health like that [KII-7]*
> *Well…. uhm, no we don't. I mean if you look at the problems we face, we want to solve the pressing ones. Here, poverty and poor sanitation take all our attention so that is what we talk about more [FGD-JTF2]*

The participants' narratives suggested that the only times mental health issues are talked about is upon meeting mental illness; either in terms of when someone close to them develop mental health problems or when they meet an individual with mental illness:

> *Usually, when you hear that someone you know has developed mental illness, then people talk about it for a while. Apart from that, we don't really have conversations about mental health [FGD-JTF4]*

> *When people meet someone who is mad, especially if they know who the person is, then they will talk about it. I don't think we talk about mental illness issues here, unless we see some [FGD-UTM5]*

Issues about mental disorders are discussed at the family level, often in secrecy. The participants indicated that individuals rarely open up to others, especially when it comes to severe health problems in its broader sense, including mental illnesses. For this reason, any or all forms of conversations around mental health is confined to the family space:

> *This community, it is difficult for people to open up to others about something bothering them. When they get to hear your problem, everybody in the community will hear and start gossiping and spreading rumours. So, people keep their problems secret [KII-8]*

> *In this community, if your loved one is showing signs of mental problems, people keep it to themselves at home. They only talk about it among the family members. If other people get to hear it, they spread rumours and gossip all over. So, we keep some of these things a secret, and deal with it as a family [FGD-JTF3]*

A 41-year-old local Pastor in Jamestown lamented why people would rather keep to themselves and suffer in secrecy than risk their problems getting out:

> *Sometimes, when people come to see me as a pastor, some of the things they tell me, I ask them, why they have not discussed with friends and colleagues for help. But you see, they are always concerned that people will use their problems against them. So, here, people keep their problems and struggles to themselves [KII-17]*

Mental illness representations drive care

Mental illness representations in the communities were found to drive care at the relational level, mainly in the family space, and sometimes in the friendship space.. Narratives from the participants suggested that individuals within the communities always protect their own. This means that individuals seek for the interest of their family members suffering from stigmatising health conditions:

> *Here, people keep their family matters secret to protect their loved ones [SHG-P16]*
>
> *When somebody or their loved ones has problems, unless you are very close to them, you will never know. People like to keep issues of their loved ones secret, in order to protect them because when people get to hear of it, they will spread rumours and gossip [SHG-P10]*

Sometimes, close friends with deep interpersonal trust also protect their friends who are experiencing mental ill-health. One participant for instance narrated how a man tried to kill himself was saved by his friend who decided to check on him:

> *Sometimes, some people here when they cannot handle the pressure, then they decide to kill themselves to end it all. There is this man in our neighbourhood whose wife has been cheating on him because he doesn't have money. Last month or so, he tried to kill himself. If not the fact that his friend was going to visit him and saw him hanging, he would have died. The friend shouted for people to come and help and they saved him. So, there are people here who try to kill themselves [*SC-P4]

The man who attempted suicide as a result of depression for instance indicated the instrumental role that his friend played in his wellbeing during those moments:

*…..A friend of my suspected. He disturbed me aaaa till I told him what is bothering me. He informed others and they talked me out of it and also helped me with some money to start something [*KII-8]

He continued about how the said friend helped him receive the needed medical diagnosis and care:

That my friend that I was talking about took me to see his friend at Korle-bu and there I got to know I have depression [KII-8]

A 54-year-old woman in Jamestown also indicated how she has been trying to help her friend get over her psychological stress:

Too much worry…… One friend like this I always advise her but nothing. Constantly worrying. That can make a person get sickness in the mind [SHG-P13]

Informs self-diagnosis and self-care

At the level of self, mental disorders representations were found to inform self diagnosis and self-care, where individuals look for signs of mental ill-health and take action. The man who attempted suicide as a result of depression for instance said that

..Since then I have become careful about it. It is very dangerous. I never knew depression can catch my mind like that as a man [KII-8]

A 32-year-old man in Usshertown who uses drugs also indicated how his friends' mental disorders experience is making him take actions to stop using drugs:

Oh yea….some of our friends that we used to do everything together at base, they went mad. Even now as am speaking, sometimes I see some of them, totally mad. So, I know drugs can cause madness. Now I want to stop. There is a pastor here who is helping me small small [KII-7]

The woman who is providing care to her sister receiving treatment for depression at Usshertown also indicated how her sister's divorce experience has made her careful in her own marriage:

..so me I am careful. I won't put all my hopes in a man. I do everything I need to do as a wife but I will not let this happen to me. You can kill yourself for a man but he will still leave you. So, whenever am getting stressed out about what my husband is doing, I always remind myself of my sister's situation and I just stop worrying myself [KII-6]

5.6 Discussion

This chapter assessed the community members' knowledge of mental health, where they draw their mental health knowledge from, and what they do with their mental health knowledge. The findings show that lay mental health knowledge within the communities is complex, multifaceted and nuanced. The findings largely contradict dominant mainstream assertion of poor knowledge of mental health in lay communities (Benedicto et al., 2016; Gibbons et al., 2015; Yu et al., 2018). With regards to content of mental health knowledge, the community members articulated range of mental health disorders within the communities. They spoke of the conditions they regarded mild and severe, in ways that aligned with biomedical or scientific definitions and classifications. They provided causal theories of mental disorders that ranged from genetics to structural poverty. Mental disorders were attributed to multiple causes.

Four key causal theories emerged; supernatural (witchcraft, juju, curses, sakawa, evil spirits), natural (genetics, pregnancy, childbirth, chronic illnesses), psychosocial (lifestyle factors such as drug use and interpersonal factors stress such as intimate relationship stress) structural (poverty, unemployment, abundance of illicit drugs). The causal theories of mental disorders and the ways the participants drew on them align with previous studies in Ghana (Adeeku, 205; Adombiri-Naba, 2013; Opare-Henaku & Utsey, 2017; Read et al., 2009; Read & Nyame, 2019) and other African countries (Brooke-Sumner et al., 2014; Johnson et al., 2009).

Some nuanced differences emerged in the current study. First, in this study, the participants made stronger gendered associations between causal theories and mental illnesses. Even though multiple causal theories are reported in previous studies, gendered dimensions to the causal theories are silent in existing studies. In this study, depression for instance, and its associated natural causes (childbirth and pregnancy) and psychosocial causes (intimate relationship stress)

and cultural causes (childlessness and being unmarried at advance age) were attributed to women. Substance abuse disorder, and its associated structural causes (poverty and joblessness) were attributed to men. These findings demonstrate that within the communities, both men and women see mental health and mental disorders through the lens of gender.

Secondly, the participants made nuanced and multifaceted associations between the causal theories and mental illnesses, compared to narratives in existing studies. The existing studies report that supernatural rhetoric overrides other competing explanations of mental disorders in lay communities (Benti et al., 2016; Opare-Henaku & Utsey, 2017). In this current study however, the participants drew on the multiple causal theories in nuanced and fluid ways, in explaining mental disorders risk and care. Lay knowledge of mental health were drawn eclectically from a range of sources, spanning embodied experiences, scientific/medical, cultural, religious and social observation. These range of knowledge sources were drawn on to explain the stressful family and social relationships, double-edged nature of social support and community connectedness, and structural conditions of poverty and joblessness. The findings align with burgeoning social psychology of participaton-informed community works which argue that lay communities hold complex and multifaced knowledge systems, which need to be acknowledged, recognized and respected in working with such communities (Aveling & Jovchelovitch, 2014; Baatiema et al., 2013; de-Graft Aikins et al., 2020; Skovdal et al., 2017).

There are other critical themes emerging in representations of mental illnesses within the communities that require consideration in planning interventions to build mental health competence of the communities. These are self as a source of knowledge at the individual level. Self-knowledge was key in mental illness representations, as the participants drew on their embodied experiences mental disorders for mental health knowledge. The salience of embodied

knowledge in their representations of mental illnesses reflects how they exercise agency in drawing on their cognitive and emotional experiences. The dependence of embodied experience in mental illness reprensentation demonstrates the self as a valid source of mental health knowledge production at the individual level (de-Graft Aikins, 2012).

At the interpersonal level, cognitive-emotional process underlying representations of mental illnesses. A range of mixed and complex emotions of fear of strangeness and love in the family and interpersonal context simultaneously drove care, distancing and stigmatization of severe mental disorders and othering of individuals of outsider status living with mental disorders. These mix and complex emotions and underlied high level of secrecy surrounding mental health dialogue at the community level. Mental health dialogue was reserved at the interpersonal or family level which leads to a sense of individuals protecting their own. The secrecy surrounding mental health dialogue beyond interpersonal level aligns with what previous studies on chroic disease experience and care reported in the community (de-Graft Aikins et al., 2015; Kushitor et al., 2018; Kushitor & de-Graft Aikins, submitted) and in other Ghanaian communities (Atobrah, 2010; Sanuade et al., 2019). The secrecy beyond interpersonal level prevents the creation of safe social spaces for critical mental health dialogue, which are critical pathways to community mental health competence (Campbell & Burgess, 2012; Campbell & Jovchelovitch, 2000; Mathias et al., 2018).

Also, representations of mental illnesses in the communities are driven by fear of strangeness of severe mental disorders co-existing with core supernatural causal theory of mental illnesses. The cognitive-emotional process in mental illness representations shape differentiation of mental illnesses, mental illness stigma, can predispose the community members to higher risk of mental illness, undermine treatment and care and mental health competence within the communities.

The cognitive-emotional process underlying mental illness representations (de-Graft Aikins, 2012) grants some mental disorders illegitimacy, order disorders are granted conditional legitimacy and the rest unconditional legitimacy (de-Graft Aikins, 2015). Within the communities, madness, epilepsy and severe forms of drug addictions are granted illegitimacy. Depression, suicide attempt, substance use, prostitution and homosexuality are granted conditional legitimacy. Psychological distress, excessive anger and excessive thinking and worry are granted unconditional legitimacy. These differentiations inform high levels of stigma and hostility towards individuals living with mental disorders deemed illegitimate in the communities. These differentiations should inform which interventions that address social and institutional care.

Individuals living with conditional and unconditional legitimacy however receive a sense of care for People living with mental disorders as individuals, despite a distancing attitude towards the condition. This contradict some previous studies. Much of mainstream-informed research assert that communities hold binary (either positive or negative) mental health attitudes (Biringer et al., 2017; Stull et al., 2017), and that lay communities, particularly in poor context hold largely negative attitudes towards mental disorders (Gibbons et al., 2015; Adjei et al., 2013; Yu et al., 2018). Findings from the current study contradict both assertions. The study has shown that social spaces within the communities are characterized by a complex co-existence of stigmatizing and caring attitudes, which the community members drawn on in engaging with individuals living with mental disorders (and their families), as shaped by type of condition and proximity of sufferers to community members. Accordingly, individuals with ‘madness’ who are not from the communities are therefore othered and stigmatized as ‘mad strangers’.

These are in line with critically-informed studies from similar contexts that suggest that there are safe social spaces in poor and marginalized communities which can be leveraged for health development with such contexts (Mahr & Campbell, 2016; Mannell et al., 2018; Mathias et al., 2018). The complex co-existence of stigmatizing and empathizing attitudes is driven by differentiation representations of mental illness within the communities, that categorizes mental disorders into a hierarchy of strangeness and severity (Foster, 2001; de-Graft Aikins, 2012, 2015). At the deeper level, the findings offer practical insights into the need for fundamental awareness of the dynamic and complex nature of community social spaces within which mental health dialogues are formed, shaped and contested.

CHAPTER SIX

SOCIAL IDENTITIES AND MENTAL HEALTH WTHIN THE COMMUNITIES

6.1 Introduction

The third objective explored social identities shape mental disorders experience within the communities. The focus was to assess who is affected and how they are affected by mental health problems in the communities. First, perspectives of individuals and groups who are affected and how they are affected by mental health problems in the communities were also explored. Next, social group memberships and the benefits and problems they pose were also examined. Lastly, identification of social groups and its association with mental illness symptoms were tested. The findings are presented in three thematic areas; (i) groups affected by mental illness/mental health problems, (ii) group membership and the benefits/problems they pose, and iii) social group identification and mental illness symptoms.

6.2 Groups affected by mental illness/mental health problems within the communities

This section draws on the qualitative data to identify individuals and groups who are affected and how they are affected by mental disorders in the communities. In tracking the content, sources and functions of participants' representations, it becomes clear how mental disorders experience and stigma operates from the perspectives of six groups of individuals emerged; people living with severe mental disorders, men experiencing depression, young men who use drugs, caregivers of people living with mental disorders, minority ethnic groups and tenants, and lay health people with recurring psychosocial struggles.

People living with severe mental disorders

First, people with severe mental disorders do not received the needed quality of care and treatment due to poverty. Widespread poverty emerged strongly as an overarching material condition which shape every day experience of living with mental disorders within the communities. There are high levels of unemployment and underemployment within the communities, and the few individuals who work receive low income. Thus, poverty levels are high not just at the community levels, but also more critically at the family and individual levels. This shapes the quality of care and treatment that individuals living with mental disorders within the communities receive:

A 42-year-old mother in Usshertown who has a 12-year old son with undiagnosed mental disorder for instance recounted how poverty has prevent her family from seeking treatment for her son:

> *Every time people tell us to take her to the hospital, as if we don't know that she needs hospital. But where is the money for that. My husband doesn't work and me too because of her, I used to sell things small small but now I don't go, so where is the money to take her to the hospital? The health insurance too, it doesn't cover this [KII -3]*

A 71-year old male local community leader in Jamestown also recounted a situation where poverty has prevented a family, he knows from seeking treatment for their relative with signs of mental illness:

> *One boy is mentally sick in our house like that but there is no money to take care of him. The problem is money. They don't have money. The parents don't work. It is only one of their daughters who sell things at the market and they use the money to take care of the home. So, there is no money for them to take him to the hospital. They use herbal medicine, and there is a pastor that they take him to. So, far, that is how they have been have been managing it [*KII-1]

A female mental health nurse at Usshertown also laments how poverty prevents members of the community from seeking treatment for people with signs of mental illnesses:

> *In this community, the poverty levels are too high. Even the money to feed, they don't get and so when someone is mentally sick, they don't bring the person to the hospital [*KII-*10]*

Again, individuals living with mental disorders also face restricted access to some shared communal facilities such as public toilet and water facilities. For instance, individuals with mental health problems are sometimes denied access to (public toilet facilities) for reasons that they dirty it, or water facilities for reasons that they will spoil it. Two mothers recount how their children with mental disorders are constantly prevented from using public toilet facility in their neighbourhoods. Both parents are not able to tell what conditions their children live with because they have not been formally diagnosed. One of the children [a 14-year old girl, who from personal observation, shows signs of schizophrenia]:

> *The public toilet here, they don't allow him to use it. Can you imagine? Anytime he goes there, they sack him because they say he will dirty the place. We have done all we could, but because we are not from this community, they don't mind us. Now he goes to toilet in the room and we take to throw away. Sometimes in the evening too, he will go to the beach [*KII-6]

> *It's not everywhere that they will allow her to go. Even some public places like the public toilet they don't allow her. I can't even send her to fetch water for me, even though she can. When she goes, they will say no and that she might destroy the pipe [*KII-3]

Men experiencing depression

Men who live with depression are found to experience constantly being teased for experiencing mental disroder that is seen as women's condition. The 45-year old man in Jamestown who attempted suicide as a result of depression for instance recounts how he is constantly teased:

KII-8: Ohh…..we all know that thing is for women. They like crying. But for a man to experience it, I was even embarrassed. Some of my friends even till now they tease me. They will ask you, has your depression come?

Another participant – a 30-year-old woman at Usshertown also recounted how a man in her neighbourhood who was pushed to commit suicide because of constant teasing by neighbours due to impotence and depression:

In our neighbourhood, somewhere July or August [in 2019], one man tried to kill himself. He drank DDT but someone found out and they rushed him to the hospital. He didn't die. That man everyday, people are teasing him that he is impotent. Some ladies spread that rumour last year and since then people teased him. So, he became depressed and wanted to kill himself. He stopped talking to everybody and then they teased him that he is a woman because he can't stand teasing. There are stories like that where people are always teasing and insulting men who are impotent. The pressure can be too much on them [SC-P10]

Young men who use drugs

The young men who use drugs in the communities are associated with 'madness' by adult community members. A 41-year old man in Jamestown for example indicates that the young men who use drugs are mad:

In this community, I would say drug abuse. The young people here use drugs too much. When you see them, you see that they are mad, but it's the drugs that have made them like that [FGD-JTM6]

A 73-year old community leader in Usshertown also lamented how all the young men who use drugs in his neighboorhood have all gone mad:

They [those who use drugs] are all mad. I see them here all the time, totally mad. When you advise them to stop smoking, they don't listen [KII-2]

A 42-year old woman in Jamestown also associated young men who use drugs to madness:

Its through tramadol and some of these hard drugs. When they use the drugs too much, it cause mental illnesses. They are mad and just roaming about [FGD-JTM3]

Caregivers of people with mental disorders

There are also caregivers (of people with mental disorders) whose mental health are compromised by other structural level factors. In the communities, caregiving appears to be reserved for women. However, most of these women are also entangled in complex structural factors such as poverty or cultural expectations of marriage, which compromise both their wellbeing and caregiving.

A 39-year-old woman, who is the only daughter in 4 siblings, taking care of 71-year-old mother with dementia, Usshertown, recounts how she feels trapped in her caregiving role due to the fact that she is not married:

> *If you are a woman here and you are not married, it is difficult living in this community. The pressure they put on you, it is as if you have decided not to get married. Teasing you and calling you names every day. Sometimes I just want to leave the community and go somewhere else where nobody knows me. But because of my mother that I am taking care of, I can't go. Every day is stressful for me because I don't have a husband [KII-4]*

Another caregiver – 38-year-old woman caring for her mother lamented how burden of caregiving and poverty compromised her social engagement in group activities:

> *I am taking care of my mother. She is old and sick too so I always have to be at home to be able to take care of her. Because of that I am not even able to work, how much more going to meetings. Some of my group members are always accusing me of not being active in the group but me I don't mind them* [KII-5]

Minority ethnic groups and tenants with severe mental illness

Housing and accommodation challenges also shape the experience of living with mental disorders within the communities, particularly for minority ethnic and tenant households. Housing conditions within the communities constitute a major challenge. Household sizes are

large, in the midst of limited residential accommodation. The communities are therefore characterized by overcrowded bedrooms and crowded compounded houses. This has led to the increase in wooden structures as bedrooms, which themselves are also overcrowded. For this reason, accommodating individuals with mental disorders in the home is very challenging within the communities. The situation is more pronounced for tenants and migrants who live with or have family members living with mental illness. When it comes to tenants, landlords do not accept the individuals with mental illness living in the house. Most tenants also tend to be migrants, who usually lived in rented rooms compared to natives who usually lived in family houses or rent-free rooms. Thus, for tenants in general and migrant tenants in particular, they lose their accommodation when mental illness strikes:

A 42-year old woman who is an Asante and a tenant recounted how she had to send her child to live with the mother in her village because the landlord did not want her in the house:

> *When his condition started, he started being a bit violent and hostile. The family head, he is the landlord, he called us and told us that they can't live with him anymore so I should find a place for him to stay. If someone tells you this, you know that he wants you out of the house because of your child's condition. [*FGD-UTF4]

A woman who also provides care for her brother who live mental disorder recounts accommodation challenges:

> *We are many in the room. There are small children as well and we all sleep in the same room. My parents sleep on the bed and we and the small children sleep on the floor. Sometimes he wakes up at night and maybe want to go and urinate. The last time he almost stepped on one child's head. Anytime he wakes up I wake up as well because I sleep close to him. I saw it and the way I shouted, everybody woke up. The crowded room makes it difficult for us to live with him [*KII-4]

Another woman in Jamestown also recounts challenges they face with co-tenants as a results of her brother being addicted to drugs:

*The house where we live, they are always fighting with us to live because of my brother is a drug addict. But what can you do, house is not like a box that you can easily travel with yours. As long as you live in someone's house, there is nothing you can do [*SC-P8]

Lay healthy people with recurring psychosocial struggles

There are also lay healthy community members whose mental health are compromised by structural poverty, exposing them to recurrent psychosocial problems. For example, A 42-year-old single mother of 4, with additional responsibility of caring for ailing mother and 2 young siblings recounted her struggles:

Here, people think too much. Me for instance I will not be telling the truth if I tell you I don't think. Every night I am not able to sleep because the pressure on me is too much. I alone am taking care of my 4 children, my sick mother and 2 small siblings. The food I sell too, my capital is not much. The stress is too much for me [FGD-JTF3]

A fisherman in Usshertown, married with 2 children, and 3 other children with two other women also recounts his recurrent psychosocial stress:

In this community, we struggle too much. There are no jobs, no money, nothing. It makes life too difficult. So, there are so many people who are frustrated and hopeless here. Me, every day is frustration for me. Every little thing and I am getting angry. Is not our fault, but what can you do? All these are part of what cause illness in the mind [FGD-UTM1]

6.3 Social group membership and the benefits/problems they pose

Participants' memberships and engagements in social groups within the communities were explored using qualitative approaches. The findings from the study are presented on Figure 6.1. As shown on Figure 6.1, the findings are presented in three overarching areas; (i) the types of social groups the members belonged to, (ii) motivations for joining social groups, and (iii) tensions within social groups.

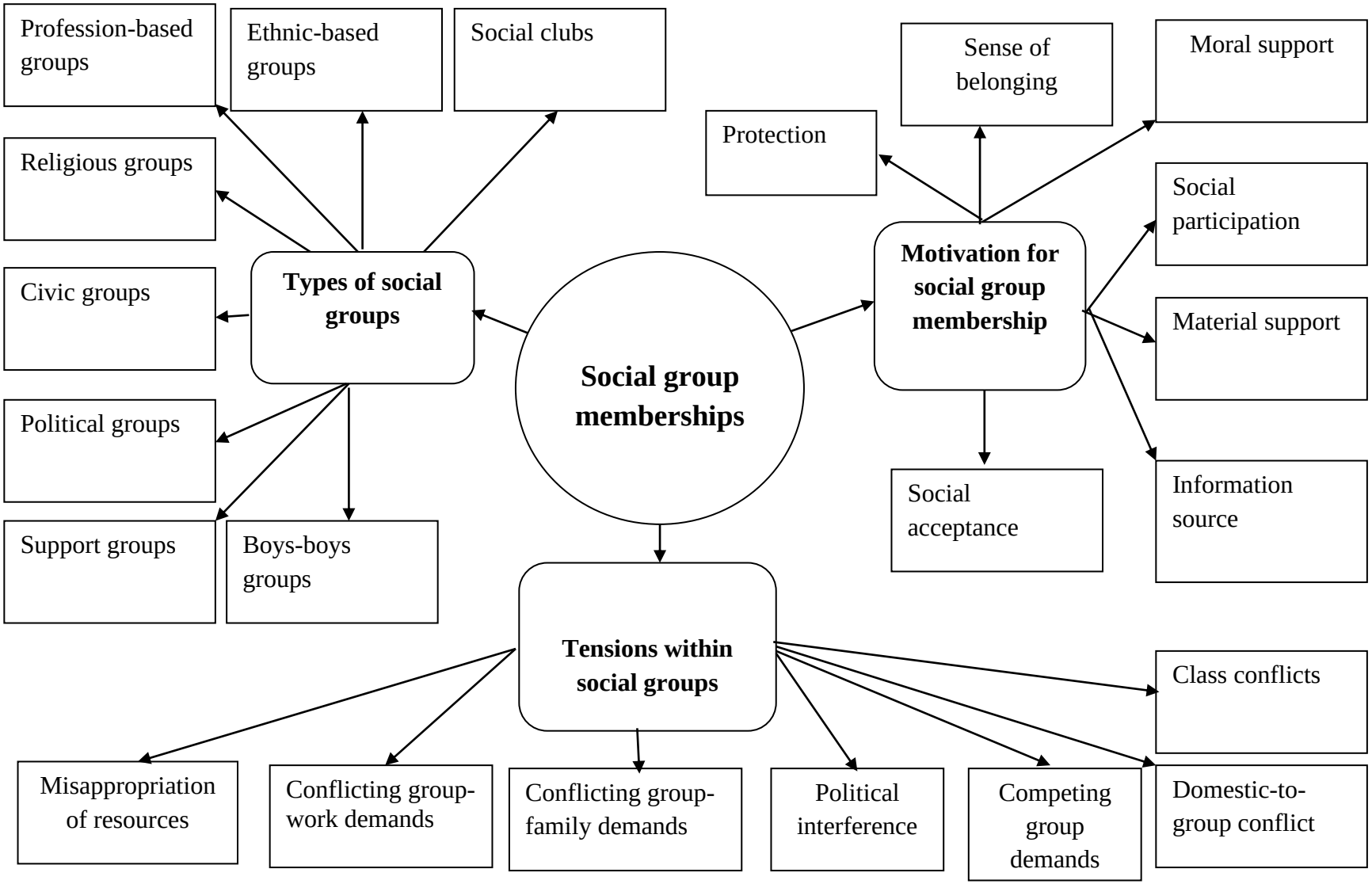

Figure 6. 1: Social group memberships among the participants

6.3.1 Types of social groups

The types of social groups that the participants belonged to was first examined. Findings (as shown on Figure 6.1) showed eight thematic social groups that participants belonged to. These included; profession-based groups, religious groups, support groups, civic groups, political groups, ethnic-based groups, social clubs and 'boys-boys' groups. The nature of each group, description of groups, sample group name, and demographic compositions of each groups are provided on Table 6.1.

Table 6. 1: Description of types of social groups

Types of social groups	**Description**	**Sample groups**	**Composition**
Profession-based groups	Organized around the economic and livelihood activities that participants are engaged in	Fishermen Association Butchers Association Market Women Association Greater Accra Amateur Boxing Association (GAABA) *Ga* Shifimo Kpee (*Ga* Standfast *Association*) Young Boxers Movement Artists' Club	Cuts across men and women of all working ages
Religious groups	Organized around the religious beliefs and practices of participants	Men's Fellowship Women's Fellowship Pentecost Prayer Group Pentecost Youth Susanna Wesley Global Women's Fellowship	Cuts across men and women of all working ages
Support groups	Organized around collective health needs of participants	James Town Health Club (JHTC) Basic Needs	Predominantly older women
Civic groups	Organized around social participation agenda of participants for their communities	Ga-Mashie Youth for Change Act for Change Gumption Social Club Hope for Humanity New Generation Red Cross Society Great Thinkers	Mainly young men and women
Political groups	Organized around participants'	NPP Youth NDC Youth	Mainly young men and women interest in

	political interests and ideologies	Young Progressives Concern Youth	political issues
Ethnic groups	Organized around ethnic identities of participants	Association of Asantes Ewes' Group Northerners' Association	Men and women of all ages
Social clubs	Organized as fun clubs around social interests and leisure activities of participants	Drama Fun Club Dromo Fun Club Such Is Life Fun Club Wuutie Fun Club Rock Fun Club Atinka Fun Club	Mainly young men and women
Boys-boys' groups	Organized as young fraternity for protecting members' safety and group territory	Boko Haram Roman Boys Roma Academy Road Close Water Boys Nothing Bhard Boys	Mainly young men between the ages of 16 – 30 years

6.3.2 Motivations for social group membership

The reasons or motivations for joining social groups were also explored among the participants. Findings (see Figure 6.1) showed that motivation for joining social groups included seven themes; sense of belonging, source of information, social acceptance, protection, emotional support, social participation, and material support. Table 6.2 provides spread of themes.

Table 6. 2: Spread of dominance themes in motivations for joining social groups

Themes	Key informants	Male FGDs	Female FGDs	JTHC	Situated Conversations
Sense of belonging	+++	+++	+++	+++	+++
Source of information	+	+++	+++	+++	+++
Social acceptance	n/a	+	+	+++	+
Protection	n/a	+	+	n/a	+
Emotional support	+++	+++	+++	+++	+++
Social participation	+++	+++	+++	+++	+++
Material support	+	+	+++	+++	+++

+++ theme mentioned agreed by at least half of participants of the group; **+** theme mentioned by few members in the group; **n/a** theme did not emerge in the group

Sense of belonging

Sense of belonging emerged as a strong thematic motivation for joining social groups. Narratives from participants from all the groups interviewed indicated that humans cannot live in isolation, which makes belonging to groups is essential in life for human beings. For this reason, they join groups within their communities as means of fulfilling that need:

> *Oh, errm…I will say that I join the groups because as human as we are, you cannot say that you will live life without joining any group at all. At least, as for one or two groups, you have to join. That is what makes us human. So, for me…yea, that is why I join [FGD-JTM2]*
> *Ok I understand that. First, my reason for joining the groups is because sometimes, it is good to know that you belong to groups. At least, that way, when you are there, you know that you are not alone. It is one of the reasons that I join groups [SC-P4]*
> *When you belong to a group, you cannot be alone. At least you will attend meetings and meet your friends and group members. So, for me, it is good to belong to groups, that is why I join [SHG-P11]*

Source for information

Source for information also came up as among the reasons why the participants belonged to social groups. Majority of participants from all the five groups interviewed indicated that belonging to groups ensures that there is always access to information and knowledge, which makes them become abreast with the world around them. These are exemplified by sample quotes below:

> *I joined groups here because when you belong to a group, at least you always get information about what's happening in the community (*SC-P2*)*

> *As for me, I joined the group because there are a lot of good and informative discussions that go on sometimes. We discuss a lot of things such as politics, education, savings, and several things. It helps me to learn a lot [FGD-JTM4]*
> *Oh, I also joined because they give us knowledge on how we can control our BP. Every month, we discuss different things. Sometimes we talk about diet, exercise, drugs and many things. I am learning a lot that is why I joined [SHG-P17]*

Social acceptance

Social acceptance also emerged as one of the thematic motivations why participants joined social groups. Narratives from participants from four out of the five groups interviewed indicated that they were drawn to groups that accept who they are unconditionally. For others, they joined groups where members had similar health conditions so that there is a feeling of acceptance. This is reflected in the sample narratives below:

> *Here, everybody says am a prostitute. But when am with my group, nobody judges me. I am accepted [*SC-P3]
>
> *When we meet, we all have the BP so when you are there, you don't feel any kind of different. We are all the same because we all have BP so you don't feel different [*SHG-P13]
>
> *We are all young guys trying to do the same thing. We all want jobs and we all want our life to get better. Because of this when I go for meetings, I feel ok. I mean, nobody will make you feel bad for not having a job to do. We all talk and laugh and do everything together [*FGD-UTM4]

Protection

This theme emerged from three out of the five groups interviewed. The participants, particularly young men indicated that they joined groups to protect them against violence of other community members. For them, one a member is attacked, their group members will retaliate on their behalf, which makes them always feel protected:

> *When someone attacks you, the members will attack the person too (*FGD-UTM3*)*
>
> *If you don't have a group that can step in to protect you, what will you do if somebody abuses you or your sister. As for my friends, if you touch one person, you have touched all of us. Yea…we protect ourselves like that [*SC-P2]
>
> *The reason why I joined is that as for the ladies, like when your boyfriend or any guy beats you badly, they will go and do the person wild. Me too, my boyfriend was beating me always so I went to join them. We he beat me again, they went and gave him a strong warning….he broke up with me but I don't care. We protect ourselves from abuse [*SC-P3]

Moral support

Another thematic motivation for joining social groups was moral support. This theme emerged from all the five groups interviewed. The participants indicated that they joined groups so they can get people to support them during occasions like weddings, funerals and outdooring:

> *When you are bereaved, we all in the group will come and mourn with you. We contribute and make donation and we all dress the same way to mourn with the person. You when it happens like that, at least you can take heart [FGD-UTF4]*
>
> *It is good to join groups. At least, when you are doing something like wedding or funeral, you get people to come and support you. But if you are not in any group, who will come? That is why l joined the group [FGD-JTM5]*
> *In this life, we all need people sometimes. Sometimes when life becomes very difficult or when you need people around you. Let's say you lose a relative, at least you need people who will come and mourn with you and comfort you. When you are in a group, they will do that for you [FGD-JTF4]*
> *Oh yes. I joined so that when I am getting married, I will get people to come and support me. We do that for all the members. Things like weddings, outdooring, funerals, even birthdays. We go and celebrate with the person [SC-P10]*

Material support

Material support also emerged as an important motivation for joining social groups. This theme emerged from all five groups interviewed. The participants spoke of the material support they get from belonging to their social groups, which attracted them to join. The material support came in the form of subsistence allowances, renewal of health insurance, supply of drugs and provision of foodstuffs:

> *I joined because they do health insurance for us free. Sometimes they asked all those whose health insurance have expired and they ask us to bring it, then they renew it for us [*SHG-P15]
>
> *For our groups, sometimes the MP comes and give us something small [money] to share. So, it helps us [*FGD-UTM2]
>
> *I joined the group because sometimes they bring us foodstuffs to feed our children [FGD-JTF1]*

6.3.3 Tensions within social groups

The everyday dynamics of groups interactions were explored among the participants. Findings revealed social groups in the communities are characterized by inherent tensions. As shown on Figure 6.1, the tensions within social groups cohere around seven thematic areas; misappropriation of funds, conflicting group-work demands, conflicting group-family demands, political interference, competing group demands, Domestic-to-group conflict and marginalization. Table 6.3 describes the spread of themes across the groups interviewed.

Table 6. 3: Spread of themes on sources of tension in social groups

Themes	**Key informants**	**Male FGDs**	**Female FGDs**	**JTHC**	**Situated Conversations**
Misappropriation of resources	+++	+++	+++	+	+++
Conflicting group-work demands	+	+++	+	+	+++
Conflicting group-family demands	+	n/a	+++	+	+
Political interference	+	+++	+	n/a	+++
Competing group interest	+	+++	+	n/a	+
Domestic-to-group conflict	n/a	+	+++	+	+++
Class conflicts and marginalization	+	+	+++	n/a	+++

+++ = theme mentioned agreed by at least half of participants of the group; + = theme mentioned by few members in the group; **n/a** = theme did not emerge in the group

Misappropriation of group resources

Misappropriation of group resources emerged as one of the key tensions that characterize social groups within the communities. Narratives from participants across all the five groups interviewed suggested that the executives of the groups, particularly the political groups, they belong to always appropriate resources meant for the groups for their personal gains. Group resources were defined both in material and symbolic terms. The material resources were defined in terms of financial or any physical materials that are meant for the groups:

> *When the MP brings us money, they [executives) share without giving us some. Sometimes, some of we the members complain. The last time for instance, some of the group members went to the MPs office to complain, and the executives said we have betrayed them. This keeps happening always [*SC-P7]

> *During every Christmas and Easter, some people bring us rice and other things to use to celebrate. However, the executives will keep all the items and give us only one one rice each. We always complain about it and because of that some members have even stopped coming for meetings* [KII-1]

Symbolic resources were defined in terms of opportunities, recognition or even taking individual photographs with some influential figures associated with the groups:

> *Sometimes, the MP will tell the executives to bring names of members who are unemployed and looking for jobs. Before you know it, the leaders will put in names of their family members, some of whom are not even members of the group, and they will send the list to the MP without the members knowing [*FGD-JTM3]

> *The people, they sometimes come and take some children in this communities out to other areas of Accra and even buy books for them. The woman who they have chosen to select the children eh, she will include all her grandchildren but when you want to include your grandchildren too, then she will say the number they are looking for is up* [FGD-UTF4]

> *When some influential person visits us in our meeting, we take pictures with the person as a group, and after that the leaders will also take pictures together with the person. Then each of the leaders will also take a personal picture with the person. But when the members want to also take personal pictures with the person, then the leaders oh no it will delay the person's time. That thing the way it angers the members paa eh* [SC-P7]

There are times some people visit us from abroad and when they come, you will see the leaders, they act as it they own the white people. Like, as if they will take them go abroad. They don't allow members to even have personal chats with them [FGD-UTF5]

Conflicting group-work demands

Conflict arising between demands of work and group activities also emerged as another key source of tensions and conflict within social groups in the communities. Participants from all the five groups indicated that for some of them, their job demands sometimes do not allow them to participate in the activities of their groups and other members always feel aggrieved:

You see, when you say you join a group, then you join a group. For some people, they will never come to meetings or even when we are going to a funeral or anything like that, you will never see them. The excuse they keep giving is that because of their work it is difficult for them to come. As if the rest of us we don't work [FGD-JTM3]

Sometimes I don't attend meetings. The time for the meeting is not always favourable for me. The things I sell, people buy them in the morning, and every month too the meetings we have are in the morning. So, it is difficult for me to attend meetings [FGD-JTF3]

Me, one fun club like this, I have stopped attending meetings. The meetings times did not favour the kind of work I do so I stopped [FGD-UTM7]

Conflicting group-family demands

The participants from four groups indicated that sometimes demands from their family obligations conflict with demands of their groups, and that always create tensions for them and other group members:

I have small children so I always have to be at home to take care of them. Because of this when we are going for programs or other activities that are not in this community, I am not able to join them. Yesterday like this, they went for a funeral at Bubiashie but I couldn't go because of my children. When you explain to them too, they don't want to understand. Even this morning I told one of our leaders that the way some members are doing, I will stop the group and he said I shouldn't think like that because some members always want to pick fights [FGD-UTF3]

I am taking care of my mother. She is old and sick too so I always have to be at home to be able to take care of her. Because of that I am not even able to work, how much more going to meetings. Some of my group members are always accusing me of not being active in the group but me I don't mind them [KII-4]

Political interference

Interference from national political parties in the activities of the groups was came up strongly as a source of tension within the social groups in the communities. Narratives from participants from four groups suggest that some of the political parties always try to annex, for their own agenda:

> *When elections are coming then there's always conflict because different parties want to use us to do campaign* [SC-P2]
>
> *Sometimes, when we go for meetings, the representatives of the political parties visit and they want to talk to us. Sometimes NPP, sometimes NDC. And you know that members to have their different parties and that always create confusion* [FGD-UTM5]
>
> *As for our group, it is politics that is killing it. So, many people have stopped the group because the politics has become too much [*FGD-JTM6]

Competing group demands

Competing group demands was also seen as a source of tension within social groups in the communities. Narratives from participants from four groups suggested that, for those who belong to two or more groups, they are not able to meet all the demands of all the groups and that is a source of stress for them and their groups:

> *I am even planning of stopping some of the groups. Right now, I belong to four groups and they all have meetings and other things every week. If you decide to go to all of them, then you will spend all your week on the groups and not do anything for yourself [*FGD-JTF2]
> *It is difficult when belong to different groups. Some of our members for instance, you don't see them at our activities, but you will see them in other groups' activities. So, what that does that tell you? If you ask them to leave the group too, then they are angry [*FGD-UTM6]

Domestic-to-group conflict

Domestic-to-group conflict also emerged as another source of tension for the groups. Participants from four groups indicated that because the communities are traditional ones, group members are

mostly relatives or extended relatives, and they always bring domestic matters into their social groups. There were also instances where participants brought issues within their neighbourhoods to meetings:

> *When people have conflicts at home, then they bring it here. It always creates confusion [*FGD-UTF5]

> *Last week, two women fought during our meeting. We had to just close. They were sister in-laws and they have issue at home, then they carried the issue to the meeting. Such things happen a lot here [*FGD-JTM2]

> *Some people are not able to understand that what happens at home remains there and what happens at meetings remains at meetings…. Our group members always live close to each other at home. Sometimes you can get four or five members living in the same house. Because of this, they easily bring conflict at home to meetings and also carries conflicts at meetings home……[* FGD-UTM1]

Class conflicts and marginalization

Class conflicts emerged as a strong source of conflict and tensions in the groups. Participants from four groups indicate that it is easy for some group members to show disrespect towards other group members for various reasons, particularly non-payment of group dues. Others use their social status to marginalize opinions of others and that create tensions and confusion:

> *These days I don't go [for meetings] because some people talk to you anyhow….[* FGD-UTF4]

> *You see, let's say we have gone for meeting today and there is a problem that we are all trying to solve. Those who have made themselves like they have been to school a little, they always behave as if those who didn't go to school don't have sense in our heads. Everything you say, they disregard it [*FGD-UTF1]

> *Oh, as for the groups, that is how it is. If you are rich, the way they treat you is different from if you are poor. There is one woman whose children are abroad. For her, everybody respects her but people like me who is poor, even when you are sick, nobody checks on you. But for her, if she doesn't come for meetings, the leaders will ask other members to check on her [*FGD-JTF5]

6.4 Association between social groups membership and mental illness symptoms

This section draws from the survey data to assess how membership in and identification with social groups were associated with depressive and anxiety symptoms. Table 6.4 shows the bivariate correlations, means and standard deviations of variables. Depressive symptoms had significant positive correlation with number of groups ($r = .32$, $p < .01$) and identity centrality ($r = .59$, $p < .001$); but was negatively correlated with identity satisfaction ($r = -.50$, $p < .001$), identity homogeneity ($r = -.42$, $p < .01$) and identity solidarity ($r = -.52$, $p < .001$). Anxiety also had significant positive correlation with identity centrality ($r = .59$, $p < .001$); but was negatively correlated with identity satisfaction ($r = -.36$, $p < .01$), identity homogeneity ($r = -.32$, $p < .01$) and identity solidarity ($r = -.39$, $p < .001$).

Table 6. 4: Correlations, means and standard deviations

Variables	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
1. Depression	-								
2. Anxiety	.67**	-							
3. Number of groups	.32**	.08	-						
4. Frequency	-.07	-.04	-.07	-					
5. Centrality	.59***	.49**	.27**	-.15**	-				
6. Satisfaction	-.50***	-.36**	-.22**	.05	-.53**	-			
7. Stereotyping	.02	.09	-.11*	.09	.15**	.23**	-		
8. Homogeneity	-.42**	-.32**	-.19**	-.06	-.21**	.39**	.26**	-	
9. Solidarity	-.52***	-.39**	-.17**	.02	-.46**	.31**	-.013	.43**	-
10. Age	.24**	.19**	-.06	.03	.06	-.09	.06	-.09	-.06
11. Gender	.04	.07	.01	-.01	-.06	.06	.010	.03	.06
Mean	***4.77***	***3.67***	***2.52***	***3.07***	***5.16***	***6.16***	***7.54***	***5.37***	***6.66***
SD	***3.80***	***2.72***	***1.14***	***2.59***	***3.02***	***3.15***	***2.55***	***2.32***	***2.63***

Notes: *p < .05; **p < .01; ***p < .001

Table 6.5 provides hierarchical multiple regression results of the association between social identification and depressive and anxiety symptoms.

Table 6. 5: Regression results of social identities predicting mental illness symptoms

		Model 1		**Model 2**	
		Depressive symptoms [a]		**Anxiety symptoms [b]**	
Step		**SE**	**β**	**SE**	**β**
1	Usshertown	-.778	-.100*	-.258	-.046
	Females	.003	.010	.373	.218**
	Age	.020	.003	.034	.179**
	Tertiary education	-3.065	-.387***	-2.196	-.387***
	Migrant ethnic groups	1.799	.226***	.332	.430
2	Number of groups	.121	.127**	.102	.085*
	Group stigma	.293	.146**	.245	.112**
	Stereotyping	.061	.056	.051	.069
	Homogeneity	.069	-.165**	.058	-.164**
	Centrality	.061	.257***	.051	.272***
	Satisfaction	.055	-.145**	.046	-.065
	Solidarity	.061	-.191**	.051	-.088

**** p < .05, ** p < .01, *** p < .001***

[a]Step 1: R = 467, R^2 = .218, F (3, 371) = 33.871, p < .001
Step 2: R = .772, R^2 = .596, F (11, 360) = 47.661; p < .001, ΔR^2 = .377; ΔF (8, 356) = 41.521; p < .001

[b]Step 1: R = .515, R^2 = .265, F (3, 371) = 43.719, p < .001
Step 2: R = .666, R^2 = .443, F (11, 360) = 25.791; p < .001, ΔR^2 = .179; ΔF (8, 367) = 14.282; p < .001

Model 1 significantly predicted depressive symptoms, explaining a total of 59.6% variance (R^2 = .596; F = 47.661, p < .001). In step 1, the control variables together significantly predicted depressive symptoms (F = 33.87, p < .001), accounting for 21.8% variance (R^2 = .218).

At step 2, social identity significantly predicted depressive symptoms (ΔF = 41.521; p < .001), explaining additional 37.7% variance (ΔR^2 = .377). Specifically, multiple groups (β = .127, t = 3.49, p < .01), group stigma (β = .146, t = 4.01, p < .001) and identity centrality (β = .257, t = 5.38, p < .001) were significantly associated with high depressive symptoms. On the other hand, ingroup homogeneity (β = -.165, t = -3.98, p < .001), satisfaction with group (β = -.145, t = -3.21, p < .01) and perceived solidarity (β = -.191, t = -4.58, p < .001) where significantly associated with lower depressive symptoms.

Model 2 also significantly predicted anxiety symptoms, accounting for a total of 44.3% variance (R^2 = .443; F = 25.791, p < .001). In step 1, the control variables together significantly predicted anxiety symptoms (F = 43.719, p < .001), accounting for 26.5% variance (R^2 = .265). However, only education had significant effect on anxiety symptoms, having tertiary education had significant negative association with depressive symptoms (β = -.317, t = -6.89, p < .001). At step 2, social identity significantly predicted anxiety symptoms (ΔF = 14.282; p < .001), explaining additional 17.9% variance (ΔR^2 = .179). Specifically, multiple groups (β = .085, t = 1.98, p < .05), group stigma (β = .112, t = 2.63, p < .01) and identity centrality (β = .272, t = 4.86, p < .001) were significantly associated with high anxiety symptoms. All the other dimensions of social identification did not have significant association with anxiety symptoms.

6.5 Discussion

This chapter assessed social identities and how they influence mental disorders experience in the communities. Social identity is critical to mental health. Membership in and identification with social groups are argued to be capable of exerting complex and double-edged impact on individuals, either enhancing or undermining their mental health (Campbell, 2014; Jetten et al., 2017). First, the findings show how material realities shape mental illness experience of individuals living with mental disorders and their families in the communities. Housing and accommodation challenges also undermine proper care for individuals with mental illness, particularly among tenants and migrant households. People living with mental disorders also encounter restricted access to salient shared communal facilities as public toilet and water.

The material conditions of living with mental disorders pose challenging task to community-based mental health delivery. This aligns with previous studies in similar community contexts which suggest that widespread poverty and material deprivation undermine local community competence in addressing collective health problems (Campbell et al., 2013; de-Graft Aikins et al., 2020; Gibbs et al., 2015; Mahr & Campbell, 2016; Read et al., 2010). With increasing calls to deinstitutionalize mental health delivery, navigating decent housing and accommodation for individuals living with mental disorders as they receive treatment and care is critical. In poor communities such as Jamestown and Usshertown, which have housing and accommodation crisis at the community level in general, decent accommodation for individuals with mental disorders pose a challenging task to right-based approach to community mental health.

Further, the findings show high levels of engagements with social groups within the communities. The types of social groups that participants indicated being members of included profession-based groups, religious groups, support groups, civic groups, political groups, ethnic-

based groups and social clubs. These suggests that participants highly engage in interactive social groups. This is important because the type of social groups that individuals belong to have implications on how social identification impact on their mental health (Campbell, 2019; Campbell & Burgress, 2012; Cruwys et al., 2014; Greenaway et al., 2018; Sani et al., 2010). Research suggests that identification with interactive social groups have higher impact on mental health than identification with non-interactive social groups (Greenaway et al., 2018; Sani et al., 2010).

The social groups offered double-edged impact on the mental health of the participants. On one hand, social groups provided significant psychosocial support for the participants. They join these social groups for several reasons. The qualitative findings showed that the motivations for joining the social groups include; sense of belongingness, source of information, protection, emotional support and material support. These findings suggest that social group memberships are used as conduit for meeting interpersonal needs (both material and symbolic), interpersonal needs (e.g. consensual validation, self-preservation, emotional support), and social and civic needs, through social participation These groups provide spaces for youth, adult men and women, older women. The spaces are supportive and protective. However, there are limited social groups that deals specifically with older men.

On the other hand, social groups were sites for tension. Social groups memberships are characterized by inherent tensions, cohering around; misappropriation of funds, conflicting group-work demands, conflicting group-family demands, political interference, competing group demands, Domestic-to-group conflict and marginalization. There were fundamental class conflicts within the groups, where people with more education and money look down on those without. This is important because it illustrates the heterogeneity of identities in the communities

– not everyone is poor and uneducated. This align with critical social psychology literature that there are heterogeneities of identities with often competing interests in local communities (Howarth, 2001; Howarth et al., 2013). The tensions associated with heterogeneity of identities occur at different levels within the communities. At the group level, the study survey highlights how belonging to groups can be simultaneously positive and negative. The negativity is linked to social legitimation, which dictates which group is seen as legitimate or not by the broader community.

The findings also show how different groups get stigmatised. For example, youth engaged in substance use/abuse are associated with mental health problems; mental health problems and people living with mental health problems are stigmatised, depending on how serious their conditions are. The findings contradict mainstream literature that belonging to multiple groups is protective of mental health (Lam et al., 2018; Miller et al., 2015; Sani et al., 2015), but align with the few critical psychology studies that suggest that social group membership double-edged impact on mental health (Campbell, 2014; Howarth et al., 2013).

At the interpersonal level, there are tensions between individuals protecting their own, caregiving and on marital tensions. These tensions compromise the mental health of caregivers of people with mental disorders. For example, the demands of caregiving make some caregivers feel trapped in their caregiving role within the communities. The family and home are safe spaces for people with mental health problems, ultimately care occurs at this level, but is compromised by the other levels and especially by structural poverty. The qualitative findings show that widespread of poverty shape access to treatment and care for individuals with mental illness.

CHAPTER SEVEN

SOCIAL CAPITAL AND MENTAL HEALTH

7.1 Introduction

The fourth objective explored power, which was defined as social capital of the communities. The focus was to assess existing and potential social capital that can be drawn on to build mental health competence in the communities. Following Campbell (2019), three forms of social capital were assessed – bonding, bridging and linking social capital. Bonding social capital focused on sense of solidarity in the communities which can be leveraged to build mental health competence, using the survey data. Bridging social capital focused on productive alliances between Ga Mashie and similar marginalised communities. The linking social capital focused on potential links that communities have with powerful external social actors who have access to material and symbolic structural resources that can help transform mental health needs of the communities.

7.2 Bonding social capital

For bonding social capital to function well, it is essential for connectedness to translate willingness of individuals to participate in mental health promotion in the communities. Therefore, the survey data was used to estimate a model to explain collective and individual strengths promote participation in mental health promotion in the communities. Figure 7.1 shows the hypothesized model estimated.

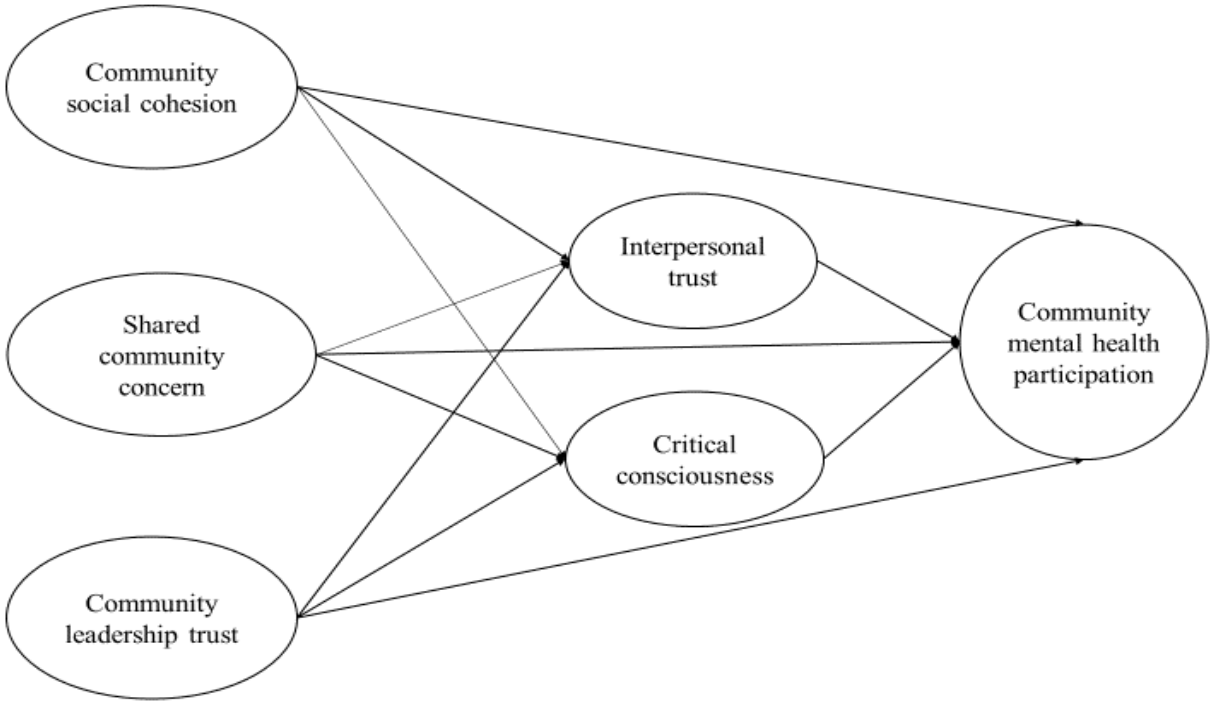

Figure 7. 1: Hypothesized model for community mental health participation

Table 7.1 shows a CFA test that compared the six-factor hypothesized model to other competing models. The CFA results (on Table 8.1) indicates that Model 1 better fits the data. In comparing model 1 to the other models, the measurement model showed a significant fit better than Models 2, 3 and 4. This suggests that the six factors are all distinct variables.

Table 7. 1: Confirmatory factor analysis of hypothesized model

Model	**χ^2**	**df**	**RMSEA**	**CFI**	**SRMR**	**$\Delta\chi^2$**	**Δdf**
Model 1 (six factors)	175.38***	169	.05	.96	.05	-	-
Model 2 (four factors)	399.04***	178	.08	.85	.09	223.66***	9
Model 3 (three factors)	429.94***	181	.11	.81	.10	254.56***	12
Model 4 (one factor)	777.60***	184	.12	.78	.13	602.22***	15

***p < .001; Notes: CFI = Comparative fit Index; RMSEA = Root mean square error of approximation; df = degrees of freedom; SRMR = Standardized root mean square residual, change in chi square for comparing models

Table 7.2 shows standardized loadings, composite reliability (CR) and average variance extracted (AVE) for the latent variables. The standardized loadings of all the items of each of the constructs were above .60. The AVE for each of the constructs were acceptable, all above the suggested limit (i.e. AVE ≥ .50). Also, the composite reliability (CR) of all the constructs were also acceptable, with the CR of each construct above the suggested limit of CR ≥ .70.

Table 7. 2: Standardized loadings, AVE and CR

Constructs	Standardized loadings	AVE	CR
Shared community concern		.66	.84
Item 1	.833		
Item 2	.807		
Item 3	.799		
Item 4	.777		
Item 5	.719		
Item 6	.717		
Community leadership trust		.64	.81
Item 1	.837		
Item 2	.823		
Item 3	.802		
Item 4	.790		
Item 5	.788		
Community social cohesion		.71	.88
Item 1	.782		
Item 2	.747		
Item 3	.736		
Item 4	.685		
Item 5	.654		
Interpersonal trust		.62	.77
Item 1	.822		
Item 2	.809		
Item 3	.717		
Critical consciousness		.64	.79
Item 1	.626		
Item 2	.652		
Item 3	.642		
Community mental health participation		.68	.81
Item 1	.866		
Item 2	.848		
Item 3	.830		
Item 4	.635		

Table 7.3 shows the descriptive statistics and correlations among the variables. There were significant correlations among variables. For example, community mental health participation is positively correlated with all the three hypothesized predictors; community social cohesion ($r = .11$, $p < .05$), shared community concern ($r = .48$, $p < .001$), and community leadership trust ($r = .31$, $p < .01$). Additionally, community mental health participation was also positively correlated with the two hypothesized mediators; interpersonal trust (r - .29, $p < .01$) and critical consciousness ($r = .54$, $p < .001$).

Table 7. 3: Correlation coefficients, mean scores and standard deviations

Variables	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**
1. CMHP	-										
2. CSC	.11*	-									
3. SCC	.48***	.20**	-								
4. CLT	.31**	.34**	.23**	-							
5. IT	.29**	.44**	.19**	.29**	-						
6. CC	.54***	.35**	.55**	.51**	.26**	-					
7. Age	.04	.17**	.04	-.15**	.12*	.01	-				
8. Gender	-.07	-.04	-.01	-.12*	-.21**	-.08	-.07	-			
9. Community	-.18**	-.39**	-.14**	-.19**	-.18**	-.19**	-.21**	.03	-		
10. Ethnic	-.29**	-.19**	-.15**	-.03	-.07	-.24**	-.24**	.44**	.12*	-	
11. Education	-.13*	.19**	-.04	.03	.07	.06	-.36**	-.02	.03	-.02	-
Mean	*11.42*	*14.91*	*18.12*	*16.44*	*8.63*	*9.18*	*34.38*	*.55*	*.56*	*.65*	*1.86*
SD	*4.33*	*5.19*	*4.88*	*4.32*	*3.01*	*2.01*	*14.37*	*.50*	*.50*	*.36*	*.87*

CMHP = Community mental health participation; CSC = Community social cohesion, SCC = Shared community concern, CLT = Community leadership trust, IT = Interpersonal trust, CC = Critical consciousness, *p < .05; **p < .01; ***p < .001

Table 7.4 shows the model testing results in determining the best-fitting model among different alternative structural models.

Table 7. 4: Comparing hypothesized model with alternative models

Model	χ^2	df	RMSEA	CFI	SRMR	$\Delta\chi^2$	Δdf
Model 1 (full mediation)	279.72***	269	.05	.97	.05	-	-
Model 2 (Direct model)	395.03***	275	.06	.91	.11	119.31***	6
Model 3 (Partial mediation)	255.31***	278	.08	.96	.09	24.41**	3

***p < .001; Notes: : CFI = Comparative fit Index; RMSEA = Root mean square error of approximation; df = degrees of freedom; SRMR = Standardized root mean square residual, change in chi square for comparing models

As shown on Table 7.4, Model 1 (full mediation model) was estimated where paths from social cohesion, shared concern and leadership trust to mental health participation were constrained to zero. The full mediation model showed a very good fit to the data. Afterwards, Model 2 (direct effect) was also estimated where paths from interpersonal trust and critical consciousness to community mental health participation were constrained to zero. However, direct effect (Model 2) showed a mediocre fit. The paths from community social cohesion, shared community concern and leadership trust to community mental health participation were significantly different from zero. The paths were all in the expected directions expect community social cohesion which was negatively associated with community mental health participation. Thus, shared concern and leadership trust were associated with high levels of mental health participation, whereas social cohesion was associated with low levels of mental health participation.

When Models 1 and 2 were compared, Model 1 showed a significantly better fit to the data than Model 2. Modes 1and 3 were then compared, in which paths from community-level factors (i.e. community social cohesion, shared concern and community leadership trust) to community

mental health participation, as well as paths from interpersonal trust and critical consciousness were freely estimated. The chi-square test produced significant differences between Model 1 and Model 3. Specifically, the degree of freedom for Model 3 (df = 278) was higher than that of Model 1 (df = 269). Therefore, based on the principle of parsimony, Model 3 was retained as the best-fitting model. The standardized path estimates and R^2 figures (in parentheses) for Model 3 are provided on Figure 7.2.

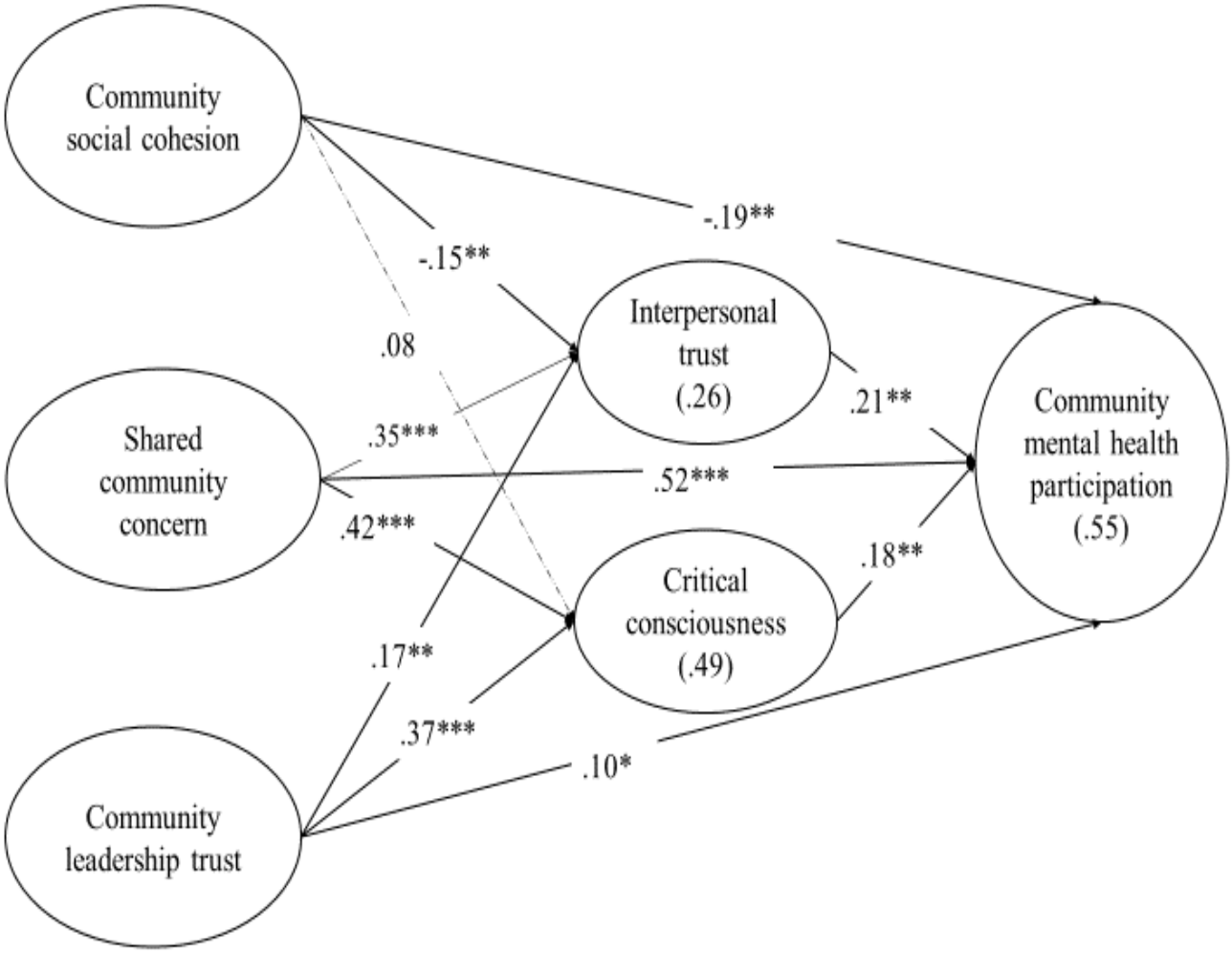

Figure 7. 2: Standardized path estimates and R square for partial mediation model

***p < .001; **p < .01; *p < .05; control variables not represented, R^2 values in parenthesis

The direct paths from community social cohesion to interpersonal trust (β = -.15, p < .001) was negative while to critical consciousness was not significant (β = .08, p > .05). These suggest that high social cohesion was associated with low interpersonal trust and has no effect critical consciousness. Direct path from shared community concern to interpersonal trust (β = .35, p < .001) and critical conscious (β = .417, p < .001) are both significant and positive. These suggest that high level of shared community concern is associated with both critical consciousness and interpersonal trust. Direct paths from community leadership trust to interpersonal trust (β = .17, p < .01) and critical consciousness (β = .37, p < .001) are both positive and significant. These suggest that high levels of leadership trust are associated with high levels of both interpersonal trust and critical consciousness.

Similarly, paths from both interpersonal trust (β = .202, p < .001) and critical consciousness (β = .178, p < .001) to community mental health participation were all significant and positive. These suggest that high interpersonal trust and critical consciousness are associated with high level of community mental health participation. Model 3 also showed further that the direct association between shared community concern (β = .523, p < .001) and community leadership trust (β = .098, p < .001) were both positive and significant, while the direct path from community social cohesion (β = -.193, p < .001) was negative and significant. These suggests that the paths from community-level bonding capital to mental health participation at the individual level are both direct and indirect.

When the mediation effect was examined, the standardized indirect effects of; social cohesion on mental health participation was -.27 (95% CI: -.21 - .33), shared concern on mental health participation was .37 (95% CI: .32 – 44) and leadership trust on mental health participation was .31 (95: CI: .29 - .41). Table 7.5 presents results Sobel's test of mediation effects.

Table 7. 5: Sobel test of mediation effects

Relationship	**Mediation effect**
Community social cohesion – interpersonal trust – community mental health participation	Z = -3.52, p < .001
Shared community concern – interpersonal trust – community mental health participation	Z = 4.88, p < .001
Community leadership trust – interpersonal trust – community mental health participation	Z = 2.14, p < .05
Community social cohesion – critical consciousness – community mental health participation	Z = -2.96, p < .01
Shared community concern – critical consciousness – community mental health participation	Z = 3.64, p < .001
Community leadership trust – critical consciousness – community mental health participation	Z = 2.00, p < .05

Table 7.5 showed that interpersonal trust (Z = -3.52, p < .001) and critical consciousness (Z = -2.96, p < .01) each both partially mediated the relationship between social cohesion and mental health participation. Similarly, interpersonal trust (Z = 4.88, p < .001) and critical consciousness (Z = 3.64, p < .001) each both significantly partially mediated the relationship between shared concern and mental health participation. Lastly, interpersonal trust (Z = -2.14, p < .05) and critical consciousness (Z = 2.00, p < .05) each both significantly partially mediated the relationship between leadership trust and mental health participation.

7.3 Existing mental health partnerships and alliances

This section presents findings on existing partnerships and alliances in the communities that are concretely acting on mental health development. The existing partnerships and alliances are provided on Table 7.6. There is a Department for Mental Health of the Polyclinic at Usshertown that provides out-patient care for people with mental disorders in both communities and surrounding communities. There are also some self-help groups that address mental health issues. For instance, Basic Needs has self-help groups for addressing the needs of people living with epilepsy in the communities. Jamestown Health Club (JTHC) also provides psychoeducation and psychosocial support in dealing with physical and mental health needs of individuals who live with chronic physical conditions such as stroke, hypertension and diabetes, and their caregivers.

There are also existing periodic mental health education sessions given by Community Mental Health Nurses at Ussher Polyclinic (a public health facility with a Department for Mental Health). There is the need for concerted alliances among all healthcare providers, including CMNs, pharmacists, herbalists, faith-based healers (as individuals and members of official groups). There exist public health education programs on some localized radio (and TV) stations, but not specific to mental health and not to Ga-mashie. There is the need to leverage the local media landscape to promote context-specific mental health education to the communities. The prospective social actors in this regard include local radio stations, community information center, community mobile information systems, which can be used to provide evidence-based mental health education to the communities.

There have been some development agencies established and development interventions implemented in Ga-Mashie. These include Old Accra Development Agency (OACADA) and

Ga-Mashie Development Agency (GAMADA), a quasi-Local Government Agency, which is currently responsible for coordinating all developmental activities in both communities since their establishment in 2006. There has been collaboration with several developmental agencies and some INGOs such as UN-Habitat in implementing development interventions such as the UN-Habitat Participatory Slum Upgrading Programme (PSUP) with funding from the European Commission. Other development interventions include Korle Lagoon Ecological Restoration Project (KLERP) and Ga-Mashie Millennium City Initiative (GMCI). Ga-Mashie also has research collaborations with local academic institution, such as the Regional Institute for Population Studies (RIPS) of the University of Ghana.

There is an existing multidisciplinary research alliance between the communities and some research institutions, including Regional Institutes for Population Studies (RIPS) of University of Ghana, New York University and Columbia University (de-Graft Aikins et al., 2020). The RIPS research team engages with identified local social groups (Butchers' Association, Fishermen's Association, Market Women), clubs (Arts Clubs, Sports Clubs), Jamestown Café and school aged-children in the communities. As part of the project, there is an existing engagement at the local level with NHIS (through renewal of pilot CVD-based self-help group (JTHC) participants' health insurance). There is the need for strategic alliance to focus on pushing for insurance coverage of mental health disorders in the coverage of NHIS. Currently, people with mental disorders are exempted from paying premiums, but mental health conditions are not covered under the health insurance. Most individuals living with mental disorders in the communities therefore do not receive the needed treatment and care.

However, the research alliance focuses on development, population and community health, particularly NCD care. Mental health research is yet to gain explicit research attention. The

engagement so far has been based on improving cardiovascular health. Mental health issues are gradually being layered onto the engagements. The partnerships therefore constitute strategic alliance that can be leveraged to create critical dialogue and consciousness around mental health in the communities. However, there is the need for creating other prospective alliances such as community mental health engagement, school-based and church-based mental health education There is the need for further prospective alliances that target community members in general to highlight mental health promoting lifestyles to them.

Table 7. 6: Existing partnerships and alliances for mental health competence

Social capital	Social Actors	Mental Health Promotion
Existing Bonding social capital (within Ga Mashie)	• Ga Mashie Development Agency (GAMADA) • Local self-help support groups (e.g. James Town Health Club (JTHC, Basic Needs) • Mental Health Department of Ussher Polyclinic • Local unorthodox medical practitioners (herbalists and, faith-based healers) • Local profession-based groups, religious groups, civic groups, political groups, social clubs • Community mass media (Local radio stations, community information center, community mobile information systems)	• Public education and awareness on mental health matters • Clear, consistent and targeted mental health information • Access to mental health education • Psychosocial support from trusted groups • Encourage mental health seeking; • Ethical care and practice from unorthodox practitioners
Existing Bridging social capital (Between Ga Mashie and similar marginalized communities)	• Local social groups (e.g. civic, political, profession-based groups): that bring people from neigboring communities like Agbloshie, Korle Gonno, Chorkor, Bubiashe • INGO (Basic needs): that bring people living with mental disorders from other communities	• Improve capacity for mental health advocacy • Capacity building for care and treatment of people living with
Existing Linking social capital (Between Ga Mashie and Powerful External Actors)	• Academic Research Institutions (UG Academics (RIPS) and collaborators, e.g. NYU, Columbia University) • Millennium Cities Project (UN-Habitat, Earth Institute, Columbia University; Accra Mayor's Office, GAMADA); Old Accra Conservation and Development Association (OACADA), UNESCO, Ghana Office, Housing the Mass (HM); CHF International	• Health development research in the communities. However, Mental health research yet to gain explicit research attention • Improving livelihoods, housing and accommodation situation in the communities

7.4 Potential mental health partnerships and alliances

This section presents potential partnerships and alliances that can be leveraged to build mental health competence in the communities. Table 7.7 presents various potential bridging and linking alliances. The focus is main on how the alliances can help the communities to tap into structural resources to transform their mental health realities. At the community level, the community health department of the Ashiedu-Keteke sub metro, the governmental agency under which the two communities fall, focuses on environmental health, and has no designation for mental health. This is a potential source of bridging social capital for the communities.

There is a Mental Health Act of 2012 (Act 846) which is meant to strengthen mental health system in Ghana (MHA, 2012). The Act established the Mental Health Authority (MHA) to oversee the implementation of the Act and the broader strengthening of the mental health system in Ghana. The MHA has a community care strategy, which seeks to "strengthen community mental health services including rehabilitation activities". This it seeks to achieve through 5 main strategies: (i) providing community mental health services through CHPS[1], (ii) promoting the formation of self-help groups in communities, (ii) providing rehabilitation and support services to mental health patients, (iv) providing half way homes, day care and community centres, and (v) providing occupational therapies.

The community elements of the Mental Health Act has not been implemented in the communities. This is reflected in the broader level where the MHA is underfunded, and therefore has not been able to implement its community care strategies across communities with mental

[1] CHPS (Community-based Health Planning and Services) is Ghana Health Service's national strategy for delivering essential community-based health services. The primary focus is to provide deprived communities with health services. The general principles of CHPS include focus on community participation, empowerment, ownership, gender consideration, task shifting to achieve universal access, and communities being regarded as social and human capital for health system development and delivery. However, much of implementation of CHPS have focused on physical health to the neglect of mental health.

health needs (such as Jamestown and Usshertown). The community element has not been implemented in the communities based partly on inherently mainstream and institutional approach in the community care strategy. The strategies outlined largely require construction of physical structures (such as CHPS compounds) for rehabilitation and occupational therapies. The community care strategy, which prioritizes provision of materials and personnel over community strengthening, is thus rendered invalid due to limited funding.

There is also the Ghana Psychology Council (GPC) established under Act 857 of Parliament of Ghana to regulate the standards of the training and practice of psychologists, therapists and lay practitioners in Ghana (de-Graft Aikins, 2018). Indirectly, there are a number of existing strategies and alliances at the structural level, that can be strategically leveraged to build mental health competence of the communities. For instance, there is the Livelihood Empowerment Against Poverty (LEAP) policy which seeks to provide safety net for improving livelihoods of individuals living below the poverty line (MGCSP, 2016). However, the coverage of LEAP is limited, and therefore does not cover all poor communities in Ghana. Also, there is a National NCD policy in Ghana being developed to guide NCD care in Ghana. Even though mental health is classified as an NCD, the policy is yet to explicitly focus on mental ill health.

In terms of fiscal strategies, there is the need to use taxes as tools for reducing the abundance of mental health compromising substances in the communities. Addictive and abusive substances such as alcoholic bitters and tobacco products for instance are in abundance in the communities, which make substance abuse disorders extremely high in the communities. Partnership with industry and private sector is needed, particularly alcohol and tobacco industry to check the production and importation of addictive alcohol and tobacco products that find their way into

low income communities. The Food and Drugs Authority (FDA) constitute key actor in this regard.

Strategic alliances with academia and research institutions is also critical. The ongoing multidisciplinary health development project in the communities also offers potential for multidisciplinary mental health research and interventions. The current thesis builds on the ten-year RIPS project on NCDs which identified a gap in mental health research and support in the communities (de-Graft Aikins, 2020). These potential alliances have both direct and indirect implications on building mental health competence within the communities.

Table 7. 7: Potential partnerships and alliances for mental health competence

Social Capital	Social Actors	Mental Health Promotion
Potential bridging social capital	• Community Health Department of the Ashiedu-Keteke Sub-metro • Mental health advocacy groups that bring people living with mental disorders from other communities: (Basic Needs Ghana, Ghana NCD Alliance, Friends of Mental Health, Mental Health Society of Ghana, Mental Health Foundation of Ghana, MindFreedom Ghana)	• Strengthen capacity building for mental health advocacy • Strengthen links between the communities and advocacy groups
Potential linking social capital	• Policy Actors (Mental Health Authority, Ministry of Health, Ghana Health Services GHS, National Health Insurance Authority, Ghana Psychological Council; NCD Control Program) • Development Actors (Accra Metropolitan Assembly) • Donor Agency Actors (World Bank, WHO) • Social Protection Actors (Livelihood Empowerment Against Poverty Program, Ministry of Gender Children and Social Protection, Ministry of Youth and Employment) • Academic Research Institutions (University of Ghana, Earth Institute, Columbia University) • Health Institutions (Mental Health Department of Korle-bu Teaching Hospital; Accra Psychiatric Hospital, Pantang Hospital)	• Getting mental healthcare and treatment captured by the National Health Insurance Scheme • Improving livelihoods and access to mental health care within the community • Promoting multidisciplinary mental health research and interventions • Checking abundance of hard liquor and tobacco products, particularly in low income communities • Providing institutional care for mental disorders that require institutional care in the communities

7.5 Discussion

This chapter has presented findings with regards to how different dimensions of social capital offers power for the communities to build mental health competence. Intersections between the qualitative and the quantitative data have provided insights into the communities' existing and potential bonding, bridging and linking social capital, and how these can be leveraged to transform the mental health realities in the communities.

With regards to bonding social capital, the survey showed that while shared community concern and community leadership trust directly promote mental health participation, community social cohesion directly undermined mental health participation. Interpersonal trust and critical consciousness partially and significantly mediated the effect of all the three community-level social capital (i.e. community social cohesion, shared community concern, community leadership trust) on mental health participation. These mean that intrapersonal and interpersonal level factors act as psychosocial mediators between community level factors and individuals' willingness to participation in mental health promotion within the communities. The survey findings intersect with the qualitative data in chapter five where the quantitative data showed that belonging to several groups creates tensions, and the qualitative data showed that interpersonal spaces provide the most health protection for the vulnerable.

For community social cohesion in particular, critical consciousness and interpersonal trust each turns its negative effect on mental health participation into positive. Critical consciousness ensures that individuals develop the conviction at the intrapersonal level on the realities of mental health problems within the communities and the need to actively participate in addressing these challenges. Interpersonal trust ensures that individuals develop quality and trusting relationships in order to be able to work together. What these findings mean is that there is the

need to conceptualize community bonding social capital in multilevel terms, so that all critical community, interpersonal and intrapersonal resources can be aligned and drawn on to promote mental health in poor communities.

The findings contradict mainstream narratives that hegemonize community-level elements of bonding social capital (Hamdan et al., 2018; Kobayashi et al., 2015; Lippman et al., 2018). Mainstream literature suggest that community cohesiveness is a social insurance for communities members (Bruhn, 2009; Chen et al., 2015). Community social cohesion is seen to be a property of communities, associated with prosocial behaviours among community members (An et al., 2019; Maass et al., 2016; Murayama et al., 2015). The current study contradicts that assertion. Findings shows that community is associated with lower mental health participation at the individual level. This aligns with findings from research within the critical social psychology of community literature which argues that community-level elements of bonding social capital do not directly translate into individual level prosocial outcomes (Grief & Dodoo, 2015; Howarth et al., 2013; Kushitor et al., 2018).

The fundamental assertion that hegemonizes community-level elements of bonding social capital, particularly in African context (Barolsky, 2016; Bwalya & Seethal, 2016; King, Samii & Snilstveit, 2010) is underpinned by the idea of collective identity which ensures communal living (Kitayama et al., 2010; Langer et al., 2017; Markus & Kitayama, 2010; Shittu et al., 2014). The studies implicitly assume a fundamentally homogenous identity for all members of a community, which promotes peaceful coexistence among members of the community. Thus, a sense of community level togetherness becomes a default state of sociocultural pathway to psychosocial functioning in addressing collective communal problems (Gordeev & Egan, 2015; Chen et al., 2015; Momtaz et al. 2014).

However, empirical evidence from critical social psychological studies in communities suggest that communities everywhere are rarely homogenous, and that members of communities do not always share the positive outcomes of togetherness (Campbell & Murray, 2004; Howarth et al. 2013). In all communities, there are competing individual interests, interests that are mostly conflictual (Howarth, 2001; Howarth et al., 2013). In African communities in particular, research on identities show that the assertions of homogeneity and communalism are not holistically true (Adams & Dzokoto, 2003). Even within collectivistic societies, there are tensions (Adams & Dzokoto, 2003; Howarth et al. 2013). Adams and Dzokoto (2003) highlights the risks and dangers that characterize interdependence in African settings, which create possibility of enemyship, where individuals perceive hatred and sabotage in the close relationships.

The notions of communalism and homogeneity in African communities occurs within the context of poverty and material lack, creating a material interdependence as a necessity to manage limited resources such as many households living in the same house and many people sleeping in one rooms. The material interdepence of everyday life in African communities simultaneously create opportunities for interpersonal fricitions and also make it virtually impossible to avoid relationships where frictions have been developed. Thus, the ‘material structures of interdependence afford mental structures of interdependence (Adams & Dzokoto, 2003, p.350). Poor communities are therefore inherent grounds of tension-filled social and interpersonal relationships. This provides insights into the high levels of tensions within social groups in Jamestown and Usshertown which the participants recounted.

Much of the supposed interdependent assumptions in collectivistic communities, are materially shaped, particularly within poor communities where individuals are forced to be materially interdependent (Adams & Dzokoto, 2003). Within the communities where the current study was

conducted, several generations of family members share limited dwellings. The communities are characterized by frequent tensions and open conflicts within family members, in social groups and the community as a whole (Grief & Dodoo, 2015; Kushitor et al., 2018). Thus, beneath the community-level sense of togetherness, are fundamental interpersonal tensions and conflicts.

The intra and interpersonal dynamics are crucial mediators because, at the deeper level, individuals within such communities still draw on their intrapersonal and interpersonal psychosocial resources in their every day lives, particularly in meeting the stressors associated with forced material connectedness (Adams, 2005; Adams, Bruckmüller & Decker, 2012). These suggests that, individual and interpersonal lives matter, when it comes to the decision to participate in communal good. Consistent with this understanding, individual and interpersonal psychosocial mechanisms were found to partially and significantly mediate community-level bonding social capital and individual level mental health participation. Therefore, promoting willingness to address collective problems would require paying attention to the quality of interpersonal relationships that make individuals want to work peacefully with others to promote mental health within the communities.

With regards to bridging and linking social capital, findings show that there are limited existing partnerships at all levels that targeted at addressing mental health problems within the communities. At the structural level for instance, the community elements of the Mental Health Act are yet to practically implemented. Two reasons could account for the lack of implementation. First, at the structural level, there is limited funding allocated to the Mental Health Authority to enable it implement the community elements of the Act. Over the years, of the percentage of funding allocated to mental health in Ghana is between 1 – 1.4% of total health budget (Anum et al., 2020; Ofori-Atta et al., 2010), which is ridiculously inadequate. Secondly,

at the institutional level, there are limited strategic partnerships with communities, particularly in poor communities with high risk of poor mental health.

Drug addiction disorders are also high in the communities. This reflects the fact that majority of illicit drugs find their ways into poor communities. Greater percentage of alcoholic, hard liquor and tobacco products in Ghana still find their way into poor communities and neighbourhoods (Domestic Drug Consumption in Ghana, 2019). These findings show the limited coordinated mental health-based partnerships and alliances at all levels within the communities. The findings align with previous studies which show that poor communities lack the critical alliances needed in transforming the social realities of their health challenges (Alexander et al., 2010; Campbell et al., 2013; Hearld et al., 2013; Hearld et al., 2016; Skovdal et al., 2017).

However, communities in need are not always without resources. There are alternative possibilities and opportunities that can be drawn on or leveraged to transform the social realities of health in communities in need (Aveling and Jovchelovitch, 2014; de-Graft Aikins et al., 2020; Guareschi & Jovchelovitch, 2004). There are a number of existing partnerships at the community levels, which offers potential for embedding mental health-based alliances to strategically transform the social realities of mental health within the communities. First, there is the existence of a strong multidisciplinary research on community health development within the communities. Community-based multidisciplinary and transdisciplinary research offers cross-boundaries and trans-boundaries understanding of the factors that undermine health and health systems within communities (Kirwan et al., 2013; Skovdal et al., 2017). A strong community-based mental health research can therefore be anchored within the multidisciplinary research team to highlight and diagnose the social realities of mental health problems within the communities.

There are some ongoing millennium cities projects such as Housing the Masses in the communities. The project focuses on improving accommodation and providing subsistence income-generating activities and improve housing conditions within the communities (Boakye & Beland, 2018; Wrigley-Asante & Mensah, 2017). Income and housing emerged as critical material constraints of managing mental illness. The millennium projects therefore offer potential strategic alliance for creating conducive material resources for addressing mental health challenges. The projects can be strategically tailored towards improving livelihoods and housing conditions for community members, including individuals living with mental disorders and their families.

Further, there is growing existence and awareness of self-help groups within the communities. For instance, there are NGO-led self-help group for individuals living with epilepsy and other neurological disorders, and a research-led CVD-based self-help group, whose activities include psychosocial education and support. The Mental Health Department of Ussher Polyclinic also undertakes periodic home visits by community mental health nurses to individuals with mental illnesses. Strategic alliances can be created between the mental health departments and self-help groups to improve psychosocial support. Strategic alliances can also be forged between and among the vibrant local community information systems, community-based NGOs, faith-based and traditional practitioners, to drive mental health competence within the communities. overall, the partnerships and alliances ensure that communities have access to critical material and symbolic resources to transform the realities of mental health within communities, including shaping psychosocial behaviours at the individual level.

CHAPTER EIGHT

SYNTHESES AND GENERAL DISCUSSION

8.1 Introduction

The study had four objectives: i) conduct critical social psychological assessment of the social realities of mental health problems in the communities, and ii) assess existing and potential opportunities for building mental health competence of the communities. This chapter presents the synthesis and discussions of the key findings. The key insights that intersect the symbolic, relational and material realities of mental health problems are first highlighted, and then discuss the insights that can be drawn for participatory mental health interventions to transform the social realities of their mental health.

8.2 Social realities of mental health problems in the communities

There is high prevalence of mental disorders in the communities. Depression and anxiety are common in the communities, with prevalence of severe and moderate depressive and anxiety symptoms ranged between 11.5% - 28.1%. The prevalence levels in the communities are higher that national prevalence of mental illness symptoms in Ghana (Canavan et al., 2016; Sipsma et al., 2013) and other African countries (Omar et al., 2010). Other serious mental health problems found to be common in the communities include madness, epilepsy, substance addiction, suicide, psychosocial stress, excessive anger, worry and frustration. Informed by the social psychology of participation framework, diagnosing the social realities of mental health in communities requires understanding how the social psychological features of social representations, social identities and power (defined as social capital in this study) intersect on these mental health problems (Campbell & Jovchelovitch, 2000; Campbell, 2019). These three social psychological features

provide insights into the symbolic, material and relational risks of mental ill health, and resources for addressing mental health challenges.

The communities have complex and nuanced understanding of mental illness, broadly as a concept, and also specific mental disorders that are common in the communities. Representations of mental illnesses are cognitive polyphasic – with lay mental health knowledge being drawn from various sources simultaneously. Lay mental health knowledge is drawn on to inform categorization and stigmatization of mental disorders, and empathy towards individuals living with mental illness. Mental illness representations are informed by cognitive and emotional processes that shape social legitimization of specific mental disorders, depending on seriousness of the condition and proximity of the sufferers and their families to the communities. The findings align with the argument that social representations habour both symbolic resources and risks for everyday life (Campbell & Jovchelovitch, 2000; de-Graft Aikins, 2012; Jovchelovitch, 2007).

The differentiation inherently drives categorization of mental disorders in a hierarchical manner, showing mental disorders that are more dangerous and those that are less dangerous. The hierarchical differentiation of mental disorders drives simultaneous existence of stigma and empathy towards mental disorders within the communities. These findings align with some previous discussions on mental health representations among students (Foster, 2001) and health professionals (Morant, 2006), how unfamiliar health conditions are familiarized (de-Graft Aikins, 2012). The differentiation of mental disorders provides valuable insights into mental health conditions that are amenable to social cure within communities and those that pose destitution risks and therefore require custodial care. A recent social psychological analysis of mental illness and destitution in Ghana supports this assertion (de-Graft Aikins, 2015).

Fundamentally, individuals living with mild mental health conditions are granted some form of legitimacy and accommodated at homes and within communities, a situation which facilitates social care (de-Graft Aikins, 2015). Individuals with severe mental disorders on the other hand are perceived as a threat to community members, and therefore face destitution risks, if left within the communities. Patients with severe mental health conditions within the communities might therefore require custodial care (de-Graft Aikins, 2015). These findings reveal the complexities in social representations of mental illnesses within the communities, which drive conditional legitimacy to some mental health conditions, while othering or pushing away other conditions.

The current study shows that social spaces within the communities predispose individuals to psychosocial distress and poor mental health and also offer psychosocial resources simultaneously. The study shows a dynamic coexistence of symbolic risk factors and resources that shape mental health problems in the communities. The symbolic risks included a high sense of stigmatization towards mental disorders as a condition, fundamental lack of conversations and dialogue about mental health at the community level. Conversations about mental health only happen at the interpersonal and family levels, and are often characterized by distancing, secrecy and hostility. Building mental health competence within the communities would therefore require nuanced approaches to strategically negotiate the complexities of the symbolic context of mental health within the communities, identifying which symbolic risks to challenge and which symbolic resources to leverage.

Social identities also matter in understanding how mental health problems are structured by lived experiences. What defines who individuals are, encompasses complex interactions of lived, embodied, material, as well as how they are symbolically defined by others (Campbell &

Jovchelovitch, 2000; Howarth, 2001; Skovdal et al., 2017). Therefore, the symbolic, relational, material and embodies are intricately linked and mutually influential in defining social identities. Lived experience and the subjective and embodied aspects of mental health and mental illness within the communities are critical. In examining the content, source and functions of representations, heterogeneity of community identities also emerge strongly, in terms of how mental illnesses are experienced and how stigma operates at various levels.

At the interpersonal levels for example, gendered identities matter in how these are structured by lived experiences and why it is important to factor this in segmentation and development of interventions. The interpersonal level tensions shape both quality of caregiving and mental health of caregivers. At the group level, social group membership constitutes both protective and risk factor for mental health. Class conflict within social groups drives marginalization of the poorest poor and uneducated in the communities. Social legitimization of social groups also drives stigmatization of young people who engage in substance use as mentally ill. At the community level, patients with severe mental disorders, men who experience depression, migrant ethnic groups, and tenants experience compounded mental ill health. Structural poverty exposes lay healthy people to recurring psychosocial struggles. The study shows further how chronic material deprivation undermines optimal mental health within the communities. Poverty level is high and widespread, and housing and accommodation are generally poor, both of which undermine optimal treatment and care when mental illnesses strike. There is an abundance of illicit drugs and proliferation of physical spaces for the sale of these illicit substances – both of which account for high substance use, abuse and addiction disorders among young people within the communities.

Community social capital is argued to be a community strength and fundamental to community competence (Campbell, 2019; Campbell et al. 2005; Campbell et al. 2007). Bonding, bridging and linking social capital in the communities were also examined. Findings suggested that a multilevel impact of community bonding social capital on mental health participation. Specifically, intrapersonal (i.e. critical consciousness) and interpersonal (i.e. interpersonal trust) level factors act as psychosocial mediators between community level factors (i.e. social cohesion, shared concern and leadership trust) and individuals' willingness to participation in mental health promotion within the communities.

Community bridging social capital was examined to assess the existence of partnerships and alliances between the communities and other external social actors that offer potential for transforming mental health within the communities. In terms of bonding social capital there exist a sense of bonding social capital within the communities that can be drawn on to promote collective action in addressing mental health problems. However, it is critical to pay attention to the complexities of the coexistence of cohesiveness and tensions that characterize communities, so as not to uncritically hegemonize communality - a sense of togetherness (Campbell & Jovchelovitch, 2000; Howarth, 2001; Howarth et al., 2013). Interpersonal and individual dynamics are crucial psychosocial mediators between a sense of communality and individual level actions, particularly in communities where material deprivation shapes interdependence (Adams & Dzokoto, 2003).

In terms of bridging and linking social capital, findings suggested there are pockets of mental health-based partnerships, particularly with INGO-led mental health support groups within the communities. However, at the broader level, there are limited mental health related partnerships and alliances between the communities and other external social actors. That notwithstanding,

there are several existing livelihood and physical-health related partnerships and alliances which can be leveraged to transform mental health within the communities.

8.3 Implications for building mental health competency of the communities

This section discusses the implications of the study for developing participatory interventions for building the mental health competency of the communities. This study suggests that the communities oscillate through continuum of competencies symbolically, materially and relationally. The findings show that the communities; (i) exhibit relatively high symbolic mental health competency, (ii) have severe challenges with material competency and (iii) have more room for improvement on relational mental health competency. The continuum of the communities' competencies have different implications for mental health interventions. The challenges is how to forge productive alliances for sustainable change in their mental health problems. The following insights are providing in developing mental health interventions to strengthen the mental health competencies of the communities.

Symbolically, the communities have relatively high mental health competency. The study shows that the community members are already aware of their mental health problems, and the multilevel roots of the problems. The social legitimization of mental illnesses in their representations should inform what workable in the communities when planning mental health interventions. What is workable entails working within the symbolic sensibilities of the communities, identifying context-based short term goals, and strategizing for long term mental health transformation within in the communities. There is the need to identify which mental disorders to treat using social care and which ones to treat with institutional care. In these

communities, madness, epilepsy and severe substance use disorders are granted illegitimacy. These conditions need institutional care in planning mental health interventions. Conditions such as depression and suicide attempts or suicidal thoughts are granted conditional legitimacy, while others like psychological distress, excessive worry and frustrations are granted unconditional legitimacy. These conditions may receive social care within the communities.

The communities are very low on material mental health competency. The material realities of mental health problems bothered on livelihoods, accommodation, shared public facilities and illicit drug spaces. There is the need for strategic partnerships and alliances in order to address these needs in more sustainable manner. Structural factors such as poverty and joblessness compromise their mental health of lay healthy members, while accommodation challenges and shared public facilities undermine quality of care for those with mental disorders. However, critically reflecting on the social contexts within the communities show potential for improving mental health within both communities. Critical reflexivity is at the heart of critical social science, which focuses on unearthing alternative possibilities for transformative social change (Guareschi & Jovchelovitch, 2004). This is particularly so when working in and with poor communities where there is the tendency to focus on the disabling effects of poverty and material deprivation (de-Graft Aikins et al., 2020; Guareschi & Jovchelovitch, 2004).

The material realities of mental health problems in the communities show that there is the need for both short-term and long-term mental health interventions. The short-term interventions would need to target strengthening coping mechanisms against the community factors that undermine optimal mental health. Specifically, the study shows that the family and home are safe spaces for people with mental health problems. Short term interventions should therefore factor in the burden of making the family and home safe by prioritizing the needs of individuals living

with mental disorders sufferers and their caregivers. Long-term interventions require empowerment in critical areas such as access to affordable mental health treatment and care, as well as access to livelihoods and housing opportunities. The long intervention requires a multisectoral approach, and therefore strategic partnerships and alliances are critical.

However, the communities are very low on relational competency. There are limited bridging and linking social capital within the communities. There are mental health research in communities outside of Accra such as Kitampo and Nkronzah (Read et al., 2019, 2020), Zuarungu and Sumbrungu in Northern Ghana (Naba, 2015). The mental health research in these communities provides opportunities for briding capital in community mental health practice. Also, the intersecting mental health needs of the communities transcend sectoral and disciplinary boundaries. The study therefore recommends a multisectoral and multidisciplinary approaches to transforming social realities of mental health in urban poor communities. The MH Act advocates a rights-based approach in community mental health delivery. However, implementation has become problematic in community mental health delivery in Ghana.

Appropriate internal and external social actors and groups have been identified, where appropriate, as forming critical stakeholders in transforming mental health within the communities. For instance, policy responses to addressing mental health problems in poor communities need to be integrated within the broader context of poverty reduction. This policy recommendation is shared by de-Graft Aikins (2015) who argued that a sustainable livelihood component in mental health policy is critical in addressing the role of structural poverty, both in the onset and outcome of mental disorders in Ghana. There is therefore the need to forge strong productive partnerships and alliances in working together to address the socio-structural drivers that undermine psychosocial wellbeing within poor communities.

More importantly, the study recommends the need for such partnerships and alliances to be democratically participatory, involving of all stakeholders. This include uncompromising recognition and regard for local knowledge and resources of the communities whose mental health we seek to improve. The dominant approach of community-based mental health delivery has been that scientific practitioners and policy experts develop dosages of interventions to 'heal' communities of mental ill health. This study has shown that there are local symbolic and material resources within communities that should be recognized and respected. Practical and policy interventions should therefore focus on working with communities to develop best participatory and democratic approaches of harnessing local cultural capital to transform mental health within community contexts.

In building strategic alliances and partnerships, there is the need to pay attention to respective identities and interests that different social actors bring into partnerships (Hearld et al., 2016; Skovdal et al., 2017). Social actors in partnerships have their own identities and interests which influence how and why they partner (Aveling & Jovchelovitch, 2014). Partnerships and alliances need to be democratic and participatory, in ways that recognizes and respects knowledge systems and resources of all stakeholders, particularly in community-led mental health intervention projects (Cornish & Ghosh, 2007). This would create opportunities collaboration, in terms of shared vision and partnership goals, where all groups feel involved and committed to partnership projects (Alexander et al., 2010; Aveling & Jovchelovitch, 2014; Kirwan et al., 2013).

8.4 Contribution of the Study to knowledge

The study makes significant contributions to literature. The findings expand on notions of community mental health ideology, mental illness stigma and social care for individuals living with mental illness. First, mainstream community mental health literature suggests that local communities in Africa hold poor mental health knowledge which drives largely stigmatizing attitudes towards mental disorders (Benedicto et al., 2016; Gibbons et al., 2015; Yu et al., 2018). This study challenges that evidence, and indicates that local communities hold complex (not poor) mental health knowledge. Mental illness attitudes are not largely negative, but cognitive polyphasic, with elements of both mental illness stigma and care coexisting simultaneously. Drawing on findings from the differentiation of mental illnesses, the study shows that the communities hold competing beliefs of empathy (which is good for mental health promotion) and stigma (which is bad for mental health promotion). So, there is the need to focus on what is workable in promoting community mental health.

The study further contributes knowledge on the social psychological drivers of mental illness stigma, care and response within local communities. This study has contributed empirical evidence to the cognitive-emotional processes underlying mental illness representations (de-Graft Aikins, 2012). Social representations of mental illness is fundamentally a cognitive-emotional process, which are driven by fear of strangeness co-existing with limited knowledge of condition (de-Graft Aikins, 2012). This study has shown that cognitive and emotional process informs a social legitimization process based severity of the condition and identity of the sufferers. Social legitimicy process mediates the mental disorders that evoke stigma and sufferers who may receive empathy and social care (de-Graft Aikins, 2015).

This thesis makes unique contribution to social representation research through a focus on embodied knowledge. Empirical research within social representation theory tend to focus on and overemphasize group and structural level analysis. SRT research is therefore very poor on individual and interpersonal level analyses (de-Graft Aikins, 2012). The same argument can be made for the community mental health movement which overemphasises the collective and structural factors. Thus, in both SRT and community mental health movement, micro-level factors have received limited empirical analyses. The current thesis therefore contributes to both SRT and community mental health movement, by highlighting the relevance of individual and interpsonal factors, which are crucial in every experiences and long-term illness experiences and care.

By focusing on individual and interpersonal factors, the study provides insights into concrete emotional processes (such as fear, empathy and love) in interpersonal context that drive care, distancing and stigma simultaneously. The communities grant illegitimacy to severe mental disorders and sufferers they identify as outsiders. Such conditions and sufferers are always going to be stigmatized because of the fear of the strangeness and their limited knowledge of these conditions. Severe mental disorders like‘Madness’ therefore constitues ultimate ‘familiar unfamiliar’ and always stigmatized across cultures and time periods (de-Graft Aikins, 2012, 2015; Foster, 2001; Morant, 2006; Rose, 2000). Severe disorders and strangers with mental illness are therefore going to evoke stigmatic thinking and social psychological distancing in ways that maintain the strangeness of the conditions and othered identities of the sufferers. The current study therefore argues that part of what is workable is identifying mental disorders that are amenable to social care within communities and those that do not. Thus, mental health institutions are still needed and should feature in community mental health discourse. The task is

then to identify which mental disorders need social care within the community and which ones need institutional care. In the study communities for example, madness, epilepsy and severe substance use disorders require institutional care, while depression, suicidal thoughts (or attempts) and psychological distress require social care.

This study also makes two methodological contributions. First, this thesis is the first community-based mental health study to employ both quantitative and qualitative methods in establishing prevalent mental health problems in community context. All the community-based studies that examined prevalence of mental disorders in Ghana (Atuoye & Luginaah 2017; Grief & Dodoo, 2015; Kushitor et al., 2018) and elsewhere (Benedicto et al., 2018; Yu et al., 2018) used quantitative methods in assessing mental illness symptoms at the individual level. Community-based studies that employ qualitative methods (e.g. Burgess & Mathias, 2017; Campbell & Burgess, 2012; Mathias et al., 2018) also do not explore the prevalent mental health problems within the communities. This thesis therefore adds methodological innovation to community-based mental health research that allows prevalent mental disorders to be examined both at the individual and community levels.

The study also makes methodological contribution to the community mental health competence line of research in particular, social psychology of participation framework and the health competent community line of research in general. All the competent communities studies used qualitative methods in assessing the features of community health competence (Campbell et al., 2005; Campbell et al., 2007; Campbell et al., 2013), orphan competence (Skovdal & Campbell, 2010; Skovdal et al., 2010) or community mental health competence (Burgess & Mathias, 2017; Mathias et al., 2018). de-Graft Aikins et al. (2020) is the first to apply mixed-method approach to social psychology of participation and CVD competence in community context. The current

study therefore establishes mixed-method approach to community mental health competence, which allows for a truly multi-level analysis from individual to structural. In so doing, this thesis shows the importance of individual and interpersonal levels of analysis in community mental health research and practice.

8.5 Limitations of the study

The study has a limitation that should be taken into consideration in interpretations and applications of the findings. First, there were no alternative high income communities or similar low income communities in another part of Ghana to compare. Even though some comparative analysis were done between Jamestown and Usshertown, the differences between the communities are subtle. Jamestown and Usshertown are twin communities. They share similar characteristics in terms of history, culture, social and economic lives. Therefore, there were limited notable differences with regards to how social contexts shaped mental health outcomes.

Second, the findings in the study are not entirely generalizable to all urban poor communities in Ghana. This is because, the social context of communities are complex and therefore have peculiar problems. However, the theoretical approach to diagnosing the social realities of mental health problems used in this study is applicable to all poor community contexts. The findings from actual findings within these communities may differ. Notwithstanding these limitations, the study provides valuable insights into the social realties of poor mental health, and the implications for mental health competence within the two communities.

8.6 Suggestions for future research

There is the need for more empirical community-based studies to provide deeper understanding of the social realities of mental health in community contexts. Future studies should focus on comparative analysis between communities that are socio-historically diverse. Communities differ in terms of their social histories, cultural backgrounds and developmental trajectories. It is therefore recommended that future studies should focus on comparing different communities. A comparative analysis between communities in need (e.g. poor, rural and slum communities) and high-income communities would provide deeper insights and nuances into how social contexts shape mental health at the community level.

There is also the need for community-based longitudinal studies to be carried out. Elements of social contexts (i.e. symbolic, material and relational) are fluid. Community social contexts change with the broader social changes and globalization. Longitudinal studies would provide opportunities to track how communities' social contexts shift and how those shifts affect mental health profiles of communities. Lastly, intersectoral based studies are needed in advancing research, particularly with regards to partnerships for action. There is the need to conduct further studies to examine the existence and dynamics of collaborative partnerships among institutional stakeholders in mental health in Ghana, and how that translate into the community level. Such studies would provide deeper understanding and nuances of the workings of partnerships and alliances for promoting mental health within communities.

8.7 Conclusion

Poor community mental health undermines quality of life at the individual level, undermines community vitality and regeneration, and is counterproductive to socioeconomic progress at the structural level. At the broader level, by employing a theory-driven social psychology of participation approach to community mental health, the study provides a critical reflection of the social realities of mental health problems of two urban poor communities. Critical reflection opens up the field of possibilities for facilitating participatory interventions to transform mental health in the communities by identifying all forms of capital that might otherwise be obscured by objective social realities of material deprivation.

The study has highlighted the disabling effects of structural community poverty shape the social realities of poor mental health within Jamestown and Usshertown. The findings support insights from previous critical social psychology studies and also add insights to the literature. First, the community members, like other disadvantaged Africa, Asia and Latin America communities draw on eclectic stocks of knowledge in making sense of mental illnesses. The nuanced community representations of mental illness provide opportunities for sound mental health knowledge and safe social spaces to facilitate critical mental health dialogue. Second, there are several symbolic, material and relational risk factors that account for the high prevalence of mental health disorders within the communities. Further, heterogeneity of social identities within the communities, structure mental illness experiences.

In terms of new insights, the study shows that mental illness knowledge and attitudes in local communities are cognitive polyphasic. Mental illness stigma and empathy co-exist in local communities simultaneously. Social legitimization mediates the fluidity of how community members draw on stigma and empathy in their mental illness response, depending on the severity

of the condition and identity of the sufferers and their families. The current study uncovers both existing and potential opportunities within the communities' social contexts that can be drawn on to transform mental health. Symbolically, there is complex and nuanced lay understandings of mental illnesses in the communities, which shows an existence of critical building blocks of mental health knowledge.

There are limited existing bridging and linking social capital for mental health, in terms of limited existence of mental health-based partnerships within the communities. Nevertheless, there are existing health and livelihood-based partnerships that offer potential for strategic alliances to transform mental health within the communities. Through critical reflexivity, the thesis unearths the limits and potential of communities' sociocultural capital in addressing mental health challenges, within the context of poverty and material deprivation. The thesis thus legitimizes existing local -symbolic, material and relational - resources as a critical component of transforming mental health within the communities.

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APPENDICES

APPENDIX I: Ethical Approval

UNIVERSITY OF GHANA
ETHICS COMMITTEE FOR THE HUMANITIES (ECH)
P. O. Box LG 74, Legon, Accra, Ghana

My Ref. No.....

31st January, 2019

Mr. Francis Agyei
Department of Psychology
University of Ghana
Legon

Dear Mr. Agyei,

ECH:010/18-19: Social Psychological Pathways to Mental Health Competence in Urban Poor Communities in Accra

This is to advise you that the above reference study has been presented to the Ethics Committee for the Humanities for a full board review and the following actions taken subject to the conditions and explanation provided below:

Expiry Date:	31/01/20
On Agenda for:	Initial Submission
Date of Submission:	18/09/18
ECH Action:	Approved
Reporting:	Bi-annually

UG/ISSER/ECH VALID UNTIL 31 JAN 2020 APPROVED DOCUMENT

Please accept my congratulations.

Yours Sincerely,

Prof. C. Charles Mate-Kole
ECH Vice Chair

Cc: Prof. Ama de-Graft Aikins, Regional Institute of Population Studies, UG
Dr. Annabella Osei-Tutu, Department of Psychology, UG

Tel: +233-303933866 Email: ech@ug.edu.gh

APPENDIX II: Informed Consent Form

UNIVERSITY OF GHANA

Official Use only Protocol number

Ethics Committee for Humanities (ECH)

PROTOCOL CONSENT FORM

Section A- BACKGROUND INFORMATION

Title of Study:	Social Psychological Pathways to Mental Health Competence in Urban Poor Communities in Accra, Ghana
Principal Investigator:	Francis Agyei (PhD Candidate)
Certified Protocol Number	ECH:010/18-19

Section B– CONSENT TO PARTICIPATE IN RESEARCH

General Information about Research

The aim of this study is to examine how community social contexts influence mental health outcomes of individuals within the community. Elements of community social context that will be examined are; community worldview about mental health, social identities of individuals, mental health support systems in the community, mobilization among community members and the communities' links with external agencies. Mental health outcomes that will be examined are the common mental health disorders (depression, anxiety, distress, suicidal ideation and psychological well-being). Data will be gathered using mainly survey, individual interviews, focus group discussions and observations. Participation in the study will involve either responding to a questionnaire (lasting between 20 – 30mins), being interviewed one-on-one (lasting between 30 – 40mins) or taking part in a focus group discussion (lasting between 40 – 60mins).

Benefits/Risks of the study

The benefits of taking part in the study include understanding your mental health at the personal level and helping to improve the broader well-being of members at the community-level. The major risk associated with the study is the possibility of psychological disturbance due to recall of some

painful past event. In this case, there is free psychological services to address any psychological or emotional discomfort that will arise as a result of taking part in the study.

Confidentiality

Privacy and confidentiality will be assured. The questionnaire does not contain any item that reveals respondent's identity. All personal information are only socio-demographic characteristics (e.g. gender, educational level, age etc.) which does not identify any specific individual. With regards to qualitative, even though the (individual and focus group) interviews will be recorded (with participants' permission), individuals will be identified with codes or pseudonyms in all the processes of transcription, analysis and presentations to conceal participants' identities. The data will be kept with caution. Apart from the principal student investigator, other groups that may have direct access to the research records include principal and co-supervisors, research assistants at the point of doing transcription or data entry and if need be, the Head of Psychology Department and or the Dean of the Graduate School of University of Ghana. All data collected will be used for academic purposes only and as such ethical principles of privacy and confidentiality will be ensured.

Compensation

Participants will be compensated in kind at the end of participation as a show of appreciation for their time and effort. The compensation will be in a form of GHC5.00 airtime credits based on the network used by the participants.

Withdrawal from Study

Your participation is strictly voluntary and you reserve the right to pull out of the study anytime without any penalty or obligations to provide justification. You will not be adversely affected in anyway should you decline to participate or later stop participating. Should any information become available that may be relevant to your willingness to continue participation or withdraw; you will be informed immediately.

Contact for Additional Information

Should you have any concerns for further clarifications, you can contact the researcher on 0249928886 or through the mail at fyagyei@gmail.com. You can also write to the Department of Psychology, University of Ghana, Legon. If you have any questions about your rights as a research participant in this study you may also contact the Administrator of the Ethics Committee for

Humanities, ISSER, University of Ghana at ech@isser.edu.gh / ech@ug.edu.gh or 00233- 303-933-866.

Section C- PARTICIPANT AGREEMENT

"I have read or have had someone read all of the above, asked questions, received answers regarding participation in this study, and am willing to give consent for me, my child/ward to participate in this study. I will not have waived any of my rights by signing this consent form. Upon signing this consent form, I will receive a copy for my personal records."

_____

Name of Participant

_____ _____

Signature or mark of Participant Date

If participant cannot read and or understand 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.

_____

Name of witness

_____ _____

Signature of witness / Mark Date

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.

_____

Name of Person who Obtained Consent

_____ _____

Signature of Person Who Obtained Consent Date

APPENDIX III: Qualitative Interview Guide

1. General Background Information

Prompts: name, age, educational status, occupation, marital status, years of living in the community, role in the community etc.

2. Social spaces and dialogue surrounding mental health-related issues

Knowledge about mental disorders and mental health issues within the community.

vii. What can you say about mental health within this community? (Probe into how serious it is within the community)

viii. What are the common mental health problems you have observed in this community? (Probe into severe, mild mental health problems or behaviours)

ix. Do people talk about mental disorders or mental health-related issues in this community?

- Which spaces do conversations about mental disorders or mental health-related issues usually happen in this community?
- How do community members engage in conversations about mental disorders or mental health-related issues?

x. What are the dominant beliefs about the causes of mental disorders in this community? (Probe general and community-specific beliefs on perceived causes of mental illness)

xi. What do you think expose individuals to the likelihood of developing mental health problems? (Probe general and community-specific risk factors)

xii. Are there some groups of people in this community with higher risk or likelihood for developing mental health problems? (Probe into general and community-specific at-risk groups)

- *Social groups (e.g. based on gender, age, ethnicity etc.)*
- *Identity groups (e.g. people with specific attitudes or behaviours)*

2.1 Sources of Knowledge on Mental disorders and Mental Health

Examine where the community members get their knowledge on mental health issues.

i. What are the main sources of information on mental health issues in this community?

a. Probe into formal sources: health institutions, media, religious institutions etc.
b. Probe into informal sources: cultural sources, social sources etc.

2.2 Functions of Knowledge on Mental disorders and Mental Health

Examine how knowledge of mental health influence treatment, care and stigma

i. How do people view mentally ill patients and their caregivers within this community?
ii. How do people treat or relate to mentally ill patients and their caregivers within this community? *Why?*

3 Material Contexts of Mental disorders and Mental Health in the Community

Explore the forms of support/resources available in the community for addressing mental health problems.

i. Which places in this community have you observed individuals with mental health problems usually go to receive help, care or treatment? *Probe*
    a. Formal places or social spaces where mental health services are offered
    b. Informal places or social spaces where mental health services are offered
ii. How are individuals suffering from mental disorders and their families treated in this community?
iii. Are there any strengths, skills and competences in this community which you think can be used to improve mental health in the community? (Probe into local strength and resources)
    a. How would you assess the confidence of members of this community in effectively tackling their mental health problems? *Probe* community-specific strengths, resources, feeling of helplessness, sense of agency etc.
    b. How do you see the willingness of various stakeholder groups to come together in dealing with the mental health problems of the community?

4. Relational Contexts of Mental disorders and Mental Health

Examine the social actors that are involved in mental health promotion within the community:

- In your opinion, who do you think is responsible for mental health promotion in this community? ***Prompts***: role of government, local community leaders, identified social groups, family/household and individuals
- What groups/institutions/organizations are involved in mental health promotion in this community? Generate list and probe into who these groups are and what they do within the community
- How would you describe this community's ability to access external help in efforts to promote mental health?
- Under what conditions is participation enacted between urban poor communities and external social actors for addressing mental health problems in the communities?

APPENDIX IV: Qualitative Participants' Profile
Focus Group Discussions Participants (N = 23)

Participant	Gender	Age	Education	Occupation	Community
	FGD 1 – Jamestown Males (6)				
FGD-JTM1	Male	33	Basic School	Fisherman	Jamestown
FGD-JTM2	Male	40	No School	Fisherman	Jamestown
FGD-JTM3	Male	28	Basic School	Driver's Mate	Jamestown
FGD-JTM4	Male	25	High School	Unemployed	Jamestown
FGD-JTM5	Male	31	Basic School	Trader	Jamestown
FGD-JTM6	Male	41	Basic School	Fisherman	Jamestown
	FGD 2 – Jamestown Females (5)				
FGD-JTF1	Female	31	Basic School	Market Woman	Jamestown
FGD-JTF2	Female	35	No School	Trader	Jamestown
FGD-JTF3	Female	42	No School	Fish Monger	Jamestown
FGD-JTF4	Female	29	Basic School	Trader	Jamestown
FGD-JTF5	Female	40	No School	Zoom Lion	Jamestown
	FGD 1 – Usshertown Males (7)				
FGD-UTM1	Male	41	No School	Fisherman	Usshertown
FGD-UTM2	Male	38	Basic School	Unemployed	Usshertown
FGD-UTM3	Male	29	Basic School	Driver's Mate	Usshertown
FGD-UTM4	Male	27	Basic School	Unemployed	Usshertown
FGD-UTM5	Male	33	No School	Trader	Usshertown
FGD-UTM6	Male	39	Basic School	Fisherman	Usshertown
FGD-UTM7	Male	27	Basic School	Apprentice	Usshertown
	FGD 2 – Usshertown Females (5)				
FGD-UTF1	Female	37	No School	Trader	Usshertown
FGD-UTF2	Female	31	Basic School	Fish Monger	Usshertown
FGD-UTF3	Female	29	Basic Scool	Unemployed	Usshertown
FGD-UTF4	Female	42	No School	Market Woman	Usshertown
FGD-UTF5	Female	39	No School	Food Seller	Usshertown

Individual Interviews – Key Informants Interviewees (KII) (N = 17)

Participant	Identity	Gender	Age	Education	Community
KII-1	Community leader	Male	71	Middle School	Jamestown
KII-2	Community leader	Male	73	Middle School	Usshertown
KII-3	Caregiver	Female	42	No School	Usshertown
KII-4	Caregiver	Female	39	Basic School	Jamestown
KII-5	Caregiver	Female	38	Basic School	Usshertown
KII-6	Caregiver	Female	45	No School	Usshertown
KII-7	Substance User	Male	32	Basic School	Usshertown
KII-8	Attempted suicide	Male	45	Basic School	Jamestown
KII-9	Epileptic	Male	33	Basic School	Jamestown

KII-10	Mental health nurse	Female	30	Tertiary	Usshertown
KII-11	Mental health nurse	Female	32	Tertiary	Usshertown
KII-12	OTCM Practitioner	Male	35	Tertiary	Jamestown
KII-13	OTCM Practitioner	Male	37	Tertiary	Usshertown
KII-14	Shrine Priestes	Female	65	No School	Usshertown
KII-15	Traditional priest	Male	51	Middle School	Usshertown
KII-16	Prophet	Male	45	High School	Usshertown
KII-17	Pastor	Male	41	Tertiary	Jamestown

Self-help Group Participants (N = 27)

Code	**Gender**	**Community**
SHG-P1	Female	Usshertown
SHG-P2	Female	Usshertown
SHG-P3	Female	Jamestown
SHG-P4	Female	Jamestown
SHG-P5	Female	Jamestown
SHG-P6	Female	Jamestown
SHG-P7	Female	Jamestown
SHG-P8	Female	Jamestown
SHG-P9	Female	Jamestown
SHG-P10	Female	Jamestown
SHG-P11	Male	Jamestown
SHG-P12	Female	Jamestown
SHG-P13	Female	Jamestown
SHG-P14	Female	Jamestown
SHG-P15	Female	Jamestown
SHG-P16	Male	Jamestown
SHG-P17	Female	Jamestown
SHG-P18	Female	Jamestown
SHG-P19	Female	Jamestown
SHG-P20	Female	Jamestown
SHG-P21	Female	Jamestown
SHG-P22	Female	Jamestown
SHG-P23	Female	Jamestown
SHG-P24	Female	Usshertown
SHG-P25	Male	Jamestown
SHG-P26	Female	Usshertown
SHG-P27	Female	Jamestown

Situated Conversation Participants (N = 10)

Participant	Gender	Age	Education	Community
SC-P1	Male	25	High School	Jamestown
SC-P2	Male	31	Basic School	Usshertown
SC-P3	Female	32	Basic School	Usshertown
SC-P4	Female	39	Basic School	Jamestown
SC-P5	Female	37	Basic School	Usshertown
SC-P6	Female	35	No School	Usshertown
SC-P7	Male	32	Basic School	Usshertown
SC-P8	Female	25	High School	Jamestown
SC-P9	Male	29	Tertiary	Jamestown
SC-P10	Female	30	Tertiary	Usshertown

APPENDIX V: Quantitative Questionnaire

This section requires basic socio-demographic information about you:

1. Community name: Jamestown [1] Usshertown [2]
2. Sex of respondent: Male [1] Female [2]
3. Age (please state your age as at your last birthday) _____years
4. Education: No school [1] Primary [2] Middle/JHS [3] Secondary [4] Tertiary [5]
5. Ethnicity: Ga-Adangme [1] Akan [2] Ewe [3] Mole-Dagbani [4]
   Guan[5] Grusi[6] Mande[7] Gruma[8] 9.Other(specify)_____
6. Marital status: Single [1] Married [2] Co-habiting [3] Divorced [4] Widowed [5]
7. Religious affiliation: Christian [1]. Traditional religion [2], Muslim [3], No religion [4]
8. Current employment status: Employed [1] Unemployed [2]
9. Occupation (*please state your occupation if employed*) _____

(WHO's Self-Reported Questionnaire-20, Weobong et al. 2009)

This section examines how you have felt in the past 30 days. Please respond yes or no by ticking (√) one of the options in the boxes

In the past 30 days,	**Yes**	**No**
1. Do you often have headaches?		
2. Do you have good appetite?		
3. Do you sleep well?		
4. Are you easily frightened?		
5. Do your hands shake?		
6. Do you feel nervous, tense or worried?		
7. Is your digestion good?		
8. Are you able to think clearly?		
9. Do you feel unhappy?		
10. Do you cry more than usual?		
11. Do you find it difficult to enjoy your daily activities?		
12. Do you find it difficult to make decisions?		
13. Is your daily work going well?		
14. Are you able to play a useful part in life?		
15. Do you have interest in things?		
16. Do you feel worthless?		
17. Do you wish you were dead?		
18. Do you feel tired all the time?		
19. Do you have uncomfortable feelings in your stomach?		
20. Are you easily tired?		

(WHO-5 Psychological Well-being Index, Heun, Bonsignore, Barkow & Jessen, 2001)

This section examines how you have felt in the last two weeks. Please respond by ticking (√) one of the options in the boxes: 5 = all the time, 4 = most of the time, 3 = more than half of the time, 2 = less than half of the time, 1 = some of the time, 0 = at no time

In the last two weeks …...	**0**	**1**	**2**	**3**	**4**	**5**
1. I have felt cheerful and in good spirit	0	1	2	3	4	5
2. I have felt calm and relaxed	0	1	2	3	4	5
3. I have felt active and vigorous	0	1	2	3	4	5
4. I wake up feeling fresh and rested	0	1	2	3	4	5
5. My daily life has been filled with things that interest me	0	1	2	3	4	5

Community Mobilization Questionnaire (Lipmann et al. 2016)

This section examines what your views are on the general life within this community. For each statement, indicate your level of agreement/disagreement **by ticking (√)** as follows: strongly disagree (SD) = 1, disagree (D) = 2, somehow (S) = 3, agree (A) = 4, strongly agree (SA) = 5

In general ……	**SD**	**D**	**S**	**A**	**SA**
1. Community members are willing to help their neighbours	1	2	3	4	5
2. This is a close-knit community	1	2	3	4	5
3. People in this community can be trusted	1	2	3	4	5
4. Community members get along well with each other	1	2	3	4	5
5. People in this community share the same values?	1	2	3	4	5
6. People in this community look out for each other?	1	2	3	4	5
Personally……...	**SD**	**D**	**S**	**A**	**SA**
7. I feel emotionally attached to this community	1	2	3	4	5
8. I feel a sense of belonging in the community	1	2	3	4	5
9. I am proud to live in this community	1	2	3	4	5
Generally, people in this community……	**SD**	**D**	**S**	**A**	**SA**
10. Are concerned about mental health	1	2	3	4	5
11. Consider mental health an important issue	1	2	3	4	5
12. Talk openly about mental disorders and mental health	1	2	3	4	5
13. Believe that mental disorders impacts the community	1	2	3	4	5
14. Talk about mental health at community meetings	1	2	3	4	5
15. Work together to promote mental health	1	2	3	4	5
16. Work together to reduce the effects of mental illness	1	2	3	4	5
17. Believe they can address their mental health needs	1	2	3	4	5
18. Exchange information about mental health	1	2	3	4	5
19. Take mental health seriously	1	2	3	4	5
Generally, people in this community……	**SD**	**D**	**S**	**A**	**SA**

20. Work together to solve problems in the community	1	2	3	4	5
21. Talk to each other about how to solve community problems	1	2	3	4	5
22. Discuss different ways to solve community problems	1	2	3	4	5
23. Are open to different views on their problems and solutions	1	2	3	4	5
24. Volunteer to help solve community problems	1	2	3	4	5
25. Find causes of their problems so they can address them	1	2	3	4	5
26. Cooperate among themselves to solve community problems	1	2	3	4	5
27. Not only talk about problems but they also try to solve them	1	2	3	4	5
28. Try different approaches to solving community problems	1	2	3	4	5
The leaders in this community….	**SD**	**D**	**S**	**A**	**SA**
29. Represent our opinions	1	2	3	4	5
30. Are responsive to our concerns	1	2	3	4	5
31. Work together effectively	1	2	3	4	5
32. get a lot done for the community	1	2	3	4	5
33. Represent all the different kinds of people in the community	1	2	3	4	5
34. Encourage participation in community decision making	1	2	3	4	5
35. Are trustworthy	1	2	3	4	5
36. Act responsibly with the power they have	1	2	3	4	5
37. Put the community’s' needs first-before their own needs	1	2	3	4	5
38. Are honest; there is little corruption among them	1	2	3	4	5

Social Identity Mapping Questionnaire (Cruwys et al. 2016)

				Rate on a scale 1 – 10, the extent to which…					Which group is...	
No.	Social Groups	How long have you been a [illegible]?	How many times in a moth do you engage in group's	You identify with this	You feel positive about the group	The group is respected in the [illegible]	The group's norms promote	It is difficulty being a member	More similar to this group?	Very different from this group?
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										

APPENDIX VI: Methods, Flow Chart and Summary of Systematic Reviews

Methods and Search Processes

A systematic literature search was undertaken on online databases (Google scholar, ScienceDirect, PubMed, Sage, AJOL). Then reference list of the obtained articles was also checked for mental health studies conducted at the community level in Ghana but do not contain the search terms. In addition, a search was conducted in some departments (Departments of Psychology, Department of Community Mental Health, Department of Sociology, Department of Social Work, D), institutes (Regional Institute for Population Studies, and Institute of Statistical, Social and Economic Research), and centres (Centre for Social Policy Studies) of University of Ghana (UGSpace) for masters and PhD theses on community-based mental health research in Ghana.

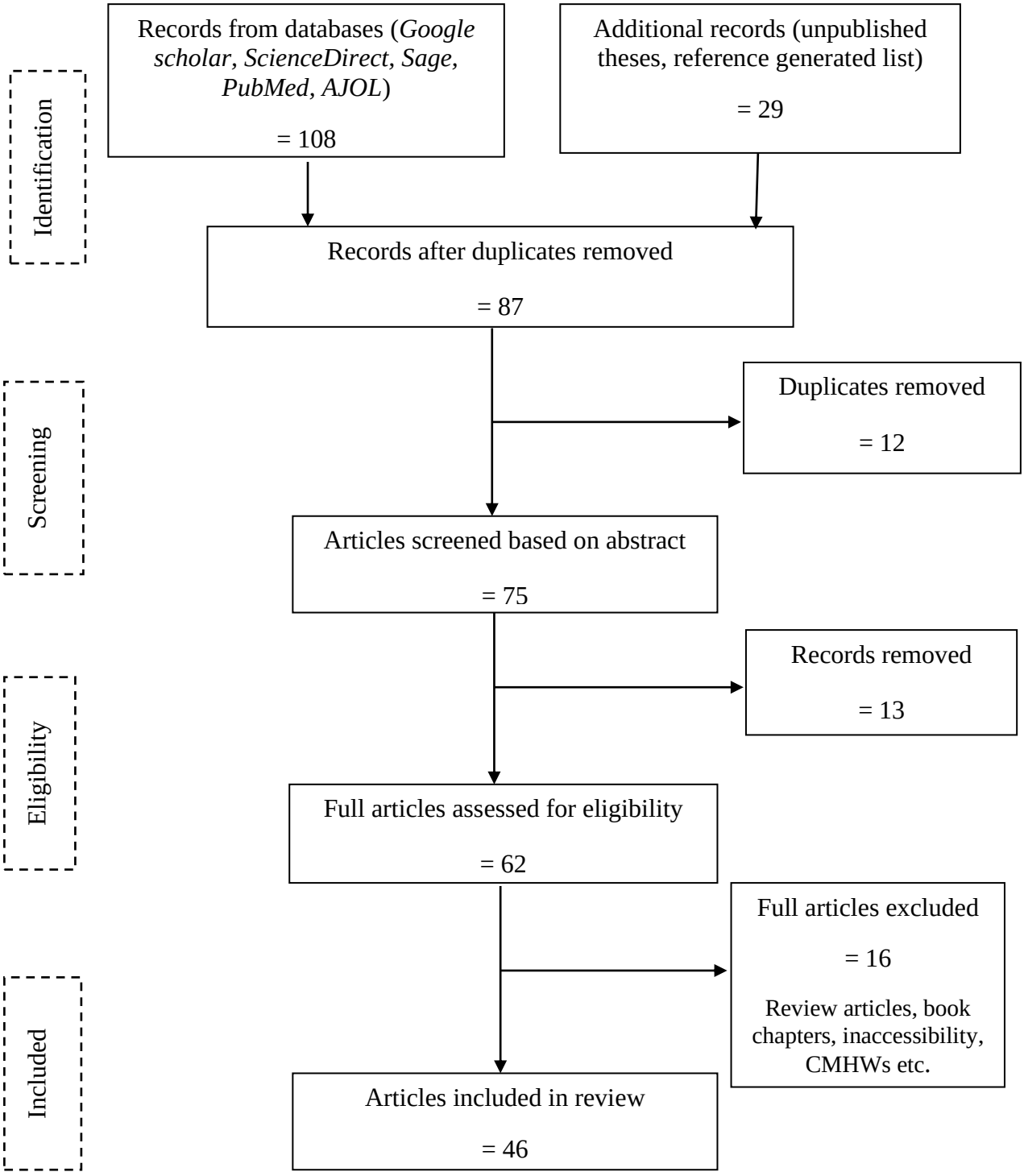


Figure 2. 2: PRISMA Flow of Community Mental Health Research in Ghana

Table 2. 1: Synthesized themes in community mental health research in Ghana

Research theme	**No of articles**	**References**
Community representations of mental illnesses (knowledge, perceptions, beliefs, attitudes, stigma), including perception of psychotropic drugs	12	Field (1958); Atuoye & Luginaah (2017); Opare-Henaku & Utsey (2017); Adeeku (2015); Barke et al., (2011); Adjei et al., (2013); Tenkorang (2017); Adombiri-Naba (2013); Kyei et al. (2014); Read (2012); Bampoe, 2017
Community responses to mental disorders (self-help groups; family support, mental health help-seeking, reintegrating individuals with mental disorders into community, experiences of community mental health professionals)	12	Quinn & Evans (2010); Quinn (2007); Read et al. (2009); Cohen et al. (2012); Ofori-Dua (2014); Read (2017, 2019); Sakyi (2015); MacIntosh (2015); Sahl (2017); Bampoe (2017); Bonsu (2018); Smith (2018)
Community-level determinants of mental health problems (disorders, food insecurity, migration status, homelessness, cohesion)	11	Grief & Dodoo (2015); Atuoye & Luginaah (2017); Kushitor et al. (2018); Dzator (2013); Asafu-Adjaye (2015); de-Graft Aikins & Ofori-Atta (2007); Boyce et al. (2009); Asante (2016); Amoah (2018); Tornuxi (2015); Kushitor et al. (2018)
Community social groups at risk of mental health problems (chronic non-communicable disease patients, suicide attempts, attempt survivor families, informal caregivers, girls in mining, women, children with disability, elderly, siblings of children with mental disability)	12	Teye (2013); Osafo et al., (2015); Kyei-Arthur (2013); Kyei-Arthur (2017); Doh et al. (2016); Asare-Doku et al. (2017); Kyeremanten (2012); Agbolosoo (2014); Akorful (2015); Ofosu-Budu (2014); Cooper (2016); Ae-Ngibise et al (2015)
Total	**46**	

Social identity systematic review: Methods and Search Processes

A systematic literature search was undertaken using four databases (i.e. ScienceDirect, PubMed, Sage and Google Scholar), using the search terms such as “social identities” OR “social identity” AND “mental health” OR “depression” OR ‘well-being”. Backwards literature search was used where the reference lists of key research articles were checked for eligible studies that were missed by the search terms. The search and selections processes are reported on Figure 2.3.

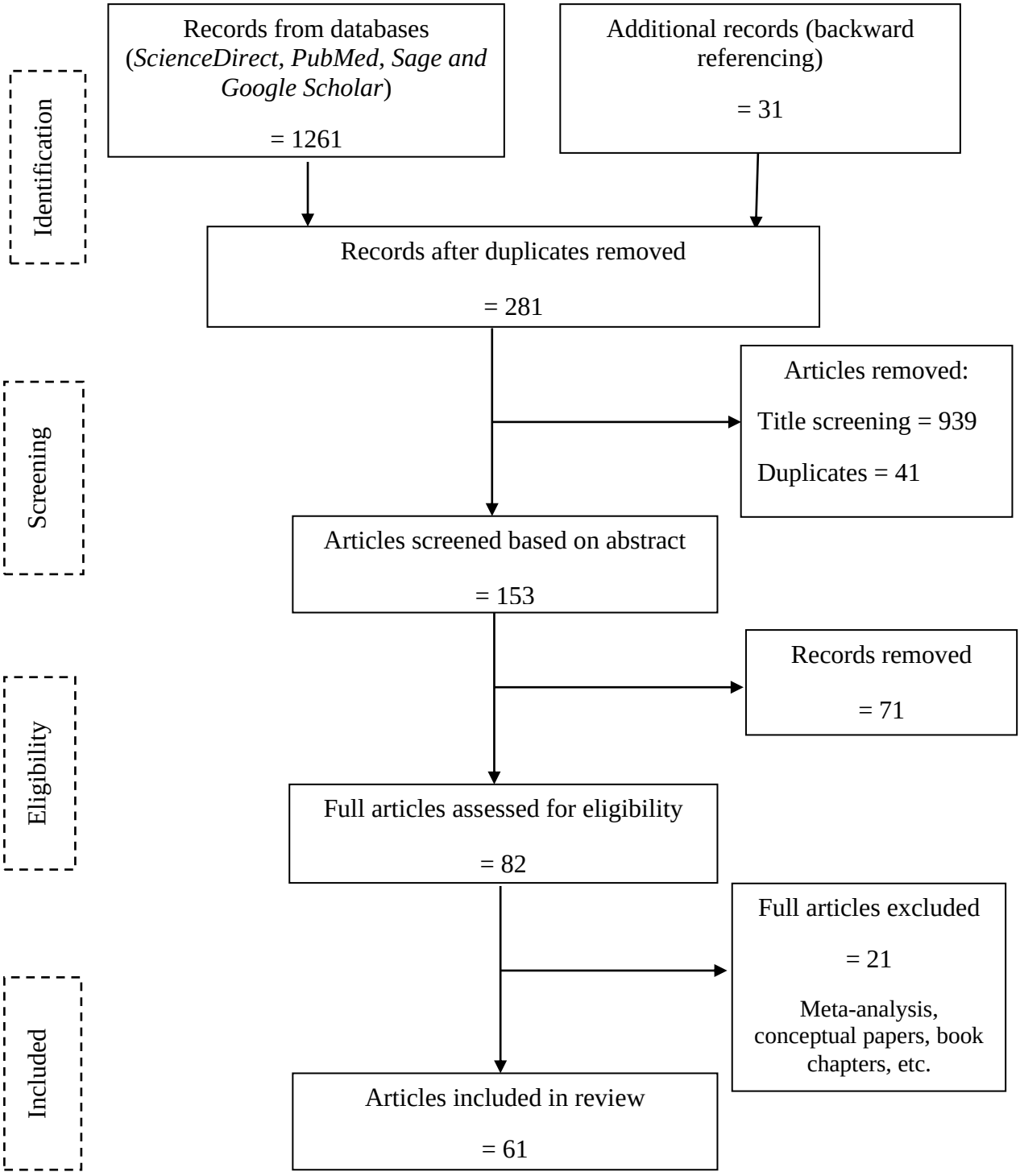


Figure 2. 3: PRISMA Flow of Social Identity and Mental Health Literature Synthesis

Table 2. 2: Thematized mental health outcomes in social identity literature synthesis

Mental health indicator	***f (%)***	**References**
Depressive disorders	26	Ai et al. (2015); Arbona & Jimenez (2013);

(geriatric depression, depressive symptoms, depressive attribution style)	(42.6%)	Arbona & Jimenez (2014); Bizumic et al. (2009); Bogart (2015); Branscombe & Wann (1991); Cameron et al. (2018); Chang et al. (2017); Iyer et al. (2009); Cruwys & Gunaseelan (2016); Cruwys et al. (2014); Cruwys et al. (2013); Cruwys et al. (2016); Haslam et al. (2016); McIntyre et al. (2018); Sani (2012); Sani et al. (2010); Sani et al. (2015); Settles (2004); Smeekes et al. (2017); Stirratt et al. (2008); Tong, Reynolds, Lee & Liu, 2019; Yip et al. (2007); van Dick (2017); Ysseldyk et al. (2013);
Stress-related (psychological distress, posttraumatic stress, stressor acceptance, chronic stress, perceived stressor intensity, college stress)	12 (19.7%)	Ai et al. (2015); Cameron et al. (2018); Crane et al. (2018); Cooper et al. (2018); Cruwys et al. (2016); Yip et al. (2007); Cruwys & Gunaseelan (2016); Wohl & van Bavel (2011); Sani (2012); Chang et al. (2017); Saeri et al. (2018); van Dick (2017);
General well-being (General health, quality of life, life satisfaction, self-rated health, personal well-being)	12 (19.7%)	Branscombe et al. (1999); Cameron et al. (2018); Cassidy (2003); Cruwys et al. (2014); Cruwys et al. (2016); Haslam et al. (2016); Miller et al. (2015); Miller et al. (2017); Settles (2004); Smeekes et al. (2017); Ysseldyk et al. (2013); van Dick (2017);
Psychological well-being (Self-esteem, Subjective happiness, Cognitive functioning)	11 (18%)	Bizumic et al. (2009); Branscombe & Wann (1991); Cooper et al. (2017); Crabtree et al. (2010); Haslam et al. (2014); Haslam et al. 92016); Kerby, Wilson, Nicholson & White, 2005; Latrofa et al. (2009); Lam et al. (2018); McIntyre et al. (2018); Settles (2004); Stirratt et al. (2008);
Anxiety-related (general anxiety, social anxiety)	9 (14.8%)	Bizumic et al. (2009); Bogart (2015); Cruwys et al. (2014); Cruwys et al. (2016); Haslam et al. (2016); McIntyre et al. (2018); Sani et al. (2010); Smeekes et al. (2017);
Social/relational health (social well-being, Social support, collective well-being, social functioning, collective self-esteem, alienation; loneliness, alienation)	6 (9.8%)	Branscombe & Wann (1991); Branscombe et al. (1999); Cooper et al. (2017); Haslam et al. (2016); Kearns et al. (2018); Lindsay-Smith et al. (2018)
Emotional dysregulation (loss of emotional control, negative emotions state, suppression of emotional expression, positive affect)	4 (6.6%)	Bizumic et al. (2009); Chang et al. (2017); Hunt & Burns (2017); Iyer et al. (2009)
Minority stressors (minority stress, acculturation stress, internalized homophobia,	5 (8.2%)	Arbona & Jimenez (2014); Chang et al. (2017); Kearns et al. (2018); Stirratt et al. (2008);

Perceived discrimination, Perceived stigma)		
Paranoid schizophrenia (paranoia, auditory verbal hallucinations)	2 (3.3%)	Greenaway et al. (2018); McIntyre et al. (2018);
Substance use and misuse (amphetamine type stimulants; alcohol; other drugs)		Beckwith, Best, Dingle, Perryman & Lubman, 2015; Best et al., 2016; Curtis & Eby, 2010; Dingle et al., 2019; Kerby et al., 2005; Mawson, Best & Lubman, 2016; Ottu & Oladejo (2014)
Eating disorders		Bouguettaya, Moulding, King & Harrold (2019)
Unspecified mental illness		Klik, Williams & Reynolds (2019)

Table 2. 3: Thematized social groups in social identity and mental health literature synthesis

Social groups	***f* (%)**	**References**
Stigmatized groups (older adults, sexual minority, racial minority, mental health patients, chronic disease patients, refugee groups, ethnic minority, mental health support groups, disable groups, therapeutic communities, drug users)	23 (36.1%)	Ai et al. (2015); Arbona & Jimenez (2013); Arbona & Jimenez (2014); Best et al., (2015); Beckwith et al. (2015); Bogart (2015); Branscombe et al. (1999); Cameron et al. (2018); Cruwys et al. (2016); Cooper et al. (2017); Cooper et al. (2018); Crabtree et al. (2010); Cruwys & Gunaseelan (2016); Curtis & Erby (2010); Dingle et al., (2019); Dirth & Brascombe (2019); Kerby et al. (2005); Latrofa et al. (2009); Haslam et al. (2016); Lindsay-Smith et al. (2018); Jackson et al. (2009); Mawson et al. (2016); McNamara et al. (2017); Smeekes et al. (2017); Stirratt et al. (2008); Wohl & van Bavel (2011); Ysseldyk et al. (2013); Yip et al. (2007)
Non-stigmatized groups (students, religious groups, professional groups, political groups	20 (32.8%)	Arbona & Jimenez (2013); Bizumic et al. (2009); Branscombe & Wann (1991); Cameron (2004); Cassidy (2003); Cruwys et al. (2013); Cruwys et al. (2015); Haslam et al. (2016); Hunt & Burns (2017); Iyer et al. (2009); Kearns et al. (2018); Leach et al. (2008); Yip et al. (2007); Bizumic et al. (2009); McIntyre et al (2018); Miller et al. (2015); Sani et al. (2010); Sani (2012); Settles (2004); Van Dick et al. (2017); Tong et al. (2019)
Interactive groups (Community recreation group, sports groups, social clubs, family, friends	5 (8.3%)	Branscombe & Wann (1991); Cruwys et al. (2014); Greenaway et al. (2018); Sani et al. (2010); Sani (2012)
Non-interactive social groups (adolescents, people with mental illness, women recovering from eating		Bouguettaya et al., (2019); Klik et al., (2019); Ottu & Oladejo (2014)

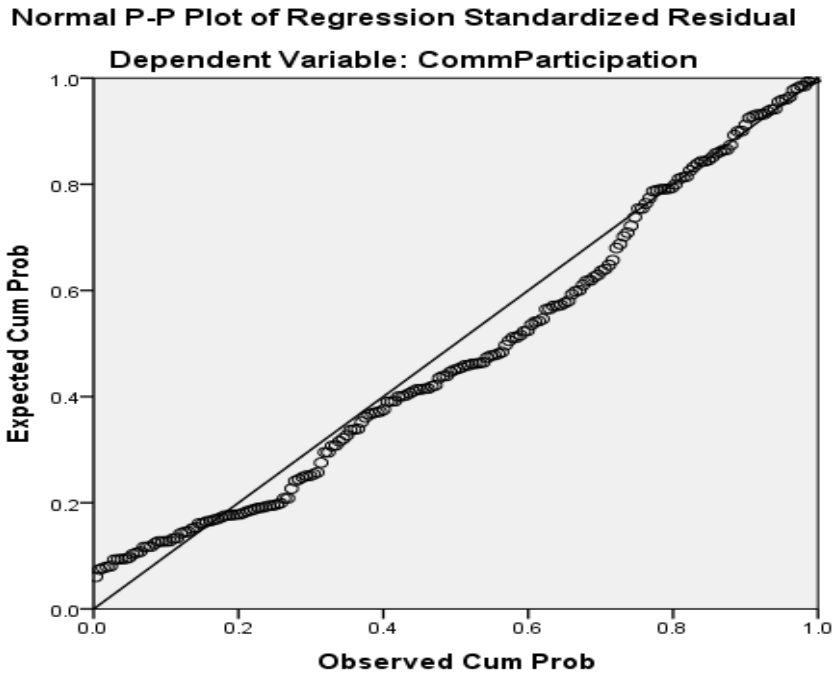
disorders)		
Social categories (racial groups)	1 (1.7%)	Chang et al. (2017);
Unspecified social groups (general population)	5 (8.3%)	Crane et al. (2018); Haslam et al. (2014); Lam et al. (2018); Saeri et al. (2018); Sani et al. (2015);

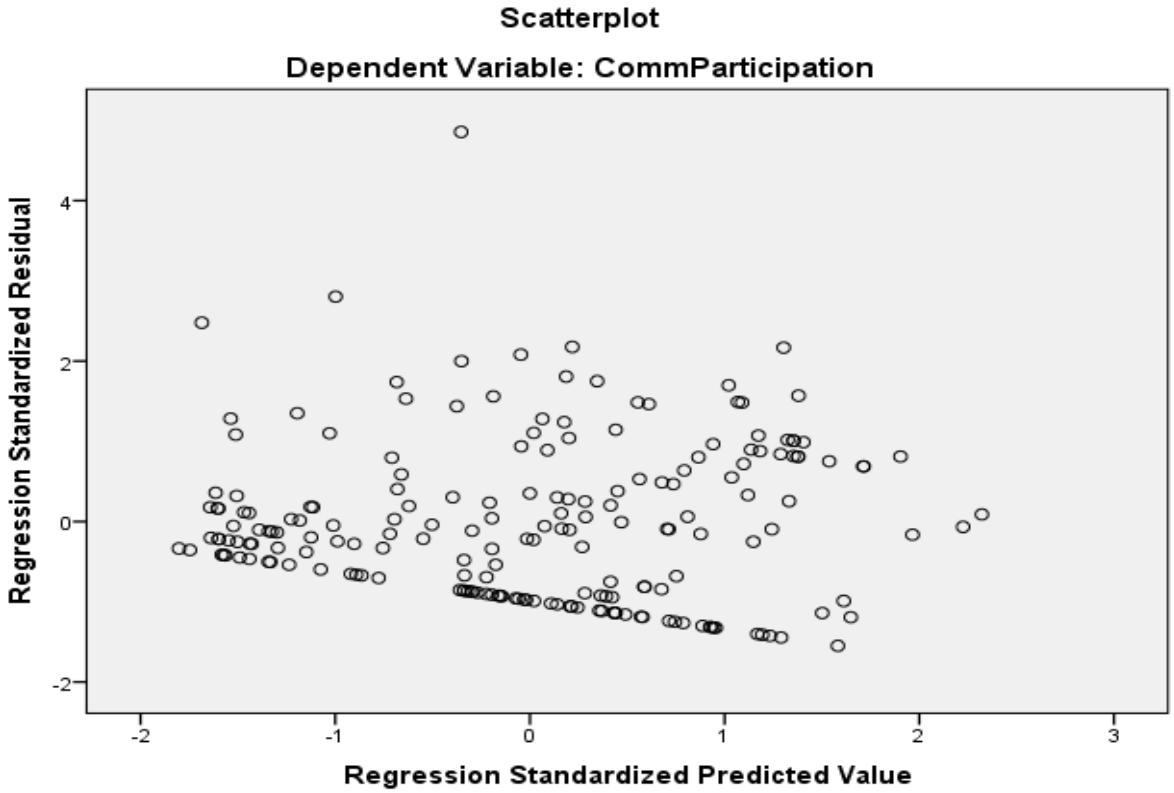
Table 2. 4: Conceptualization of social identification in social identity and mental health

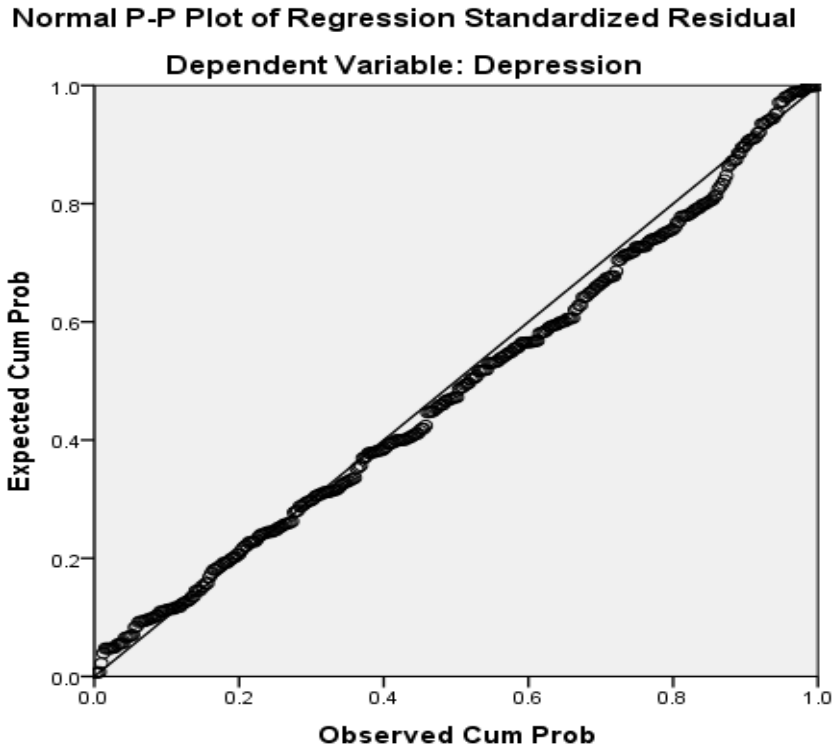
Social identification conceptualization	***f* (%)**	**References**
Multiple groups memberships and multiple identities (identity continuity, congruence, compatibility)	14 (23%)	Cruwys et al. (2013); Cruwys et al. (2015); Cruwys et al. (2016); Greenaway et al. (2018); Haslam et al. (2014); Haslam et al. (2016); Iyer et al. (2009); Lam et al. (2018); Miller et al. (2017); Smeekes et al. (2017); Sani et al. (2015); Stirratt et al. (2008); van Dick et al. (2017); Ysseldyk et al. (2013)
Centrality (perceiving group as central aspect of self-concept)	11 (18%)	Bogrart (2015); Cooper et al. (2017); Crabtree et al. (2010); Crane et al. (2018); Cruwys & Gunaseelan (2016); Kearns et al. (2018); Lindsay-Smith et al. (2018); Quinn & Chaudoir (2009); McIntyre et al. (2018); Settles (2004)
Satisfaction with group (positive feelings of group membership)	10 (16.4%)	Ai et al. (2015); Arbona & Jimenez (2014); Cassidy (2003); Cooper et al. (2017); Cooper et al. (2018); Crabtree et al. (2010); Cruwys & Gunaseelan (2016); Kearns et al. (2018); McIntyre et al. (2018); Wohl & van Bavel (2011)
Individual stereotyping (perceiving self as similar to other group members)	9 (14.8%)	Bizumic et al. (2009); Branscombe & Wann (1991); Branscombe et al. (1999); Cooper et al. (2017); Cooper et al. (2018); Crabtree et al. (2010); Cruwys & Gunaseelan (2016); Kearns et al. (2018); Latrofa et al. (2009)
Solidarity (perceived sense of belonging and psychological and emotional bond with and commitment to group)	7 (11.5%)	Cooper et al. (2017); Cooper et al. (2018); Cruwys & Gunaseelan (2016); McIntyre et al. (2018); Miller et al. (2015); Saeri et al. (2018); Wohl & van Bavel (2011)
In-group homogeneity (perceiving group as sharing commonality that makes group homogenous, which establishes the group as a coherent social identity); *Group boundary permeability*	5 (8.2%)	Chang et al. (2017); Cooper et al. (2017); Cooper et al. (2018); Cruwys & Gunaseelan (2016); Sani et al. (2010); Dirth & Branscombe (2019)
Social engagements and connectedness (connected, companionship, affiliation,	4 (6.6%)	Haslam et al. (2014); Hunt & Burns (2017); Jackson et al. (2009); Sani (2012)

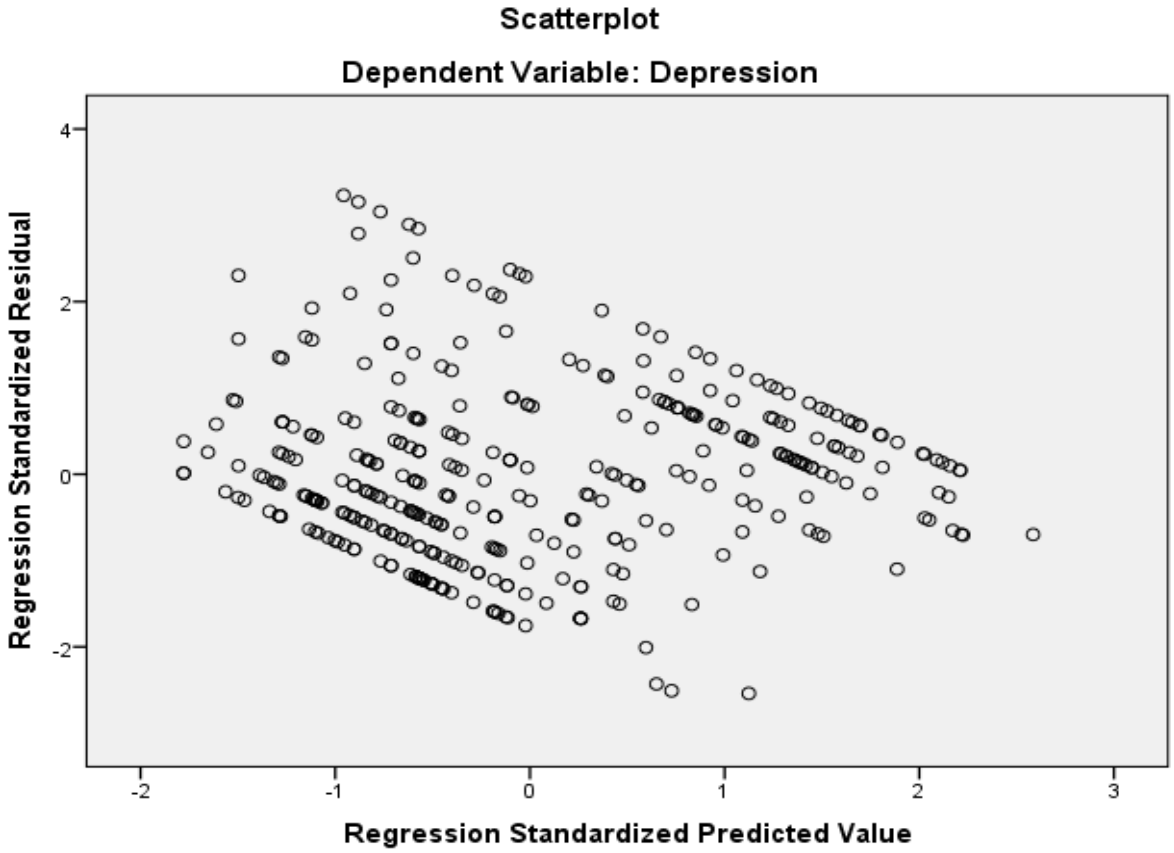
social contact, social integration)		
One item identification with social group	1 (1.6%)	Miller et al. (2015); Tong et al. (2019)
Multiple item measure of social identity		Beckwith et al. (2015); Hynes & Zinkiewicz (?????); Kerby et al (2005); Ottu & Oladejo (2014)
Identity differentiation		Dingle et al. (2019)
Social group memberships		Mawson et al (3026)
Identification to mental illness		Klik et al (2019)

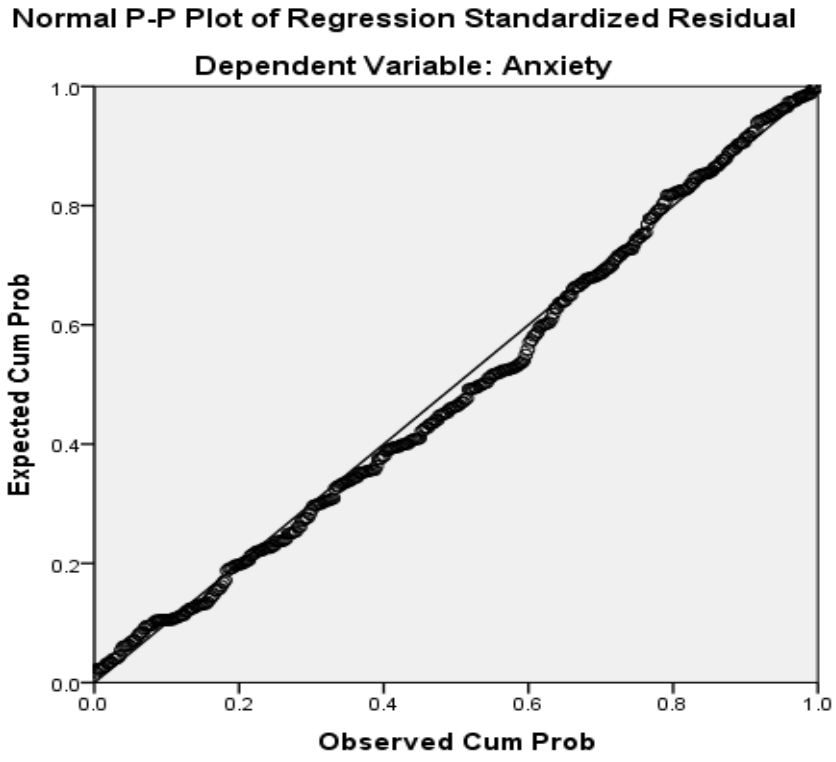
APPENDIX VII: Outputs of Quantitative Test of Assumptions

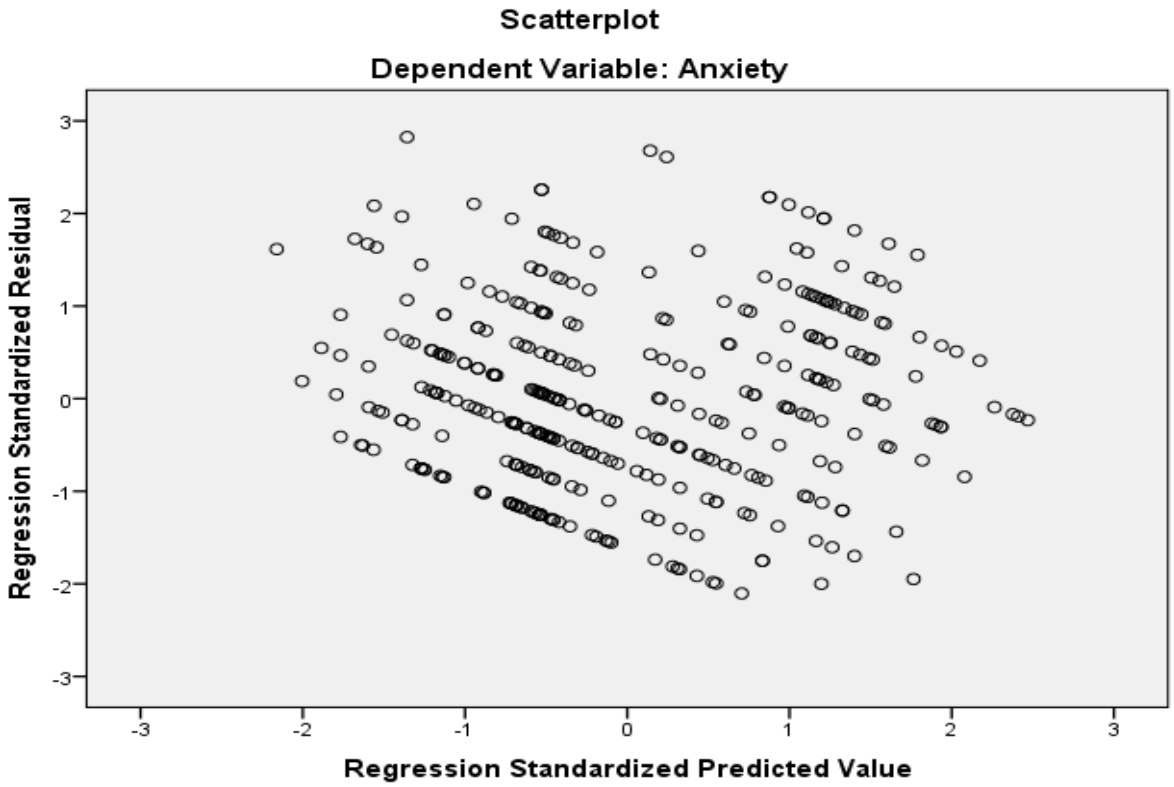



Scatterplot
Dependent Variable: CommParticipation
Regression Standardized Residual
Regression Standardized Predicted Value
4
2
0
-2
-2
-1
0
1
2
3


Normal P-P Plot of Regression Standardized Residual
Dependent Variable: Depression
Expected Cum Prob
Observed Cum Prob
1.0
0.8
0.6
0.4
0.2
0.0
0.0
0.2
0.4
0.6
0.8
1.0


Scatterplot
Dependent Variable: Depression
Regression Standardized Residual
Regression Standardized Predicted Value
4
2
0
-2
-2
-1
0
1
2
3


Normal P-P Plot of Regression Standardized Residual
Dependent Variable: Anxiety
Expected Cum Prob
Observed Cum Prob
0.0
0.2
0.4
0.6
0.8
1.0


Scatterplot
Dependent Variable: Anxiety
Regression Standardized Residual
Regression Standardized Predicted Value
3
2
1
0
-1
-2
-3
-3
-2
-1
0
1
2
3