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PSYCHIATRIC INSTITUTIONS IN
GHANA: TOWARDS AN UNDERSTANDING
OF ERVING GOFFMAN'S TYPOLOGY

A THESIS SUBMITTED TO THE UNIVERSITY OF GHANA
IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE

M. PHIL (SOCIOLOGY) DEGREE



BY

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LEGON, NOVEMBER 1989.

DECLARATION OF ORIGINALITY

I declare that this Thesis, with the exception of quotations expressly identified herein, is a record of an original work done entirely by me.



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ABSTRACT

The main thrust of this thesis has been to examine Erving Goffman's typology of a Total Institution in the light of Ghanaian psychiatric institutions.

In the typology Goffman classifies mental hospitals as Total Institutions. The typology came into being when he was examining psychiatric institutions in western cultures.

A central problem that was posed in the Thesis was to see whether Goffman's typology has applicability in the Ghanaian cultural environment taking into consideration its western origin and the improvement in psychiatric medicine in recent years.

Two hypotheses which were investigated and confirmed by this study are:

1. "That the psychiatric hospitals in Ghana are closed systems in which inmates do not have an easy contact with the wider society due to lack of resources".
2. "That the psychiatric hospitals in Ghana have partially renounced their custodial nature and have resorted to diagnosis treatment and rehabilitation of patients as a result of the emergence of new ideas in the field of medicine."

The findings in this Thesis are that the mental hospitals are characteristically custodial establishments inspite of recent improvements in therapeutic techniques and therefore in principle confirm Erving Goffman's model.

The study has suggested then that since the Ghanaian psychiatric hospitals like those elsewhere are only keeping the mental patients in custody there is the need to strengthen their rehabilitation programmes designed for the patients to enable them to function physically and socially in society.

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CHAPTER ONEMETHODOLOGYINTRODUCTION

This study aimed at finding out whether the psychiatric institutions in Ghana operated in accordance with Erving Goffman's model of the mental hospital. The motivation for the study arose out of the need to re-examine the extent of the validity of the model in the light of present - day technological changes that have occurred in the field of psychiatry since its formulation.

Erving Goffman's typology of the mental hospital is contained in his book entitled Asylums which was published in 1961. In the book he outlined his theory of a total institution. The theory showed the relationship between the organization of certain social institutions including psychiatric hospitals. He defined a total institution as:

"a place of residence and work where a large number of like-situated individuals cut-off from the wider society for an appreciable period of time together lead an enclosed formally administered round of life". (P 11)

Goffman focused on the socio-cultural description of a mental hospital with emphasis on the inmates' social world and moral careers.

The other organisations include prisons, monasteries, homes for the blind, orphanages, old people's homes and military camps.

The total institution is mostly residential and all aspects of the inmate's life-eating, bathing, worshipping, reading, washing and shopping - are carried out inside it.

It is physically out off from the rest of the community by a barrier like a wall, a barbed wire or a long distance.

All the activities of the inmates occur in the immediate company of the others and are carried out together. The phases of the activities follow a strict schedule aimed at fulfilling the objectives of a rational plan supposedly designed to meet the official goal of the institution.

The institution is usually under one authority and all the inmates are treated alike.

The establishment is mostly made up of a small number of a staff of supervisors and a large number of inmates. The nature of the establishment, however, creates a built-in hostility or conflict between the two groups. This is because the supervisors consider themselves as superior and righteous and refer to the status of the inmates as inferior and guilty of failure in the normal world. As a corollary than, there is a caste-like form of social stratification

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in the total institution that gives rise to a great social distance between the staff and the inmates.

The organization is bureaucratic in nature. It is a hierarchically segmented formally organised collection of officers devoted to a rational attempt of accomplishing a mission and in the case of the mental hospital it is a custodial care. The supervisory staff are required to maintain a spirit of impersonal and universalistic approach to duty. Inmates are treated as cases but not as individual human beings. The duty of the staff is not guidance or protection but surveillance, a seeing to it that the inmates do clearly what they have been told to do.

The total institution is characterised by a strict social control system aimed at enforcing conformity and re-shaping the supposedly antisocial attitudes and values of the inmates. Their ways of bathing, dressing, walking and even eating are observed and reports are submitted on them by the staff to their superior officers. The ultimate objective here is that the inmates are to be resocialised to assume new roles that are commensurate with the requirements of the norms of the society in which they live.

After sketching the essential features of the total institution in general Erving Goffman went on to outline those

that pertain to the psychiatric hospital in particular. These themes are examined below; they however constitute the focus of this study.

The theory states that due to the historical development and the nature of mental illness the psychiatric institution has been starved of adequate resources, technological and human, and therefore plays a custodial role. The mental hospital is a prison - like institution where the inmates have been kept so as to separate them from the wider society to prevent them from harming themselves and the general public as well. There is more restriction on their movement than that of patients of other hospitals partly because their judgement is considered questionable and partly because they have suicidal impulses.

The mental hospital is a closed system. A most obvious characteristic of the inmates' social system is the lack of social contact with the outside world. Patients' movements are confined within the hospital walls only. They receive visitors only with permission and even their conversations with them have to take place in the full view of the staff. Similarly all letters they receive come under censorship.

A patient cannot easily get out of the hospital without passing through a series of formalities for permission because

the staff members feel that he is self-sufficient in terms of his material requirements in the establishment. When a patient takes French leave the hospital authorities take retributive measures against the entire patient population including revision of rules on parole, trial leave and out patient status.

There is a social control device in the psychiatric hospital which Goffman calls the "privilege system". This device aims at achieving the co-operation of the inmates and comprises three basic elements: the house rules, rewards and punishments. When the patient enters the institution, he is given a number of rules which comprises the prescriptions and the prescriptions that are to govern his conduct while on admission. They spell out in a general outline what to do and what not to do - for example when to eat, to sleep, to receive a visitor, to go out and to go to work.

Rewards are provided in exchange for obedience to the staff. Offer of rewards has been institutionalised and obedient inmates may obtain extra food, receive more visitors, better jobs or even presents from the staff.

Punishments, on the other hand, are administered for infraction of the house rules and may take the form of flogging, chaining of an inmate to a post, a lock up of an inmate in an isolated ward, an electric shock or a ridicule.

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The patient becomes depersonalised as a result of his confinement and the attitude of the staff towards him. In their attempt to adjust him to the hospital environment the supervisors reduce him to a dependency child. He is subjected to a series of abasements, degradations, humiliations and profanations. He may be required to remove and dispose of his own toilet, confess his sins, stand upright when talking to a staff member or he may be cained for breaking a house rule.

Another humiliating process in the mental hospital is the admissions procedure. One phase of the admissions procedure is personal defacement. On admission, the patient is thoroughly searched and is stripped of all his personal belongings which are returned to him only after discharge.

In addition, he is shaved in a way that pleases the staff; his finger print is taken and he is given a numbered uniform. In the establishment he is known by his number but not by his name.

The patient is exposed to yet another defaming experience which is personal disfigurement. By this process he undergoes surgery, shock therapy or whipping.

He undergoes physical contamination as well. He is thrown into a crowd of people of different intensity and forms of mental disorder. The patient therefore lives in a state of

perpetual insecurity since a fight may follow even a slight disagreement within his group at any time. At times he may be required to eat unclean food and may be made to sleep near the dead in the same ward.

Another bitter experience to which the patient is exposed is verbal profanation. He is given nicknames and is ridiculed before his colleagues.

The depersonalization processes and the admission procedure give rise to a situation which Goffman calls "the mortification of the self." It is a situation in which the inmate drastically loses his self-esteem.

The theorist goes on to show that the mortification of the self brings about certain behaviour patterns on the part of the inmates. In other words, they adapt themselves to the prevailing social conditions in the hospital in several ways. Some of them adopt an intransigent line while others tow the line of the staff.

Several patients do not show any form of compromise towards the policies that originate from the institution. They are disobedient generally. Majority of the intransigent patients are the long - stay ones. They are recidivists or have chronic mental disorders and have therefore become acclimatised to the hospital's social environment. Their hope of ever leaving the institution for their homes is either little or

nonexistent.

On the other hand, those patients who are hopeful of being discharged early as indicated by their diagnosis are not stubborn. They obey the hospital rules to the letter.

Certain features are identified by Goffman as problem areas in the inmates' world. The problems centre on the signs and symptoms of their mental disorder, sexual relations and alienation. Signs like delusions and hallucinations constitute conflicts in their lives. When they become possessed by these conditions they tend to unknowingly commit offences. They may slap or injure other people or spoil property. When the disturbance subsides and they return into a sober mood they become very sorrowful on being made aware of the harm they had caused.

The deprivation of heterosexual relationship creates a similar problem in the patients' social system. Male patients are not allowed to interact with their female counterparts in any way. Violation of rules relating to sexual relations is punishable because the supervisors believe that sexual matters tend to induce anxiety among the patients especially the males. The theorist is of the opinion that the sexual problem is the source of the homosexual impulses among the male patients which the supervisors try in vain to eradicate.

The patients have a feeling of alienation from the wider society. Their physical and social separation from their

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families and friends is considered by them as a betrayal by society. The feeling is aggravated when the frequency of visits is reduced or ceases altogether. This situation gives rise to the loss of a sense of belonging among the patients.

Goffman does not consider the psychiatric hospital as a therapeutic agency. He believes that the hospital is a "forcing house" where people - the patients - are held in captivity against their will, and through no fault of theirs, for the purpose of sheltering them from stresses and strains of the wider community. He sees this as the sole purpose of the hospital. While on admission, he explains further, the patients are made to work - to wash plates, to scrub the floor, to rake leaves or to learn a skill in the occupational therapy workshop. The claim presented to the patients by the hospital authorities is that these tasks help them to re-learn how to live in the wider society and that their capacity and willingness to handle them are considered as diagnostic evidence of their improvement.

Every patient requires a guardian or as Goffman puts it "next-of-kin". This person must be a relative and must accompany the patient while being admitted. He has to sign a form to guarantee the hospitalization of his patient. The hospital asks him to supply all the needs of the patient which the hospital may not be in a position to provide. He is also expected to visit his patient as often as possible. On discharge he

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arranges with the hospital authorities how best to handle the patient in the house to avoid recidivism. In case of the death of the patient in the institution he takes care of the evacuation of the corpse for burial.

There are specific occasions on which the social gap between the staff and the patients is bridged. These are the periods of institutional ceremonies. At these ceremonies the two groups of people come close enough together to get a somewhat favourable image of the other and to identify sympathetically with the other's situation.

These solemn practices constitute a symbol of unity, solidarity and joint commitment among the occupants of the institution.

The ceremonies are annual in nature and take the form of get togethers, dances and games. They usually occur during the Christmas season. At the functions the usual chain of command and formality that governs staff - inmate contact is softened.

In the theory Erving Goffman throws some light on the etiology and the treatment of mental illness and the stigma that accompanies an institutionalised patient after his discharge. He believes that the causation of psychiatric disorder cannot be understood by using a single formula. It may be brought about by a series of factors which combine to make the person behave that way. The patient's past life, his present circumstances,

his personality and social environment are all etiological factors. It is therefore impossible to understand the illness without understanding a good deal about the patient's life. As no two personalities are the same the illness differs in form from one person to another. For example, the psychotic patient lives in his own world, - a world of fantasy - the schizophrenic has hallucinations and delusions, while the neurotic patient is haunted by phobias. These conditions can hardly be repaired in the same sense as an attempt is made to repair or unite a fractured bone. Mental disorder is therefore a phenomenon which is ill-defined.

Accordingly, the search for a quick cure for mental illness has proved fruitless. There is no pill, and no injection that are administered which bring the patient back to health overnight. The treatment involves a therapeutic programme which is standard for all persons; it is not specific. Several therapeutic methods may have to be applied and treatment may be extended over a year or more before results may perhaps be achieved.

Generally, in mental illness, treatment does not provide a probability of success great enough to justify the practice of institutional psychiatry as an expert service occupation because no particular method is actually effective and de-

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pendable. For example, psychotherapy functions to point out the wrong ways of the patient to him - to see the errors of his ways; sedative treatment is given to hypnotise and immobilize patients so as to reduce staffing; work assignment is described as an industrial or occupational therapy and it allows the patient to express his capacity for doing household duties or for using his skill.

However, since several hospitalized patients relapse the institution tends to damage the life chances of such individuals.

As far as the mental patient is concerned, institutionalization has another disadvantage. Once a person has a record of having been in a mental hospital the public at large, formally in terms of employment restrictions and informally in terms of day to day social treatment or interaction, considers him as a person who is to be set apart. He is to be watched in the way he behaves because he may turn to be antisocial at anytime. Even his employer is told to bring him back to the hospital if his condition deteriorates. His illness is thought to be in a state of slumber and may erupt at anytime. In a word he is stigmatised.

Finally Goffman dwells on the protection that the law gives to the mental patient by way of his exemption from criminal penalty. He shows that a person adjudged mentally ill

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or defective (insane) by medical certification cannot be punished for any crime he commits. This is because according to law, such a person's reasoning faculty is defective and therefore does not understand the nature and the wrongfulness of the act he is committing. He believes that although the law exempts the insane from criminal responsibility yet it creates a problem for him in another area in his social life. Since he is considered to have a defective mind he is thought to be unable to take reasonable decisions on his own. He is therefore deprived of his civil rights. He cannot vote in an election, he cannot make a valid will or institute a divorce action etc.

Erving Goffman's description of the mode of operation of the psychiatric hospital touches on several issues: interpersonal relationship between the staff and the patients, the role of the hospital, the moral career of the patient on admission, the causation of mental illness, treatment processes and the stigma that accompanies institutionalization of the mental patient.

The propositions discussed above could be grouped under seven broad headings.

- (1) Is the purpose of psychiatric institutions in Ghana custodial or therapeutic?
- (2) Is the psychiatric hospital a close system?

- (3) How does the privilege system function in the mental hospital?
- (4) What is the admissions procedure in the psychiatric hospital?
- (5) What are the problem areas of the mental patients?
- (6) What are the treatment programmes in the psychiatric hospital?
- (7) Are psychiatric patients stigmatised?

What this research attempted to do was to find answers to these questions. In pursuance of this objective the activities of the psychiatric hospitals in Ghana were examined in the light of these themes in Chapters Two and Three below.

Panel discussions were engaged in mostly with therapists and patients at group therapy sessions and at occupational therapy workshops.

All the male and female occupational therapy workshops in the three mental hospitals were visited and there were discussions with staff and patients on duty.

II DATA COLLECTION METHODS

The bulk of material contained in the study was obtained from three groups of people associated with Ghanaian mental hospitals: the staff, inpatients and outpatients.

The three hospitals constituted the areas of study. The justification for the study of all the three establishments stemmed from the requirement of this study to understand the psychiatric service in Ghana for comparison with Erving Goffman's typology.

The fieldwork lasted for six months - July to December 1988. In all thirty-six visits were made to the study areas.

Following sociological techniques in such an enquiry, the investigative methods employed comprised mainly structured interview of the selected informants, documentary study and panel discussions. The interview method was used in obtaining field material from the staff, and the inpatient and outpatient populations. Hospital documents were consulted in seeking information on the records of staff and patients.

Panel discussions were engaged in mostly with therapists and patients at group therapy sessions and at occupational therapy workshops. All the male and female occupational therapy workshops in the three mental hospitals were visited and there were discussions with the staff members on duty and patients.

The population of the study in the three hospitals was 3734 and it was made up of 497 staff members 1733 inpatients and 1504 outpatients. From the population, a sample size of 423 was chosen for interview. The sample comprised 100 staff members, 173 inpatients and 150 outpatients.

III OBJECTIVE OF THE STUDY

It is the objective of the research to find out whether Goffman's typology has cross - cultural validity in Ghana in this day and age of technological improvement in psychiatric services.

Before the advent of colonial rule in Ghana mental illness was traditionally thought to be brought about by supernatural forces - witchcraft, break of taboo, magic, demons and ancestral spirits etc. Accordingly, its treatment was in the hands of traditional healers such as fetish priests, herbalists and spiritualists. Included in their pharmacopoeia were herbs, animal parts, vegetables, roots of plants, exorcism and magical spells, (Forster, 1958; Ampofo and Johnson 1978). The traditional healers or native doctors were considered as specialists in the field of medicine and were held in high esteem by society. They flourished in all parts of the country.

British Colonial Rule was established in Ghana in the middle of the 19th century. It was not long afterwards in 1878 that Western medicine now known as modern medicine was introduced. And towards the end of the century an Asylum was opened in Accra.

At present there are three psychiatric hospitals in the country: Accra, Pantang and Ankaful. The three hospitals together have a total bed capacity of 1809.¹

Mental patients seek psychiatric care at these hospitals as a last resort after abortive treatment by traditional healers, (Twumasi 1986). This situation prevails particularly perhaps because the Ghanaian Society is not well informed about the effectiveness of psychiatric service today. Asare (1986, 1988) maintains that with the introduction of effective psychotropic drugs in the psychiatric hospitals since the 1960s the role of the hospitals is changing considerably.

1. Source: This figure was obtained from a ward to ward counting of beds at the time of the study.

In line with the objective the following hypotheses are to be tested:

- (1) That the psychiatric hospitals in Ghana are closed systems in which inmates do not have an easy contact with the wider society due to lack of resources.
- (2) That the psychiatric hospitals in Ghana have partially renounced their custodial nature and have resorted to diagnosis, treatment and rehabilitation of patients as a result of the emergence of new ideas in the field of medicine.

IV. RELEVANT BACKGROUND REVIEW

Geoff Shepherd (1984) traces the history of the concept of asylum and the rationale for its custodial character. He maintains that the prehistory of asylum (place of refuge) can be traced back to the early part of the medieval period. He shows that the first Lunacy Legislation took place in England in the year 1320. By that Act Lunatics were confined to a hospital in London called Bethlem and their properties were vested in the crown. Shepherd believes that that period marked the first institutionalisation of the mentally ill in the world.

The main objective of their institutionalisation was to segregate them from the wider society and thus protect society from their harmful activities.

In 1601 another legislation came into force in England. It was the Poor Law Act and it simply lumped the lunatics together with the rest of the poor who according to the definition of the law included the old, the blind, the orphan, the lame and any other person who could not look after himself. Prominent people at that time like church leaders and landowners were appointed by each parish or community to take care of these destitutes.

During the period of Enlightenment in the 18th and 19th Centuries, the community became more interested in the mentally disordered. With authority from the British Government private people were allowed to take charge of the lunatics. Private madhouses were built for the safe keeping of the mad. The madhouses however varied in terms of the services they offered. Some were undoubtedly caring and concerned while others displayed a level of callousness and brutality which was highly appalling. In addition they were not subject to any kind of outside scrutiny. There was as such much growing public concern about the nature of their operations.

During the period under consideration, one important shift in public opinion was the idea that social problems might be caused by the societies containing them. Social problems were no longer seen simply as the result of some external malevolence or divine will but as the product of defective social structure. If these social structures could be perfected, it was reasoned, then the problems would disappear. People then began to suggest that mental illness might have environmental rather than solely natural causes, and therefore that if the right kind of environment could be created, mental illness might be treatable.

It was the shift in this etiological belief that contributed to the invention of the asylum. The first step was an enactment of a legislation that regulated the affairs of the madhouses. The aim was to bring about humane and therapeutic conditions in the institutions. By that Act the madhouses were not to be only safe havens where the madmen might be dumped and quietly forgotten. Instead they were conceived as an advanced social environment where through the provision of the refuge from the stresses and strains of an obvious corrupt society the mentally ill might be reformed and rehabilitated in order to be productive in life.

In 1808 the first country Asylums Act was passed in England. Local communities were made to fund and build their own lunatic asylums. Similar developments took place in U.S.A. The primary objective of the asylum was to treat the patients so far as their conditions would possibly admit, as if they were healthy human beings.

Certain principles were upheld as guidelines for the moral treatment of the patients. They comprised, an acceptance of a continuum between sanity and insanity. The mentally ill were not to be seen as belonging to a qualitatively separate category of people.

In general an attempt was to be made to create a well - ordered and homely environment like a good family unit. Staff were to mix freely with the patients on equal footing; patients were to be encouraged to help one another in time of need.

There was to be positive encouragement on the part of the staff to instill a sense of hopefulness among the patients.

The asylum was considered an important refuge for the patient and therefore he was not to be punished. It was also required to protect him against the strains and stresses of modern life. As a consequence, it had to be sited far away from the industrial towns which were polluted and noisy. It was important to avoid monotony and

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boredom in the institution. Patients had to be given work and education in order to engage their minds.

By the middle of the 19th century every local community in England and even in U.S.A. had an asylum in which these principles of moral treatment prevailed. In fact the period saw a tremendous spate of the building of mental hospitals in the histories of the two countries. In England the most popular were Bethlem Lincoln and York.

Surprisingly, these principles were short lived. Standards in the mental hospitals were maintained for sometime but began to decline woefully at the end of the first world war. Several reasons contributed to the decline. There was a triumph of legalism over medicine. The public became increasingly worried by the spectre of illegal detention of lunatics in the mental institutions. Because unlike the 19th century and before, about 90% of patients were treated in the hospitals without medical certification.

The fear of illegal ^{incarceration} led to a preoccupation with legal safeguards before admission. This made it impossible for the asylums to deal with early diagnosis and treatment of the mentally ill because before they were to be admitted they had to be obviously mad and more or less hopeless. The result was that the asylums were left with only the most

difficult and chronic cases to deal with.

This situation undoubtedly contributed to the emergence of custodial care in the hospitals. Shepherd goes on to show that condition demoralised the staff so that ambitious young and dedicated doctors who were interested in advancing the cause of the mentally ill were not attracted to the field of psychiatry. Consequently psychiatry was left with a low professional status in comparison with the rest of medicine, poor staffing and suffering standards.

The asylums were overcrowded. This condition nullified the principles of moral treatment which were fundamentally based on a recognition of the patient's individuality and the creation of a homely atmosphere. The principles were no longer possible to be practised. There was a growing public concern over the curability of mental disorder. As it became evident that the early hopes of curing mental illness through institutional means were over-optimistic because of the accumulation of chronic and incurable cases, staff felt that the option available to them was simple custody. They found it difficult to accept a concept of active care or the necessity of maintaining a continuous state of treatment which could prevent deterioration.

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The effects of the second World War were equally disastrous to the professional status of psychiatry. Memories of the war and the concentration camps were still fresh in people's minds for over a decade after the war so that the concept of institutional care came to have a distinctly pejorative ring about it.

In the opinion of Shepherd, Erving Goffman began studying his total institutions at the time the above sentiments were detrimental to the image of psychiatry. It is no wonder that his views are a reflection of those sentiments.

Twumasi (1979) draws attention to the wide range of treatments in psychiatry but regrets that they do not yield clearcut results. He observes that treatment is given by a wide variety of medical personnel - psychiatrists, psychiatric nurses, psychoanalysts, psychologists social workers and trained counsellors. Patients are treated singly and in groups. Many cures are administered - electric shocks, drugs and advice. As the services and the psychiatric personnel are enormous the mental patient is not directed to only one medical section of the hospital but is given the psychiatric service that is available. He goes on to explain that the characteristic factor common to this large number of treat-

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ments is that the treatment is not specific. Citing an example, he shows that psychiatrists cannot diagnose or locate specific emotional imperfections. He admits that psychiatric treatments that prove definite results are drugs and other physical treatments (electro - convulsive therapy for example) but even here there are strong differences in opinion concerning how and when they should be used.

Dunham and Weinberg (1960) throw light on the custodial function of the mental hospital and the mental patient's career there. They believe that the chief concern of the custodial system is to keep down costs and to manage property carefully. The patient's impaired condition to be changed is overlooked. They lament however, that that hospital culture in most cases tends to intensify the symptoms of the mental patient. The patient initially comes to the hospital aggressive, hostile, critical and argues with doctors and nurses for a need to change his condition for him. To his dismay, he finds with the passage of time, that his demands are not met. Even visits by relatives and friends may be irregular or may cease altogether.

Eventually he adjusts himself to the social condition prevailing in the hospital. He gives up any hope of recovery.

Dunham and Weinberg argue that this situation leads to a transition into chronicity and also his adoption of an intransigent attitude towards the staff.

Horster and Barbara (1978, P.85) suggest that stigma is truly a condition that accompanies psychiatric illness.

They write:

"Psychiatric label has a life and an influence of its own. Once the impression has been formed that the patient is schizophrenic the expectation is that he will continue to be schizophrenic. The label endures beyond discharge from hospital with the confirmed expectation that he will behave as a schizophrenic again".

Eventually, the patient also accepts the diagnosis with all its expectations and behaves accordingly.

Kathleen Jones (1978, Pp 330-331) writes in defence of psychiatry and its variety of therapies. In her article she insists that the psychiatrist is an innovator; that psychiatry has always been looking for new ways of treatment perhaps because the problems it deals with are so intractable and so much a part of the basic human dilemmas.

Many attempts have been made; she argues further, for new methods of treatment - from cold bath, malarial therapy, electro convulsive therapy to the psychotropic drugs. Alongside these there has been a steady development of social therapies - group therapy, occupational therapy, psychotherapy -

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outpatient clinics and community psychiatry. All these have stood the test of time and have enthusiastically added to the comfort and happiness of patients.

She concludes:

"If that is considerably an unscientific aim one might query, what else are the psychiatrists in business for?"

Gregory (1961) takes issue with the relationship between the law and psychiatry and echoes the observations made by Erving Goffman. He explains that the physician can be compelled by the judge to answer questions in court involving facts observed by him about a patient to prove his insanity. With his insanity proved the criminal defendant is then never held responsible for the criminal offence because he is considered not to have known the nature, the harmfulness and the wrongfulness of his act.

However, a person proved insane by a medical officer loses some rights; he cannot buy or sell property or sign legal papers; he cannot vote or hold an office or may not drive an automobile; he may not practise medicine, law or any other learned profession; he may not marry or institute a divorce action at a court of law (but incurable insanity is allowed for divorce); he may not make a valid will and he may not consent or refuse adopting a child.

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These rights are, however, restored after recovery.

Other writers take Goffman to task for presenting an inadequate picture of the mental hospital.

Scull (1983, Pp.335-339) writes:

"Goffman's primary source is a relatively brief period of fieldwork in a single hospital. It is an ethnography of a particular institution in this case. The outcome is a general delineation of an organizational type of which all mental hospitals belong alongside with prisons, monasteries military schools, old age homes and concentration camps".

Scull identifies several weaknesses in the evidential base on which Goffman's theory rests. He argues that there is not even a token attempt in Goffman's work to confront the issues of what explains what brought the mental patients to the hospital in the first place. The claim that they are the victims of contingencies and somehow betrayed into the institution by their kins is unsubstantiated. The blame for their situation is considered by the theorist as not lying at all on their own conduct or mental state but rather in a conspiracy of others to secure their exclusion from society. Scull concludes that the author does not make any attempt to assess the contribution of psychological and environmental influences on what he (the author) calls the "moral career" of the patient in the hospital.

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Like Sull, Siegler and Osmond (1971, pp.419-424) criticise the theory of the total institution vehemently. In their article entitled "Goffman's Model of Mental Hospital" they suggest that the definition and etiology of mental illness, the behaviour pattern including the suicidal impulses of the mental patient, the prognosis and therapies (except surgery and shock therapy) were not properly discussed in the theory. They observe that the author's point of view of the function of the mental hospital is that it is to subdue, degrade and humiliate people who are for unknown reasons exiled and confined there so that they will be easier to control. If the patient should ever leave the hospital, he is discoloured and stigmatised. His kin and employer are told to bring him back to the hospital if he happens to have difficulties.

The mental patient loses his civil rights. His only defined right is his access to food, clothing and shelter. He has no duties that he acknowledges as such when he is in the hospital; if he works, it is either because he is forced to do so or out of boredom.

Siegler and Osmond argue that:

"In Goffman's view there are medical personnel but they do not seem to have any medical function in the hospital; instead, they seem to provide a medical facade for the institution which is partly a punitive one and partly a

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a storage dump. Society has the right to lock people up in a mental hospital. It has the duty to feed, clothe and house them, to provide ordinary medical care and to keep them from harming themselves".

In sum, the review of relevant literature on the operations of psychiatric institutions portrays a picture that reinforces custodial posture. For example, the views of Shepherd, Gregory, Twumasi, Forster and Barbara, Dunham and Weinberg in many ways do not appear to depart widely from the propositions laid down by Erving Goffman.

The next Chapter examines the characteristics of psychiatric hospitals in Ghana with particular reference to their custodial posture, categories of mental patients and treatment processes.

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CHAPTER TWO

HISTORICAL DEVELOPMENT OF PSYCHIATRIC INSTITUTIONS
IN GHANA.

I Introduction:

In this chapter we are examining the historical growth of psychiatric institutions in Ghana with a view to providing the background to the discussion. The main focus is to examine whether in Ghana these institutions approximate Goffman's typology of the mental hospital.

The history of psychiatry in Ghana dates back to the latter part of the 19th Century. On the 4th of February 1888 the then Governor of Ghana, Sir Edward Griffiths signed a legislative instrument that established a Lunatic Asylum in the High Court of Victoriaborg, one of the then castles in Accra situated near the Arts Centre.

The primary function of the asylum was to protect the public against dangerous lunatics and to prevent the lunatics especially those with suicidal impulses, from harming themselves. In the asylum they were offered no medical treatment and were looked after by Prison Warders. They were mixed up with prisoners and were treated like them, Forster et al (1988).

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Two decades after its establishment the asylum could not cope up with its increasing number of patients. In 1905 it had 80 patients and in 1906, 110. The situation then called for the need to set up a separate and permanent institution for the mental patients, in order to segregate them from the prisoners. As a consequence the Accra Mental Hospital was established and was opened in 1907.

The new mental hospital continued to maintain its original name, Lunatic Asylum, and was accordingly custodial by function. The building contained General, Criminal and Female Blocks. In addition, it had an administration office, a visiting medical officer's office, a dispensary, a store, a gatekeeper's room, a night warder's room and a kitchen. A matron was in charge of the hospital and was assisted in his duties by untrained hospital attendants.

The first psychiatrist to head the Lunatic Asylum was Dr. Maclagan who was posted from Britain and assumed duty in 1929. Dr. Maclagan is still remembered in the psychiatric service in Ghana as a result of the reforms he instituted: he stopped the caning and punishing of patients, the chaining of patients to posts and their restriction to single rooms without the directive of the doctor. He instead housed the patients in wards according to their degree of mental dis-

turbance and provided a separate accommodation for those who in addition to their mental illness were physically sick. During his tenure of office he also made available to the psychiatric service in Ghana the concept of therapeutic community which had been prevailing in England.

By this system the mental hospital is considered as a community with the patients being an integral part of it. They are consulted on all matters affecting their welfare. They take part in ward meetings with the staff and their views are considered.

Dr. Maclagan left Ghana in 1942. Social development of the Accra Mental Hospital continued after him and in 1951 Dr. Forster, the first African to assume leadership of the hospital, was appointed. During his tenure of office he carried out much expansion work which included the establishment of more blocks, the introduction of more therapeutic techniques and the training of more psychiatrists and psychiatric nurses. The physical facilities of the hospital he brought into being, include the Consultation Rooms, the Outpatient Department, Reception, Dispensary, Kitchen, Hospital Welfare Office, the Wards, Occupational Therapy Workshops, the Laundry, the Refrigerated Mortuary, the Administration Block, the Reference Library, the Patients' Library, the Records Office, the Nurses

Training School.

In spite of the expansion work which has been going on since its establishment, the patient population pressure on it has always remained a problem and has to a large extent necessitated the building of more mental hospitals. As early as 1909 the Accra Mental Hospital had an inmate population of 275 and in 1934 it had risen to 600.

By 1960 the figure was 1700; meanwhile it had been built to cater for only 200 mental patients. The condition was considered alarming so it became necessary that something had to be done about it. As an interim measure an annex was established at Atimpoku near Akosombo to where 300 of the inmates were transferred.

The setting up of the Accra Mental Hospital Annex could still not solve the problem of the pressure of the inmate population on the hospital. The need then arose again for the building of another mental hospital. Consequently an appropriate site was found at Ankaful 15km Southwest of Cape Coast in the Central Region. Ankaful Psychiatric Hospital was then established and was opened in 1965. The patients at Atimpoku were sent to Ankaful and the Accra Annex was abolished.

Unfortunately, the building of Ankaful Psychiatric Hospital could again not solve the problem of congestion at Accra Mental Hospital.

In the early 1970s the nation's Health Service authorities realised that the two mental hospitals were still not sufficient to handle the enormous growth in the number of mental patients. It therefore became imperative that another one had to be built. As a result the Pantang Psychiatric Hospital came into being in 1975.

Both Ankaful and Pantang Psychiatric Hospitals have the physical facilities found at Accra Psychiatric Hospital.

They however, differ from, that of Accra in one respect; that they are not walled.

In terms of modern medicine the three hospitals, Accra, Pantang and Ankaful handle all psychiatric cases referred to them. They receive patients from all parts of Ghana and from overseas.

In spite of modern innovations in medical science, the three hospitals remain largely custodial in character. The patients are mainly kept there in order to cushion them against the strains and stresses in the wider community and in order to allow society to have peace. Their movement and behaviour even within the premises of the hospitals are under surveillance. They are exposed to a large variety of treatments all in an attempt to bring the illness under control. The drugs that the hospitals use in the treatment

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of the patients are principally hypnotics and tranquilizers which only make them calm but cannot in fact cure them.

Being aware of the chronicity of mental disorder, the psychiatric authorities make sure that even patients discharged from the hospitals are controlled by their relatives. The relatives are advised not to infuriate them so as to avoid relapse.

As a result of the indefinite nature of the treatment there is a high incidence of recidivism in the psychiatric hospitals. About 49% of the inpatient respondents have been on admission more than once.

In order to keep the number of inpatients at a manageable level the hospitals make a tremendous use of trial leave and parole. Patients on trial leave and parole status are usually patients whose mental conditions have improved. Patients on trial leave stay at home and see their psychiatrists about once a month for drugs. Parolees live - at the hospital but are allowed to go home on Fridays and return to the hospital on Monday mornings. About 47% of the inmate population of the three hospitals are made to avail themselves of these facilities. Those whose conditions deteriorate are recalled for admission.

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The psychiatric hospitals in Ghana have therefore since their inception been maintaining the custodial role and the following may be mentioned as the factors that have contributed to that situation. They are:

Inadequacy of medical resources, Overcrowding; number of patients to a ward; Governmental policy, People's outlook towards the mentally ill, the closed nature of the psychiatric institutions, Discharge rates.

These features are discussed below.

Inadequacy of Medical Resources.

Resources at the disposal of the hospitals in terms of human labour and drugs are not sufficient to meet the needs of the inpatients.

The number of patients that a psychiatrist is required to handle is invariably large. The three hospitals together have a total of seven qualified psychiatrists and 1733 inpatients.

Five out of the seven psychiatrists and 1371 out of the inpatients are at Accra; therefore at Accra psychiatric hospital each psychiatrist is in charge of an average of 274 inpatients. Even two of the psychiatrists are not the hospital's permanent employees; they are on loan from

University of Ghana Medical School at Korle Bu Teaching Hospital.

At Pantang there is only one psychiatrist and he is responsible for the 193 inmates of the hospital, while at Ankaful one psychiatrist is handling all the hospital's 169 inpatients.

These data indicate that the work load on the psychiatrists is just too much and it may be difficult for them to provide adequate treatment. Similarly on their rounds in the wards in the mornings it is hardly believable if the psychiatrists will have the time and the energy to visit all the patients since at the same time they have administrative duties to perform and outpatients to attend to.

The situation is more pathetic at Pantang and Ankaful. In each of these hospitals if the psychiatric specialist is unable to report for duty, the hospital hardly functions. The psychiatrist at Ankaful has lamented:

"The whole hospital including the outpatient department hinges on me. When I am absent no patient receives a prescription".

The inadequacy of medical officers attached to the psychiatric hospitals similarly perpetrates their custodial role. The medical officers are responsible for handling

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the non-psychiatric disorders of the inpatients. There is one medical officer each at Accra and at Ankaful but there is none at Pantang; instead there is a medical assistant. However, by the nature of their disorder mental patients with infectious diseases and those who need surgery must ideally be attended to in the psychiatric hospital. As a result of the shortage of medical officers in the psychiatric hospitals, the isolation wards where their inpatients with physical ailments are kept are characterised by congestion. At Accra during the study there were 26 patients in the male isolation ward and 24 in the female isolation ward. These wards were seen to be stinking more than the other wards. Patients in pains were seen screaming. It seems there is also lack of attention in the wards. In the male isolation ward an elderly weak patient had eased himself and had soiled his tattered pair of trousers. It was a fellow patient who was washing him.

Psychotherapeutic service in the mental hospitals is equally inadequate in terms of personnel. The whole psychiatric service in the country has two trained psychologists who carry out psychotherapy. They are both stationed at Accra Psychiatric Hospital. At Pantang and Ankaful psychotherapy is carried out by the psychiatrists themselves.

As Cochrane (1985) has argued if mental disorder is partly a by-product of strained interpersonal relations then psychotherapy may be considered as an indispensable therapeutic programme to combat it.

Indeed, the lack of trained psychotherapists in the psychiatric institutions in the country can hardly give them a therapeutic outlook.

With a total of 1733 inpatients and only two trained psychotherapists serving their needs (even one of them was on a very long course overseas at the time of the study) the conclusion may be drawn that majority of the patients are being denied this important service. This situation further reinforces the custodial character of the psychiatric hospitals because it seems the patients are being kept in the hospitals without sufficient amount of treatment.

The shortage of human resources is not the only problem associated with treatment; drugs are equally in short supply. Psychotropic drugs came into being in the late 1950s and have revolutionised mental hospitals in terms of treatment, (Sutherland 1976). In Ghana these drugs are supplied free of charge to the inpatients but the supply is restricted. In all the seven group therapy sessions that we took part in the three hospitals the patients were told by

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the nurses to "make do" with the few drugs available. In other words the drugs are rationed because the institutions do not have them in large quantities. It follows then that the patients do not obtain the quantity of drugs that they need for their recovery. The result is that they are only being accommodated and watched so that their illnesses may not get out of hand and ultimately as noted by Shepherd (op cit) to protect society against harmful elements.

Overcrowding: number of patients to a ward.

Another factor that emphasises the custodial character of the psychiatric service is overcrowding. This condition occurs at the Accra Psychiatric Hospital alone and it has been characteristic of the hospital since it was set up. The hospital has 23 wards and with a total of 1371 inpatients, there is an average of 59 patients per ward. This situation is contrary to the average of 25 patients per ward suggested by Dunham and Weinberg (op cit). The result, then, is nothing but congestion - too many patients occupying a single ward.

Coupled with the overcrowding problem is that of ventilation. Because the architecture of the hospital belongs to a by-gone age, the windows of the wards are too high, too few and too narrow. As a consequence, the ventilation

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system in the wards is deplorable.

The arrangement of the beds compounds the overcrowding problem. As a result of the largeness of the number of patients in a ward, the beds are too close to one another so that one can hardly pass through them.

As already pointed out, the hospital has 809 beds. This means 562 inpatients are without beds. During the research we observed that such patients sleep on straw mattresses spread on the floor.

Because of the congestion in the wards, for most of the time the patients stay at the courtyard in order to obtain fresh air and to stay away from the stench that characterises them.

It is an undisputable fact then that the overcrowding in the wards gives them a cell-like appearance and the fact that all their daily activities are confined to them certainly give the impression that the custodial character of the institution cannot be denied.

Governmental Policy

Governmental policy since the inception of psychiatric medicine in Ghana has itself emphasised the custodial aspect

of care. The original parliamentary act that established the mental hospital in the country as already noted, provided that the hospital should be a place where the mental patients should be made to rest so that the larger community would not be disturbed by them. This trend in governmental policy is still in force. The National Redemption Council Mental Health Decree (NRCMD) 30, 1972, maintains that the mental hospital is to protect the community by assuming responsibility for the mentally ill who would otherwise be sources of danger to it. The Decree makes the following provisions:

In part V subsection 20, it declares:

"The commissioner may establish a state psychiatric hospital or hospitals for the reception and custody of persons committed thereto in pursuance of criminal proceedings brought against them or admitted thereto from a prison".

And in subsection 26 it goes on to say that:

"Special provision, shall be made for the accommodation of patients whose conduct may be at anytime harmful to themselves or other people".

In fulfillment of these provisions the psychiatric hospitals receive patients referred to them from the general hospitals, the courts, the police, organizations, employers and from individuals".

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The law gives the hospitals more powers in their offer of protective custody to lunatics. From time to time the psychiatric hospital authorities team up with the police, the city and the local councils and arrest the madmen loitering in the streets. They refer to such madmen as "Vagrants". At Accra Psychiatric hospital there is one ward called Vagrants' Ward (Ward C2) which is mainly occupied by such patients.

People's Outlook Towards the Mentally ill: The Stigma.

Mental patients who have been institutionalised tend to lose their social acceptance because the general public feels that their illness is never totally curable. What the mental hospital does is to give them a temporary sanctuary where they may have rest in the hope that they might regain normality.

Swarte (1969) has remarked that hospitalization not only brings about the straining of the relationship between them and their social groups but also even the press portrays them in very sombre lines and special prominence is given to their danger factor and the chronicity of their disorder.

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This observation holds true in Ghana and it seems certain assumptions underlie the opinion of the Ghanaian public about the mental patient; that they are not trustworthy, that they are dangerous because of delusions and are capable of attacking innocent people at any time, that the psychiatric hospitals only mitigate the seriousness of the mental problem but do not actually uproot it and that they may commit crime at any time. In a word, mental patients are stigmatised. There are however, several reasons for the stigmatisation. Since the establishment of the Lunatic Asylum in Ghana in the late 19th Century there have been several patients with chronic mental disorders who have not had a complete cure.

In recent times many patients have been on either trial leave or on parole and have been commuting between the hospital and their homes without showing signs of improvement. Some discharged mental patients who have been roaming in the streets do not appear like people who have ever had treatments for their ailments; their conditions have not shown any improvement.

As a result, even after discharge from the mental hospital people do not get convinced that the patient's mental health is restored. Eventually he is isolated - his social

Ghanaian culture equally emphasises stigmatization of the mental patient. The traditional belief with regards to the causation of mental illness is that it is supernaturally brought about by agents like witchcraft, demons, magic and gods, (Forster op. cit). It is further believed that these agents inflict the disorder on the victim because of the offence that he might have committed like his breaking of a taboo or his inability to perform his social role of a mother a father or a lineage head. His relatives in particular therefore brand him as a person who brings evil to the family and consequently isolate him.

The Closed Nature of the Psychiatric Institutions

The mental hospital is a closed system. When the inmates are on admission they have difficulty in establishing social contact with the wider community. Their communication link with the outside society and their movement are all restricted. Many reasons account for this custodial sort of life.

Some of the inmates are criminal lunatics. They have committed criminal offences as a result of their mental state and have been brought to the hospital on court order. At Accra Psychiatric Hospital as already

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noted, lunatics have their own ward, the special ward. There is an orderly at the door which is always closed and he makes sure that none of the inmates escapes. In the words of Asare (op cit) "the custodial function of the mental hospital applies to such people". The hospital offers them custody to prevent them from harming the larger society and more importantly to separate them from other people who have committed similar offences but because they are not insane they have been committed to prison.

Some of the patients are agitated. As a result of mood swings some mental patients with ailments like schizophrenia, manic-depressive psychosis or acute excitation may become destructive and cause havoc in the outer community. Their confinement in the mental hospital and tranquilization nip in the bud their destructive behaviour.

Some mental patients, particularly psychotics, have delusions of persecution. They have a false belief that some people are plotting to kill them. If such lunatics are at large, they are likely to take revenge on their suspects or even on innocent people whom they may see when

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the mood of delusion sets in. The psychiatric hospital gives such patients a place of exile in order to prevent them from carrying out these crimes.

Because of these reasons the mental institution puts restrictions on the movement of its inmates. Patients who are allowed to go outside the hospital are those who have improved and are put on errands and those on trial leave and on parole.

The physical separation of the psychiatric institution similarly portrays its enclosed nature. Accra Psychiatric Hospital is enclosed in a very thick antiquated wall with a single gate. Even at the gate are guards who monitor the movement of patients to and from the hospital. Indeed the architectural design of the building alone gives enough impression about its physical seclusion from the outer community.

Pantang and Ankafu Psychiatric Hospitals have modern architecture and are therefore not walled but they are equally physically separated from the rest of society. The factor responsible for the separation is distance. They are both not within walking distance from the town. They can be reached only by car. Indeed their physical

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isolation by way of distance emphasises their nature as closed societies.

Visitors have difficulty in seeing their patients. They have to report to the orderly who stays at the ward's doorstep and the nurses on duty in the ward before they can see their patients.

Similarly guardians do not have it easy when seeking the discharge of their patients. A guardian who wants his patient to be discharged has to give a written notice to that effect. The N.C.R.D. 30, 1972, stipulates that if, for one reason or the other, a guardian asks for the discharge of his patient he must give a seventy-two hour written notice to the hospital authorities. The notice has to be endorsed by the psychiatric specialist in-charge of the hospital.

Discharge Rates

The discharge rates in the psychiatric institutions has not been impressive. Indeed the low discharge rate together with chronicity and relapses that characterise the hospitals' treatment processes gives the impression that the hospitals have a custodial outlook. The dis-

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charge rates in the three hospitals for 1987 and 1988 are shown below for illustration.

Table 1: Discharge Rates of Mental Patients In Psychiatric Institutions in Ghana in 1987 and 1988²

Hospital	Year	Admissions	Discharges	% of Discharges over admissions
Accra	1987	2,494	1,621	65
	1988	1,371	877	64
Pantang	1987	901	505	56
	1988	169	107	63
Ankaful	1987	1,060	625	59
	1988	193	125	65
Total		6,188	3,860	62

According to Table 1 the highest discharge rates in the hospitals were recorded at Accra and at Ankaful in 1987 and 1988 respectively. Each recorded a rate of 65%. The minimum discharge rate of 56% was recorded at Pantang in 1987. On the whole the three hospitals within

2. Source: Hospital Records Offices.

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the two-year period under consideration achieved a discharge rate of 62%.

The data clearly show that within these two years in question the hospitals were able to discharge only a little more than half of their patients on admission. Treatment appears not to give any appreciable results since the admission of several patients continues into the following year.

II. INSIDE THE PSYCHIATRIC INSTITUTIONS IN GHANA.

This section is devoted to the examination of what occurs within the psychiatric institutions in Ghana with a view to exposing their characteristics and roles.

Admissions Procedure

The psychiatric hospitals receive their patients through mediators like the general hospitals, the courts, the police, families and friends. Some of the patients are also brought as vagrants.

The admissions procedure itself is simple. A new patient reports at the Reception where a folder is prepared for him. He is then referred to the Outpatient

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Department where his particulars on the folder are recorded. He may be required to give more information about himself. His next point of contact is the consultation room where the psychiatrist after diagnosis assigns him to a ward. His admission into a particular ward will be influenced by such factors as his age, sex and the degree of the disturbance of his mental disorder.

While on admission in the hospital, the hospital authorities take care of any property that the patient may have. This action is taken in fulfillment of the requirement of the law. The Mental Health Decree NRCD 30, 1972 already referred to states:

"the chief administrator of the hospital shall take charge of the personal property which a patient brings with him upon admission. Full particulars of the property shall be recorded in a register kept by the chief administrator.

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All such property shall be restored to the patient upon his discharge from the psychiatric hospital. All perishable property which a patient brings with him upon his admission shall be disposed of in such manner as the chief administrator may consider to be in the best interest of the patient".

During the research it was discovered that any valuable property of the patient may be kept by any one of the following: hospital welfare officer, the senior nursing officer in charge of the patient's ward, the hospital senior secretary or a matron. In some cases the property may be handed over to the patient's guardian. It is a normal practice that a record of the property is kept at the hospital welfare office and at the office of the senior nursing officer responsible for the ward showing in whose custody it is.

Rewards and Punishments.

Goffman (op cit) and Sykes (1958) have both observed that normally in the total institution rewards and punishments are instituted by the staff to enable them to achieve enough control over the inmates.

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Usually the institution has 'house' rules so that those who obey the rules are usually rewarded and those that disobey them are punished.

In the psychiatric institutions in Ghana no rewards and punishments exist. As far as the inmates are concerned, no rules are specified to govern their behaviour while on admission. As a result it becomes not necessary to provide a reward in response to obedience or to punish an inmate for the infraction of a rule.

An offence committed by an inmate like slapping a fellow inmate is normally considered by the staff as something that results from his condition - abnormal state of mind. Hence such an act goes unpunished. If the patient is found to be violent he is tranquilized to become calm.

The Role of Visitors

In the mental hospitals in Ghana both the staff and the patients encourage visits. Visitors are allowed to enter the hospitals between 6 a.m. and 6 p.m. everyday. Visitors who may be friends, relatives and spouses, play several important roles in the lives of the inpatients.

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The staff members believe that visits tend to expedite the recovery of the patients. The presence of visitors brings about family reunions, strengthening of friendly ties and consequently the reduction in anxiety that afflicts the patients.

Furthermore visits enable relatives to know the condition of their patients. By paying visits to their patients, relatives get to obtain first hand information of the improvement in or the worsening of the conditions of their sick people.

To the patients visits by their relatives have the tendency of strengthening the "we - feeling" between them and the relatives because they show that the social continuity between them is not out. Visits therefore bring about the avoidance of the disruption of ties between the patients and their families.

What is more, visitors provide the patients with essential commodities that the hospitals cannot supply adequately. These items include food, clothing and footwear. Relatives and friends bring along with them when visiting their patients because hospitals have

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difficulty in providing them in sufficient quantities.

Visiting of patients in the psychiatric hospital by their relatives and friends is important in another respect. In case of the death of a patient it is only through visit that the family will get to know the news early and therefore arrange for the recovery of the body and ultimate burial.

Visitors have the tendency of relieving patients of boredom in the mental hospital. The presence of visitors enables the patients to see new faces that they may not have seen for several days. The chat between the visitors and the patients inspires the latter since it is through visits that messages for or from home reaches the receiver. Visiting of patients by their people then serves the purpose of removing the communication barrier between patients and the outside world. An important role played by visitors in the psychiatric hospital therefore is to reduce the impact of monotonous life experienced by the patients as a result of their daily exposure to the same schedule of activities.

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Problem Areas of Patients

Mental patients like other patients have problems to contend with. Some of these problems are symptoms of the disorder while others are social in nature. The table below exposes the problems of the inpatients.

Table 2: Inpatient Respondents' Problems.

Problem	Number	%
i. Relapse	33	19.1
ii. Signs and Symptoms	33	19.1
iii. Offences Resulting from agitation	6	3.4
iv. Lack of Visits	30	17.4
v. Alienation	47	27.1
vi. Expected broken home	24	13.9
	173	100.0

As table 2 above shows the respondents made mention of six core problems that disturb them.

Relapse

Resurgence of the mental disorder is a major problem facing the inpatients. As many as 33 or 19.1% of them

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expressed concern about it. As a result of their mental disorder they have been hospitalised more than once. After discharge they feel that they are completely cured but they have to return to the hospital after a few months or years. This condition, they showed, has an adverse effect on their social activities like their marriages and jobs.

Signs and Symptoms

The physical manifestations of the presence of the mental abnormality are a problem that agitates the minds of the patients. 19.1% of the respondents talked about them as their problems. They are particularly worried about delusions and hallucinations which occur spontaneously and cannot be controlled. They have no way of getting rid of them.

A 32 year old female schizophrenic at Pantang Psychiatric Hospital narrated her problem this way:

"For the past three years I have been hearing voices and have been seeing rays of light. Before I came here two years ago I used to follow the light on the instructions of the voice. The voice used to tell me to

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go to the bush and I did so. At times I used to spend about two weeks in the bush without food, but I never felt hungry. On such occasions, a search party used to bring me back home. I continue seeing the light and hearing the voice but since the nurses control my movement I am not able to go even outside this ward".

Offences Resulting From Agitation

The patients' moments of agitation have tremendous adverse effects on them. 3.4% of the patient respondents remarked that this is their problem. They are filled with grief when they are told of the harm or disturbance they cause during their mood of agitation.

A 24 year old male Schizophrenic at Accra Psychiatric Hospital and a former undergraduate of the University of Ghana had this to say about his period of hyperactivity:

"I have been told by doctor that I suffer from schizophrenia of grandeur. At times when I sit down in the ward, I get excited and filled with joy because I feel I am equal to God; I can create and destroy everything on the surface of the earth. During certain moments I feel also that I am the head of state and I am therefore capable of destroying and

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rebuilding this nation within' the twinkle of an eye. During this state of delusion I laugh widely in the ward to the hearing of my fellow patients and the nurses. Sometimes this condition causes me to parade through the ward jubilating until the nurses shout at me to sit down. On some occasions I decide to give the hospital a new shape. I do this by first trying to tear my mattress into pieces or dismantling my bed or hitting the window with my fist in an attempt to break it. I stop this activity only when the nurses overpower me.

When they demand the reason for my action I do tell them that they are my subordinates so that if they continue disturbing me, I shall bring my soldiers to shoot them. On gaining consciousness, I regret my behaviour when I am told what I had done".

Lack of Visits

Several patients complain about lack of visits.

17.4% of the respondents complained bitterly that visits by relatives and friends were either intermittent or had ceased completely. A deep probe into their hospital records showed that two groups of patients in particular have this as their main problem. They are the geriatric and the long stay patients. The geriatric patients are

old and weak and their relatives and friends feel that they have no chance of recovery. They therefore do not see the need to spend time visiting them or even to spend money on them.

The long stay patients have a similar plight. Some of them have been institutionalized for over ten years. Their long stay in the hospital, to the relatives, is an indication that they are not likely to join them at home again. Consequently such patients have been left to be cared for, for the rest of their lives, by the state.

Alienation

As the table suggests, the largest group of respondents, 27.1%, expressed concern about alienation. They claimed that by their hospitalization, as observed by Joachim Israel (1964) they have been, cut off from their families, their workplaces, their communities, their religious affinities and even from the mainstream of life. They have been released from the hold of their tradition and society. As a result they have been left without social support. They have been stripped of their

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self esteem, their confidence, their optimism and society's moral support.

The social bond between them and society has been out so that they do not realise their existence. The cohesive and stabilizing forces that bind them to the outer society have become disintegrated.

When their kinsmen come to them in the hospital, their stay with them is short-lived. The longest place at which they see them off is the hospital gate. At Accra Psychiatric Hospital a 65 year old female with senile dementia remarked in a sad tone:

"Whenever my relatives come here, their usual excuse is, we are in a hurry; we are going to work; we are going somewhere and we have decided to pass here to say hello to you. It seems society has rejected those of us who have been hospitalized as a result of this disorder".

Expected Broken Home

This problem ranked as the 5th in terms of the number of respondents who showed concern about it. 13.9% of them expressed the fear that on discharge they felt that they would lose their spouses.

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Out of the 24 patients who found expected broken home as a problem associated with their institutionalisation, 15 of them are women. They believed that their hospitalization would cast a slur on them so that their spouses would not welcome them back into the matrimonial home, especially in the case of prolonged admission.

At Pantang Psychiatric Hospital a 38 year old female with depression lamented:

"I have been in this hospital three times within three years and it is my husband who has been bringing me. He was regular in visiting me during my last two admissions. In recent days I have discovered that his frequency of coming here has diminished.

When my son came here last week, he told me that he had been seeing another woman in my husband's room in the nights. I am now pre-occupied with thoughts centring on my future stay with that man."

III. TYPES OF MENTAL PATIENTS IN PSYCHIATRIC INSTITUTIONS IN GHANA.

In accordance with the World Health Organization's (WHO's) International Classification of Diseases, 1955, the Psychiatric Institutions in Ghana have Classified their mental patients into 16 categories. The various categories of patients are listed and discussed below.

Table 3: Types of Mental Patients in Psychiatric Institutions in Ghana in 1988.

Types of Patients	Number	%
1. Psychotics	152	8.8
2. Senile Dementia Patients	41	2.4
3. Patients with brain damage	12	0.7
4. Patients with delirium tremens	11	0.6
5. Epileptics	87	5.0
6. Schizophrenics	415	23.9
7. Patients with depression	225	13.0
8. Manic Depressive psychotics	102	6.0
9. Hypomaniacs	105	6.1
10. Manic reaction patients	58	3.3
11. Patients with cases not diagnosed	75	4.3
12. Patients with anxiety states	26	1.5
13. Mentally retarded children	21	1.2
14. Drug abusers	321	18.5
15. Alcoholics	32	1.9
16. Patients with acute excitation	50	2.8
Total	1,733	100.0

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Psychotics

The psychotics comprise 8.8% of the inpatients and they are patients with emotional disorders usually characterised by severe distortion of ideas, diminished control of desires and impulses. The psychotic personality is totally disorganised in terms of reality.

The psychotic's language is disturbed making his speech incoherent. The patient has infantile regression reflected in behaviour such as ripping of cloths, requirement of bathing by another person, spoon feeding and the soiling of himself.

He experiences hallucinations, delusions, constant dreams, disorientation or loss of the ability to place himself in relation to time, place or person. He lives in a world of fantasy, - he lives in quite a different world in which he is not subject to the ordinary physical laws of society. He has no insight.

The patient normally withdraws from the main stream of social life. Even in the mental hospital many of them are found sitting mournfully secluded from their fellow mental patients.

At Pantang a twenty-two year old female psychotic objected to our interviewing her with an explanation "You are disturbing me".

Senile Dementia Patients

These patients are advanced in age. Their disorder results from reduction in intellectual functioning and much stress, (Brussel 1964).

They are characterised by depression, intellectual confusion, paranoid states, elevated blood pressure impairment of the capacity for thinking and concentration. They usually weep over trivial events. 2.4% of the inpatients are made up of these people.

At Accra except those who are convalescing majority of them are in the geriatric ward.

Patients with Brain Damage

They comprise 0.7% of the inpatients. They have structural brain damage caused by various problems: infection like syphilis, a car accident affecting the brain, head injury, brain tumour, trauma and degeneration. The patients have thought disorder, wrong perception of events resulting from a total intellectual impairment with chronic consequences.

Patients with delirium tremens.

0.6% of the inpatients have problem of delirium tremens. They are mainly elderly people who are chronic alcoholics. The patients have sleeplessness, great fear and profuse perspiration.

In an interview a 56 year old man with this disorder at Accra Psychiatric Hospital told us:

"When I sleep I have vivid nightmares and I also wake up repeatedly in terror. Sometimes a voice speaks to me commanding me to do something, and sometimes I feel that something is haunting me. Before I came here I had been drinking for 25 years. My feet are swollen and doctor has told me I have hypertension which is partly a result of my excessive drinking of alcohol".

Epileptics

The epileptic patients have disorder of unconsciousness with convulsions. Some of the patients have scars on their bodies which are results of burns received during attacks. Several attacks may occur in a day.

According to the Psychiatrists, Epilepsy may be caused by a disturbance of electrical activity in the brain, Syphilis, old age, hardening of the arteries which impedes the normal circulation of the blood, physical diseases, poison like alcohol and hereditary factors. It is chronic. 5.0% of the patients have this problem.

Schizophrenics

Schizophrenics constitute the largest single group of patients and in 1988 their number was 23.9%. Their problem is a chronic one and they have many relapses, (Carothers, 1963; Strauss, 1958).

The Schizophrenics show several symptoms which include mood swings, aberrant ideas, bizarre behaviour, bizarre gestures, incoherent speech, unpredictable movement, intellectual deterioration and split mind. They are ostensibly disagreeable, suspicious of others, defiant and antagonistic. During interview they either refuse to answer questions or are evasive. The patients according to the therapists have delusions, hallucinations, defective insight and the impairment of the registration of recent events, though the disorder does not shorten life.

The patients' world view is one of fantasy. They also show signs of regression, resuming the postures and behaviour of infants. This condition supports the view expressed by Whyte (1923) that at times the illness begins developing when the patients are young.

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At Pantang, a 22 year old female Schizophrenic replied "I am a lady" when she was asked to tell us the length of her stay in the hospital and at Ankaful a 31 year old male patient with the same problem posed a question "Do you know German" when we asked him a similar question.

Patients with depression

These people constitute 13.0% of the inpatient population.

Majority of the depressive patients are advanced in age - 50 to 60 years.

The disorder occurs during this period in life when the body chemistry changes and begins to decline as the organism as a whole weakens. Predisposing factors of depression include stressful events like loss of job, divorce, physical sickness or the loss of a loved one.

Depressive patients are characterised by symptoms like ill-health, feelings of unworthiness, damnation, sadness, anxiety, restlessness, guilty feelings, mood swings, dearth of ideas and underproduction of speech even sometimes to the extent of mutism.

They show physical signs of hypoactivity, poor taste, sleep disturbances, dryness of the mouth, constipation, poor concentration and pessimism. During the study we found most of them in pensive moods. They talked little and even with difficulty.

Manic Depressive Psychotics

About 6.0% of the patients have the problem of manic depressive psychosis. The patients show psychotic episodes and depressive moods, that is between mania and melancholia. The manic phase presents the disorder in its upstage in terms of hyperactivity through an increase in speech, movement and emotion. In the depressive aspect, however, these conditions are reduced.

Common Symptoms include loquaciousness, adorning of the body with stripes or tattooing, bizarrely exaggerated movement and facial expressions, sorrowful concentration, refusal of food, hallucinations, delusions and feeling of unworthiness. At Accra, one 41 year old man with this problem was so loquacious that he dominated one group therapy session at which we were present.

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Hypomaniaes

Hypomaniaes form 6.1% of the inpatients' population. Their mental problem is a milder form of the manic phase of manic depressive psychosis. They have manic symptoms like elation, overactivity, flight of ideas but are not greatly developed. They continue to have a keen realisation of their position and environment and do not exhibit such extreme disorder of conduct as to bring them into conflict with their fellows.

For a time they are merely considered witty persons with ideas and aggressiveness and it is only in the advanced stage of the illness when they become interfering, irritable, domineering and may have too many schemes on their hands that their friends suspect that there is something wrong with them.

They tend to monopolise conversations, express their views dogmatically, drift from one topic to another, show overconfidence and resent restraint. They are inconsistent and changeable. Their judgement is faulty; they may behave in ways that they may later regret; for example

driving too fast, spending money extravagantly or giving money away without thinking about it or doing outrageous things in public.

Hypomaniac patients show symptoms of restlessness, but are not destructive. They appear to be doing something all the time, yet they never get tired. At Ankaful there is one female patient with the problem of hypomania who parades through the verandah of her ward and retires only when she becomes hungry.

Manic Reaction Patients

These patients are psychotics with extreme manic states and they form 3.3% of the patients.

The manic reaction patient is totally disoriented for time, place and person. His conversation is incoherent and he is so excited that in the mental hospital he is restrained only by hypnotics.

He has auditory and visual hallucinations, suspicions and delusions. He is usually shameless; he displays moods of irresponsible gait, euphoria, restlessness and lack of control over his actions. The patient

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has impaired appetite, insomnia, irritability, over-production of speech and hyperactivity.

He is extravagant in all directions - spending, dressing and even gambling. This patient rejects criticisms, appears very busy to the extent that he cannot even sit at one place for a long time or to sit down to eat.

Patients with cases not diagnosed

There is a sizeable number of patients whose actual mental disorders have not been specifically identified by the psychiatrists. Accordingly, they have not been categorised. They constitute 4.3% of the inpatient population.

These patients do not show consistency in their behaviour patterns in terms of their psychiatric problems. They have mood swings and show a variety of signs and symptoms typical of many mental disorders.

Patients with anxiety states

Their central problem is neurosis, psychoneurosis or anxiety (nervousness, tension, fear). They have episodes of visible nervousness but they are invariably unable to give a reason for it.

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The neurotics do not have any discoverable physical disease. Their problem is only an indication of mental conflict representing faulty responses to the stresses in life and especially to those inner tensions that come about from confused and unsatisfactory relationships with other people whether they are a legacy from early childhood onwards which remain to hinder future adaptations or arise in the present in relation to hopes, ambitions or jealousies.

Their disorganization of the mind is only partial because they have insight into their condition. They recognize the abnormality of their behaviour, attitudes and conflict. Their thoughts and harmony are undisturbed.

The source of their danger is largely unknown; they cannot explain the reason for their fear.

Symptoms of their disorder include short rapid breath, accelerated pulses, sweating and frequent urination, insomnia and lack of appetite. The symptoms are largely manifested when the feared thing is seen.

In the psychiatric hospitals they form 1.5% of the inpatients' population.

Mentally Retarded Children

They are children having a problem of feeble mindedness. They are persons who have been from infancy habitually abnormal in their mental reactions. These children have inadequate emotional personality and intellectual development. They are psychologically immature, lack judgement, foresight or ordinary prudence. 1.2% of the patients are made up of these people. At Accra, they have their own ward but at Pantang and Ankaful they have been mixed up with the other patients.

Drug Abusers

Drug abusers constitute the second largest group of patients and majority of them are young people. According to Dr. Asare, in Ghana, drug abusers fall mainly within the age group 17-24 and many of them are students.

The drugs they use include "wee", (cannabis sativa) cocaine and heroin. As many as 18.5% of the inpatients are drug abusers.

The drug addicts are characterised by deterioration of memory, attention and grasp of events.

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The physical symptoms are that the addicts are feeble, debilitated creatures with greyish complexion, slight disturbances of coordination affecting speech, diminished general sensibility and nervousness. They have sleep disturbances as well.

Alcoholics.

Alcoholics form 1.9% of the population of the inpatients.

Alcoholism is an all-inclusive pathological situation which involves the individual's body, mind, morals and spiritual existence, environmental and interpersonal relations. The alcoholics are as a result characterised by pale complexion, unkempt appearance, poor perception and poor judgement. Many of them are hypertensive and psychotic.

Patients with Acute Excitation

These patients have a severe form of mania and are uncontrollably excited. They are 2.8% of the patients' population.

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They are characterised by flight of ideas, violence including homicidal assaults, hallucinations and delusions.

Their common physical symptoms include sleeplessness, irritability, disorientation, frequent anger, impulsiveness, frequent laughter, poor judgement and lack of insight.

IV: THERAPEUTIC SYSTEMS IN PSYCHIATRIC INSTITUTIONS IN GHANA.

Treatment in the psychiatric hospital may be said to encourage the patient to develop a new view of greater esteem of himself, to be relieved of subjective feelings of pain, anxiety, stress and to achieve greater independence and to function more effectively in society, (Forster and Barbara (op cit)).

The psychiatric patient is never referred to the hospital solely for the treatment of the mind. Every component of his total life is included in the treatment programmes: his personal relations, emotions, life history etc. In addition, various tests-physical laboratory and psychotherapeutic - are carried out.

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There are in all eight therapeutic programmes in the psychiatric institutions in Ghana: application of Psychotropic drugs, Electro-convulsive Therapy, Psychotherapy, Group Therapy, Occupational Therapy, Counselling, Spiritual Therapy and Recreational Therapy.

(a) PSYCHOTROPIC DRUGS

Psychotropic drugs are pharmacological substances used to manipulate the brain - to induce sleep, to relieve the patient of anxiety and to induce an elevation of mood. Drug therapy is the commonest treatment in all the hospitals. A large variety of drugs are used which include:

Hypnotics: They produce a calming effect on the patient. They therefore induce drowsiness and sleep eg. nitrazepam, phenobarbitone.

Antidepressants: Are used to stimulate and activate depressed patients in order to produce an elevation of mood eg. concordin, torfranil.

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Tranquilizers or neuroleptics: They reduce agitation, produce feelings of calm and produce either a diminution of or an indifference to hallucinations and delusions without also producing considerable drowsiness or excessive sleepiness eg. melleril, largactil, trilafon.

(b) ELECTRO-CONVULSIVE THERAPY (ECT).

It is a physical therapy administered to improve the mental state of the patient. In submitting himself to this therapy the patient is laid on a bed with his legs and arms held by about four attendants. A tongue pad is placed in his mouth to prevent him from biting his tongue during the period that the therapy is being carried out.

Before then he is given a drug that produces muscular relaxation in order to decrease the intensity of his convulsions. He is also required to be in a loose clothing and to have an empty stomach.

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When all is set for the therapy the physician pushes a button and electric currents pass through electrodes placed at the patient's temples into his brain. The administration of the therapy lasts for about three seconds and the machine stops automatically.

The patient instantaneously undergoes convulsions or jerks and then enters into a state of unconsciousness for about two minutes. After that he lapses into what resembles a profound sleep or coma. The convulsions are principally the grand mal type.

During the period of the sleep the patient's bed is wheeled off and another one enters the therapy.

When the patient receives consciousness, he appears pale but he is able to return to his ward unaided.

On the average, patients receive six therapies and their conditions improve. Others receive up to eight, the maximum (No patient is allowed to exceed that number). Usually two therapies are given to each patient every week.

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This form of treatment is ideally applied to cases of manic depressive psychosis, Schizophrenia especially the agitated ones. It is applied to patients with functional psychosis but not to those with organic brain damage. It tends to increase the apprehension of the neurotic patient so only selected neurotics are treated that way.

Its main advantage is that it cuts short the psychiatric symptoms. Electro-Convulsive Therapy is used at the Accra Psychiatric Hospital only; there is none at Pantang and at Ankaful.

PSYCHOTHERAPY

Psychotherapy involves efforts to help patients to understand why they behave the way they do. Psychotherapists help people to recognise what environmental factors, what ways of thinking and what aspects of behaviour seem to get them into trouble. Efforts are made to help patients to find alternative mode of behaviour. They help patients to discover for themselves that there are alternatives to maladaptive patterns of behaviour and that these alternatives may allow them to find a more meaningful

way of life.

Psychotherapy therefore involves the treatment of mental and emotional disorders by non-physical methods and without the prescription and the use of drugs. It depends mainly on verbal and non-verbal (gestural) communications.

At the Accra Psychiatric Hospital Psychotherapy is carried out by clinical psychologists. At Pantang and Ankafu there are no psychologists so it is the psychiatrists themselves who administer that therapy.

The idea behind this form of therapy is that most psychiatric patients lack satisfactory interpersonal relationships with friends or relatives or are unable to communicate with them effectively about problems in their lives. Often these are life-long behaviour patterns which are considered to be contributory or causal factors in the development of psychiatric disorder, Gregory (op cit) Brussel (op cit). There is therefore the need for the psychiatric patient to establish rapport with a trained professional who will help him to remove his problems of emotional nature by removing, modifying or retarding existing

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symptoms and promoting positive personality growth and development. This professional is the psycho-therapist. Therapists believe that the compassion and honesty that develop within the therapeutic relationship, the intimacy and the model for identification that the therapists provide, help the patient within a short time to gain a better sense of reality.

Since individuals' needs vary, each patient has a skillfully planned programme with the therapist. Normally treatment should be effected with the full cooperation of the patient.

Information is obtained from the patient through the interview method. He is required to verbalise his problems, worries, doubts, fears, impulses, conflicts, sources of anxiety and guilt, for example. These conditions usually form the basis for treatment.

Psychotherapy has several branches and at the Psychiatric hospitals in Ghana the branch adopted is Behaviour Therapy. The behaviour therapist views mental disorder as the result of the patient having learnt maladaptive habits but not as an outcome of dynamic and unconscious processes. In the words of

Corcy Brooks (1982 p.76) "behaviour therapy does not dwell on the past or digging into the client's unconscious memories. The goal is to teach himself new management techniques". Similarly Sutherland (op cit) has observed, that if people are to be taught to behave in the appropriate ways their feelings would undergo a corresponding change.

Behaviour therapy therefore involves investigating current problems of the patient and suggesting new methods for him to learn to overcome them. It concentrates on how to relieve specific symptoms and problems rather than spending time investigating their causes.

The method is applied to both neurotic and psychotic patients. In its practical application it depends on the principle of reinforcement which states that all animals including man tend to repeat behaviour emitted in a given situation if that behaviour is followed by a reward. A reward is any consequence that gives pleasure eg. praise, exhortation, money, food, (Maddison et al, 1982; Reiss et al, 1977). In the course of treatment a cooperating or an improving patient is usually rewarded in order to encourage him

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to emit or to continue showing that behaviour.

Two of its methods may be cited for illustration. In treating a neurotic patient the therapist may persuade him to approach the dreaded object. The patient, may to his surprise, discover that no harm happens to him. This enables him to break the vicious circle and overcome the problem. Before the beginning of treatment the patient is made to relax and narrate the situations that cause the phobic reaction. After successive interviews the patient is advised on how to go about a change in his behaviour. He is first made to imagine the item feared. The procedure is repeated until he can tolerate imagining it without anxiety whilst remaining completely relaxed. Finally he is made to approach the dreaded object in real life in order to effect cure. For example somebody who fears spiders may begin treatment by looking at the pictures of spiders. He may then be exposed to situations resembling actual spiders, for example by looking at or touching dead spiders. Finally he may be required to handle a live spider. Treatment may cover many sessions.

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Behaviour therapy may be used in the treatment of depression. The psychologist tries to induce the depressed patient to undertake some task that will give him concentration. He may be required to draw specific pictures. If he is able to hold on to this task for some time he will be rewarded and will be made to continue the treatment. Such a treatment is considered to provide an elevation of mood for the patient.

GROUP THERAPY

Group therapy is a milieu in which the patient is required to learn how to interact with others. According to Sutherland (op cit) it began in the early 1930s as an off-shoot of Therapeutic Community. Aguilera and Messick (1982 pp.28-29) stress on the need for this form of therapy on the basis that naturally man is a gregarious animal. They argue that from birth, an individual is a member of a group composed of himself and his parents. His life becomes a succession of group memberships expanding from the basic family unit to peer groups, play groups and groups in school, business and church. An individual

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may remain in some groups permanently or temporarily, voluntarily or involuntarily, directly or indirectly; nevertheless he will participate in some form of group activity.

Forms of behaviour that communicate feelings, needs and ideas develop through interaction with others. At the same time perceptions and reactions toward the feelings, needs and ideas of others develop.

It has been suggested, they continue, that an individual's behaviour can be controlled and influenced by the forces of groups which he is a member and that he becomes what he is because of the roles, statuses and functions that are given to him by them.

Experiences that bring feelings of comfort and satisfaction are usually tried again whereas those that result in frustration and discomfort are avoided whenever possible.

They believe that in psychiatry there has been a shift of emphasis from considering man as a biological entity to considering him as a biopsychosocial entity. Movement has been increasingly away

from an organism - centred to a social - centred conceptualization of personality dynamics. This has contributed to a rapid rise in the development and acceptance of group therapy not only in mental hospitals but also in military, veterans and private and general hospitals.

Group therapy means a treatment given simultaneously to more than one patient so that group therapists believe that they can observe and interpret the patients' behaviour very well in the context of the dynamics of the group. They are sufficiently aware that this therapy is not enough to remove the psychological root of the patients' problems, however, it may help them to establish some mental equilibrium. It is also used to complement the basic treatment methods.

In the three psychiatric hospitals in Ghana group therapy programmes exist in all the wards and all patients are required to participate in except those whose physical or mental conditions prevent them from doing so especially the aged and the agitated ones.

At the group therapy sessions which are convened everyday the nurses on duty act as moderators and sit in groups with the patients. Because of language bar-

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riers on the part of some of the patients the groups are organised along ethnic lines. In the male wards in the three hospitals English language is predominant.

At each session there is a scheduled programme to follow. Normally the sessions cover a large variety of activities and where discussions are involved they centre on topics like patients' problems, the use of drugs, preparations for discharge, employment after discharge and how to keep the hospital clean. Each patient is required or asked by the moderator to contribute to every topic discussed.

For the purpose of illustration two group therapy weekly time tables have been produced below. One from Accra and one from Ankaful.

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Table 4: Group Therapy Weekly Programme at the Special Ward (male) at Accra Psychiatric Hospital.

Day	P r o g r a m m e	
	10 - 11 a.m.	2. - 4 p.m.
Monday	Story Telling	Games and bathing
Tuesday	Problem solving	Church Service
Wednesday	Health Education and Know your doctor and drugs.	Bathing and general cleaning
Thursday	Current affairs and drumming	Ward Conference, shaving, bathing and nail cutting
Friday	Boiling of clothes	Games and bathing
Saturday	General cleaning	Bathing
Sunday	Church Service	Relaxation.

Table 5: Group Therapy Weekly Programme at Aggrey Ward (Female) at Ankaful Psychiatric Hospital.

Day	Time	Programme
Monday	9 - 10 a.m.	Story telling
Tuesday	"	Games
Wednesday	"	Plaiting of hair
Thursday	"	Discussions on drugs, problems.
Friday	"	General discussions
Saturday	"	Learning of new songs
Sunday	"	Fellowship meeting

The two tables, which are self explanatory generally emphasise group activity and interdependence; for example shaving, general cleaning, plaiting of hair, learning of new songs and fellowship meeting. The sessions also give rise to frequent interaction between the patients and their therapists. They may then be said to give validity to the view expressed by Dunham and Weinberg (op cit) that group therapy contributes to calm atmosphere and cooperation between patients and nurses in the wards of mental hospitals.

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This form of therapy has several advantages. It encourages the patient who is in an atmosphere of misery to speak up; he profits as he critically surveys, analyses and interprets problems of others similar to his own. He learns to yield selfish individualistic impulses with the help of the crowd. On the material side, the programme provides collective treatment without any financial cost.

What is more, members who are getting better often describe the course of their recovery to the new members. By including within the same group patients at different stages of recovery those who are most seriously ill may see from the example of others that recovery is possible. Patients may find this more assuring than being told by the doctor or the nurse.

Feelings of uselessness and unworthiness predominant in depressive and neurotic patients tend to be repressed by group activity and discussions.

Religious services on Sundays do not only reinforce the religious nature of man in general and the patients in particular, but they also tend to break the myths surrounding the mental hospitals as closed systems.

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They are normally organised and led by church leaders who are not employees of the hospitals.

(c) OCCUPATIONAL THERAPY

Occupational Therapy is a device consisting of work - usually the learning of trade - performed at the hospital and is often a requisite for discharge. The aim of this form of therapy is to bring the patient to the highest possible degree of physical, mental, social and economic independence.

In this therapy attention is focused more on the medium and the long stay patients. As observed by Gittleson and Lemmings (1969 pp.269-270) the short term patients, no matter how severe their illness will have little difficulty in re-entering the wider community after discharge because normal community standards may still be fresh in their minds. On the other hand, the medium and the long stay patients may be so much accustomed to hospital support that they may have almost forgotten the demands of normal society. It is these two groups of patients who will need to have community attitude re-instilled into them. This requires some kind of teaching process. One

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variant of this teaching process is the use of industrial techniques in occupational therapy.

The decision to involve a patient in such a programme is preceded by a careful assessment of the patient's mental and industrial capabilities. Normally a patient is required to specialise in one skill but has the freedom to switch on to another if he likes. The physician may also direct a particular patient to take up a specific skill; for example a depressive patient may be asked to take up art in order to elevate his mood.

The important thing as far as the therapists are concerned is not what the patients accomplish but they feel that that therapy affects their conduct positively by keeping their bodies moving, their minds occupied by giving them skills and by facilitating group participation.

Occupational therapy is an integral part of the treatment process in all the three psychiatric hospitals in Ghana. Each hospital has two occupational therapy workshops; one for males and one for females. At the men's occupational therapy

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workshop, the trades learnt include shoemaking, doormat making, blacksmithing, carpentry, tailoring and basket making. The women do dressmaking and crocheting.

At Accra Psychiatric hospital there is an occupational therapy show room where the patients' industrial products are advertised and sold to the general public.

This form of therapy has many advantages. It breaks up the hospital monotony and gives the patient something to do. It therefore brings him a more pleasant way of spending his time.

It provides the patient with a new skill. Where he has one already, it enables him to improve upon it and therefore gives him more confidence.

The therapy allows the patient to be taught how to cope with the outside world after discharge by having sample of machines to practise with inside the hospital.

The occupational therapy enables the patient's degree of psychiatric disability to be measured. This can be done by means of his output. This in-

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formation may be passed to his employer who is interested in getting it.

Tranquilizers or sedative drugs may have a limiting effect on the patient's motor ability which will slow down his output. By measuring his output it is possible to assign a numerical percentage to the patient's work performance and therefore his work disability under differing doses of the same drugs.

Training under that therapy takes into consideration differences in mental and physical disabilities. Skills are therefore determined not imposed on the trainee.

(f) COUNSELLING

The role of counselling in the mental hospital is to find solutions to patients' problems that arise from situational and interpersonal difficulties. It is assumed that once the solution is made clear the ego will be able to function adequately toward solving the problem.

Counselling is carried out in all the three psychiatric hospitals. During counselling period a

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group of patients selected for the occasion meets the counsellor who is usually a trained psychiatric nurse. During the session each patient in the group is required to make a contribution by making mention of his problem. The members of the session analyse the individual problems with the help of the leader or counsellor. A group answer is sought for each problem and conclusions are drawn. The search for a group answer to the patients' problems becomes necessary because as observed by Gregory (op cit) it is believed that they became ill because they could not solve their emotional problems alone.

Apart from the group counselling individual members of staff advise patients on problems affecting them during the course of their duties.

(g) SPIRITUAL THERAPY

Spiritual healing is an integral part of the treatment programme in all the three psychiatric hospitals. As already stated in the group therapy programmes, Sundays are devoted to religious service.

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Each hospital has a chaplain who on voluntary basis leads these services. He consoles, counsels and baptises patients where necessary. In Accra and Pantang the chaplaincy is carried out by an Anglican Priest and at Ankaful by a Methodist Priest.

Members of Syncretic Churches also go to the hospitals from time to time to pray for the patients.

(h) RECREATIONAL THERAPY.

Recreational activities are organised in the hospitals to help to alleviate the boredom experienced by the patients and to encourage them to participate in group activity. This therapy is therefore considered an important section of the treatment process.

The patients are made to watch television and video shows and are also exposed to games like ludo, oware and draft. They watch the shows and play the games together with the nurses.

Furthermore, the hospitals have patient libraries which are stocked with story books, novels, textbooks and newspapers. The literate patients are encouraged to patronise the libraries so as to re-

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kindle their intellectual capacities and to keep them from idling about.

In this chapter, an attempt has been made to examine the characteristics and the functions of psychiatric hospitals in Ghana in the light of Erving Goffman's propositions. The factors that give rise to the custodial role of the hospitals have been examined.

Some light has also been thrown on the career of the patient while on admission. Similarly the various mental disorders and the various treatment processes have been treated.

In the next Chapter analytical explanations are given showing the implications of these themes on his ideas.

CHAPTER THREEPSYCHIATRIC SERVICES IN GHANA AND ERVING GOFFMAN'S
TYPOLOGY: AN ANALYSIS.I. INTRODUCTION

In chapter one we isolated the seven salient features of the mental hospital discussed by Erving Goffman and noted that they would be the guidelines in the study. In pursuance of this objective we described the main characteristics and the role of the psychiatric institutions in Ghana in the light of his observations.

In this Chapter the focus is to show, with analytical explanations, the similarities and the differences between the operations of the psychiatric hospitals in Ghana and his observations.

II. THE CUSTODIAL ROLE OF PSYCHIATRIC INSTITUTIONS IN
GHANA.

In Goffman's typology of the mental hospital, he has advanced an argument that it is custodial in nature. In chapter two we reached a similar conclusion and examined the reasons, as far as data available allowed for

that. In this section our primary concern is to give sociological explanations to the custodial character of the hospitals. We are following the trend of the argument as outlined in chapter two.

We have already observed that the psychiatric hospitals in Ghana are largely custodial partly because of the insufficiency of qualified medical personnel and other medical resources.

The shortage of psychiatrists and psychiatric nurses in particular is principally attributable to brain drain. Forster et al (op cit pp.8-9) maintain that

"There is a large number of Ghanaian Doctors who have qualified as Psychiatrists but only few, seven in number, are in our psychiatric hospitals. Majority of them have left the country".

The Psychiatric specialist at Ankaful Psychiatric Hospital shares a similar view. In an interview on this issue he declared:

"When I completed my medical course in psychiatry there were as many as twenty psychiatrists who are all Ghanaians in active service in the country. As far as I am aware, all of them have left Ghana".

Tsikata (1980) throws light on the fewness of psychiatric nurses in the mental hospitals. He is of the

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opinion that these trained people have gone to the neighbouring countries because of frustrations that they encounter in the course of their services in Ghana.

Indeed the inference to be drawn from the statements of these observers is that service conditions in the psychiatric field in Ghana are not lucrative so that most trained people in that area prefer going to work in other countries where they think these conditions are better.

Inadequate funding is equally responsible for the shortage of medical resources in the hospitals. Here we wish to focus our attention on drugs and on food for the inpatients. At Ankaful, the hospital secretary observed:

"Our mental hospitals are not fund-generating. Our inpatients are not charged anything for the drugs they use, for the food they eat and the beds they sleep on. Because of these reasons, we feel that the government does not want to spend much money on them. As a result we have to ration food and drugs. The food problem is, however, more intractable. In all the three mental hospitals, each patient is fed on ninety cedis (₵90.00) a day. This money is not sufficient at all so those of us at Ankaful charged with the responsibility of the upkeep of the patients buy food on credit from food contractors around and when our quarterly allocation of funds comes from government we pay them. We have never been able to pay any contractor in full so we are always in debt because we buy the food on credit in excess of the food allocation of funds. As at now, we owe majority of the food contractors so immensely that we

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cannot approach any of them again for help. Furthermore, the money problem forces the three hospitals' staff to feed all their patients on porridge without sugar in the mornings".

It seems that the insufficient funding of the mental hospitals in Ghana is related to the little importance attached to the mentally ill. It appears, as Pasquall et al (1981) have rightly remarked that more money is spent on the general hospitals which cater for the physically ill - the elderly, the youth and infants. These people, unlike the mentally ill, who have little chance of ever returning to normal life, tend to arouse sympathetic responses from the mass media and from the general public. As a result they become more important than the mentally ill to politicians who are chiefly interested in catching votes. The general hospitals therefore appear to be more popular than the mental hospitals as far as the government is concerned.

Overcrowding, which has also to some extent, led to the custodial character of the Accra psychiatric hospital in particular is ascribed to its inability to expand. All the departments of the hospital except the Nursing Training School, the Reference library and the Records Office are concentrated within the wall of the

hospital. The twenty-three wards and the other departments within the wall stand on a site measuring about 100 by 150 metres. Indeed, as far as the wards are concerned there is no space for expansion.

The overcrowding problem which has become chronic is then a product of a large number of reasons; the lack of foresight of its founding fathers to acquire a larger plot of land for future expansion; the historical root of the hospital as a Lunatic Asylum; the sizes and the small number of the wards in relation to the number of inpatients, the phenomenal growth in the number of departments that occupy much of the land and the wall that restricts the movements of the patients.

The attitude of the government towards the mentally ill has always been to keep them away from society. That is reflected in the arrest of vagrants from the streets and their consequent detention in the mental hospital. This exercise is carried out from time to time. According to Carothers (op cit) in the colonial period, lunatics who happened to be arrested were those who lived near Europeans or worked with Europeans. Nowadays, the exercise is restricted to the urban centres mostly. The most important in recent history was

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that of 1965. During that year the Organization of African Unity (O.A.U.) conference was held in Accra. Shortly before the commencement of the conference, the then government ordered that all lunatics should be cleared from the streets of Accra and be kept at Accra Mental Hospital so that the delegates might not see them. Later on majority of them were transferred to the Accra Mental Hospital annex built at Atimpoku.

Society usually poses many problems to people who are or who have been psychiatric patients. Erving Goffman has argued that mental patients who, have undergone institutionalization tend to lose their social acceptance. Stallworthy (1983) goes further by remarking that the public has a general fear that hospitalization makes the condition of the mental patient worse because it offers no everlasting cure. Eventually since his relatives feel that the patient has deviated from his psychosocial functions he brings disgrace to them so they isolate him.

To find out whether hospitalised mental patients are stigmatised in Ghana we asked mental hospital out patients who had had the experience of being hospitalised to indicate the nature of their social relations

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(whether their relatives, friends and spouses relate to them positively or negatively) and their job opportunities. Some socio-demographic factors like the length of stay in the hospital, age, marital status and the job in which the patient was before the onset of the illness were taken into account. Tables 6 to 8 below summarise the assessment by the outpatient respondents of the attitude of the public towards them.

Table 6: Nature of Outpatient Respondents' Social Relations.

Nature of Relation	Number	%
Cordial	71	47.3
Poor	79	52.7
Total	150	100.0

As Table 6 indicates, the mental patients are poorly received by Society. 52.7% of the outpatient respondents said that their social ties since their institutionalization have become narrower. Unlike before they are not invited to social functions and even within their family circles, they are not allowed to share things together with other people. And in the church, in cars, people

who know of their afflictions do not like to stay near them.

One 35 year old male respondent who lives at Tema and has been receiving treatment at Accra Psychiatric Hospital remarked:

"In our house I am given a room which is hidden at a corner. When visitors come to the house I am not allowed by my relatives, especially my uncle, to join them in conversation because my judgement is thought to be poor".

Majority of these respondents indicated that they had either been on admission for one year or more or had been on admission more than once.

Some of them, however, maintained that there was a cordial relationship between them and their social groups. 47.3% of them were in this category. They explained that they had been on admission for less than one year.

Another index that was used to find out whether the mental patients are stigmatised is their marital status, and this is shown in the table below.

Table 7: Marital Status of Outpatient Respondents

Marital Status	Number	%
Divorced/unstable marriage	80	53.3
Marriage maintained	48	32.0
Marriage not contracted before	22	14.7
Total	150	100.0

Again in the marriage institution psychiatric patients are stigmatised. A large percentage of the respondents have either had their marriages terminated or do not have stable spouses because of their institutionalisation. As many as 53.3% of them have this problem. The reason, according to them, responsible for this is the chronicity of their disorder.

There are, however, few others who have maintained their marriages. These people are made up of those who either never stayed in the hospital for long or advanced in age together with their spouses so that the spouses do not see the need to look for new partners. 32% of the respondents are in this group.

A small percentage of them, 14.7 have never married before and have not even decided to marry now. They

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are in their early twenties or before twenty (relatively young) and they intend getting settled financially before contracting marriages. They believe that as far as marriage is concerned they do not know yet if they will be stigmatised.

Finally the outpatient respondents' views were elicited about their employment opportunities since their discharge from the hospital. Their responses are depicted below.

Table 8: Job Opportunities of Outpatient Respondents.

Status	Number	%
Employed/Job maintained	45	30.0
Have lost job/not getting job	61	40.7
Self employed	44	29.3
Total	150	100.0

Before employers, psychiatric patients appear to have unfavourable images. This is apparent in Table 8 above. Of the 150 respondents only 30.0% have been able to maintain their jobs after discharge from hospital. Majority of these people are technicians who are indispensable in their employments.

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Others are in government departments and were given leave of absence while on admission. Apart from the technicians and the public servants about half of the people who have retained their jobs are employees, who spent less than one year in the hospital.

In spite of this as many as 61 people or 40.7% of the respondents have either lost their jobs or are not getting any jobs because of their hospitalization. They are of the opinion that the most conspicuous element in employers' view of the mentally ill is the assumption that they are unstable and may be called for admission to the psychiatric hospital at any time. As a result employers do not like to work with them.

Majority of the respondents who have lost their jobs were employees in private organizations. They explained that when they got the attack their employers contacted their families to arrange for the collection of their entitlements because they thought the patients would not be in a good frame of mind again to return to their jobs.

Others lost their jobs because they either stayed in the hospital for a very long time or suffered relapses.

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The respondents maintained that generally they have difficulty in finding new jobs. Their would-be employers get to know of their psychiatric disorders either at the time they are being interviewed or when filling forms for the offer of employment after interview and therefore disqualify them from getting the jobs.

A small group constituting 29.3% of them are self-employed. They are mostly artisans, farmers, fishermen, traders and house wives engaged in petty trading. They have no interest in earning their livelihood by being employed by other people.

What the study has revealed is that in Ghana mental patients are stigmatised. When they get the attack their own relatives, spouses and employers tend to reject them. The factors responsible for their rejection are long stay in the mental hospital and the chronicity or relapses associated with their disorder. The data have suggested that these factors enable the social groups of the patients to get the idea that mental disorder is not curable. Their type of illness makes them social dependents so that no one gets the interest to take the responsibility for their up-keep.

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The degree of stigma increases when the patient spends much time in the hospital or with the persistence of the illness. However, if the patient's stay in the mental hospital is short-lived, it is not likely to cause much disruption in his social ties as his social groups may not lose much sight of him.

In Chapter Two we saw that the mental hospital is a closed system comprising chronic, criminal and agitated patients who have been isolated and institutionalised by society. As a result of such a situation the hospital tends to be custodial. This observation confirms what Erving Goffman has made.

The confinement of the mental patients and the "closed" nature of the mental institution have become socially necessary because of the following reasons: the nature of the illness and the lack of adequate facilities for treatment.

Since mental disorder is invariably chronic there is the need for the hospitalization of the patients. This is because the discharge of such people into the community may present many problems. The patients are helpless, criminal and hopeless so that the community may be hostile and resistant and their families may be

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inconvenienced. The patients as a result may feel isolated and insecure in the society. Therefore their confinement in the hospital gives them security and the easy life associated with their institutionalization - profuse sleeping, eating, watching of television and video shows, smoking of cigarettes, sitting in groups and looking through the window - which we observed in the fieldwork, sets their minds at ease and eventually reduces their tension.

Furthermore, the mental patients are confined because of the insufficiency of after care facilities. The three hospitals together have 52 psychiatric nurses attached to the regional hospitals who carry out psychiatric after-care service. Apart from the smallness of their number, they are not well-equipped. For example, in the Central Region there are only five of these nurses attached to the Regional Hospital in Cape Coast.

They are ideally required to visit their psychiatric patients in their homes. Meanwhile the government has placed only one motorcycle at the disposal of these people. Even during the period of the fieldwork the motor cycle was out of order. It is obvious then that under such conditions no effective after care service

can be carried out. It is therefore important to provide the mental patients with long term institutionalization in terms of custody because it is in the hospital where good nursing care is available for their maintenance.

It has already been noted that one feature of the custodial nature of the hospitals is their low discharge rate of patients. This low rate is itself attributable to the chronicity of the disorder. Data available indicate that the most chronic of all mental problems, schizophrenia, is the most common of all the sixteen classified psychiatric disorders in Ghana. In 1987 schizophrenics alone accounted for 20.9% of the inpatients in the three mental hospitals and in 1988 their number rose to 29.7%. This conclusion replicates an earlier one reached by George Tooth in his study of mental disorder in Ghana in the early 1950s. Tooth, according to Carothers (op cit) found over 17% of the mental patients he studied to be schizophrenics. His final remark was that schizophrenics are the largest number of mental patients in Ghana.

This analysis suggests that since the most chronic mental problem is the most common in Ghana the psychiatric hospitals are not likely to be able to provide effective

treatment for their patients. It is axiomatic then that they cannot completely depart from the custodial role particularly because of the nature of the disorder that they are required to repair.

What has emerged from this study therefore is the fact that the psychiatric institutions in Ghana are largely custodial in character. Their patients are made to stay within the premises of the hospitals and to undergo their daily scheduled activities of eating, sleeping, receiving of medication, working, group therapy and entertainment. As a result their therapeutic function is minimal and this is manifested by the insufficiency of medical resources, overcrowding of patients, government attitude towards the mental hospitals, the stigmatisation of the institutionalised patient by the public and the closed nature of the hospitals.

This observation confirms the view of Erving Goffman on the operations of the mental hospital. It therefore validates our first hypothesis

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That the psychiatric hospitals in Ghana are closed systems in which inmates do not have an easy contact with the wider society due to lack of resources.

III: THE SOCIAL WORLD OF INPATIENTS IN PSYCHIATRIC INSTITUTIONS IN GHANA.

In this section our concern is to examine whether the social life of the inmates in the psychiatric hospitals in Ghana correspond to or differ from the type sketched by Erving Goffman. In this connection we are focusing on the nature of their relationship with the staff and the problems facing them while playing the sick role.

In Chapter Two we examined how the staff in the mental hospital in Ghana relate to the inpatients under the captions "Admissions procedure" and "Rewards and punishments".

As far as the field data allow our conclusions are at variance with the views expressed by Erving Goffman on these issues.

Goffman maintains that on admission the mental patient is subjected to brutality and much callousness, mutilation of the flesh, ^{electric} shocks, confessions of sins, ridicule and deprivation of personal effects

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by the staff in order to coerce him to be submissive. This practice is absent in Ghana. As already shown in Chapter Two the staff's attitude towards the patients is friendly - it does not differ from the nature of the staff - patient relationship in the general hospital. We suggest two reasons for this type of attitude of the staff; the protection given to the patient by the law and the value system of the Ghanaian.

The Criminal Procedures Code, Act 29, 1960 and the Mental Health Decree (N.R.C.D.), 30, 1972, both enjoin the mental hospitals in Ghana to take good care of their inpatients - to clothe, shelter and feed, them and to investigate their cases well with a view to finding the appropriate solutions to them so that their minds will be at ease.

It seems that what the law is asking the mental hospitals to do is to safeguard the interests of the patients within the framework of a friendly atmosphere.

Similarly, the value system of the Ghanaian is an important factor when explaining the liberal attitude of the Staff towards the patients. The Rev. Kwasi Sarpong (1974) has observed that the Ghanaian's liberal attitude is found in his hospitality. He is of the

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opinion that this hospitality is boundless; it is extended to the stranger, the aged, the young and the sick. In expressing this attitude he undoubtedly expects visible results in the form of praise, and tangible rewards.

It is suggested here that under the guidance of the law and his values the Ghanaian psychiatric therapist shows much concern in the plight of his mental patient. The concern for the patient is manifested in various ways. He encourages the patient's relative, friends and well-wishers to visit him as often as possible in order to reduce his anxiety and boredom and to maintain the brotherly relationship that may be existing between him and them. He counsels the patient on the need for good interpersonal relations with his fellow patients and with his other social groups after his discharge from the hospital. Furthermore he plays games and watches entertainments with them and at group therapy sessions, he allows a free expression of their views on matters affecting their welfare.

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The system of rewards and punishments do not operate in the psychiatric institutions in Ghana. Goffman has observed that in the mental hospital there are very rigid rules so that patients are manipulated through a variety of rewards and punishments in order to get the rules to function. The system is institutionalised. In the mental hospitals in Ghana no rules have been spelt out to govern the behaviour of the inmates so that the presence of rewards and punishments to enable the rules to operate becomes unnecessary.

The hospital rules and their associated rewards and punishments were abolished in the Accra Lunatic Asylum in the early 1930s by the first psychiatrist of the hospital, Dr. Maclagan. Since then, they have not been revived in Ghana. Dr. Maclagan argued that the mental hospital should uphold the principle of normal treatment involving the provision of a homely environment in the hospital in which the patient would not consider himself as being in a subordinate position.

Instead he was made to look at how he interacts and functions in the hospital community. In other words he introduced into the hospital the concept of thera-

peutic community. It is a concept by which every aspect of hospitalisation should be used as a treatment for the patient. In a therapeutic community all staff members and the patients work as a team so that the environment shall be of maximum use to the patients.

The patients are included in the responsibility and the process of decision making. They are included in the planning and implementation of treatment approaches and in the evaluation and re-evaluation of their effectiveness. The therapeutic community is considered to present opportunities for patients to examine their behaviour and to grow in the direction of more socially acceptable behaviour.

It involves the use of many different types of therapy to facilitate change in behaviour; recreational and work activities, spiritual therapy, group therapy and community government involving meetings aimed at inculcating into the patients, social standards and values that they have not internalised.

These practices occur in all the three psychiatric hospitals in Ghana.

In terms of the problem areas of inpatients the field data confirm the views of Goffman. He enumerated three problems of the inpatients namely signs and symptoms of their illness, alienation and heterosexual troubles. During the research the inpatient respondents described the last named problem as insignificant because they were more concerned about how to recover and return to their families than about sexual gratification. They confirmed the two as important problems and named four others - relapses, lack of visits, offences committed when agitated and expected broken homes.

Even though Goffman never mentioned all of them yet other studies conducted in the Euro-American environments indicate that they are universal. Dunham and Weinberg (op cit) made mention of them and two other researches on stigma conducted in Europe reached similar conclusions. In separate studies conducted in King Seat Hospital at Aberdeen, Scotland and in the State University of Groningen Holland, by psychiatrists, the conclusion was that society tends to isolate mental patients. The patients lose contact with the general public and this constitutes a profound problem to them especially in marriage, in employment and even within their own family circles, (Gordon et al, 1979).

It seems then that a large number of mental patients' problems transcend cultural barriers. The similarity between our conclusion in this study and the Euro-American ones sketched above including that of Goffman then may be attributed to the universality of mental disorder itself and its associated symptoms. For example the psychotic may have delusions, hallucinations and lack of insight whilst the neurotic may suffer from phobia irrespective of culture. Furthermore, both of them may be stigmatised and face social isolation as this study has shown.

IV: TRENDS IN PSYCHIATRIC SERVICES IN GHANA.

INTRODUCTION:

According to Erving Goffman's theory, treatment offered by the mental hospital is not effective so that no definite results in terms of patients' recovery are attainable. In this regard the hospital tends to be custodial.

As shown in Chapter Two and Section I of this Chapter our fieldwork has proved that his assertion holds true in Ghana. In other words, the psychiatric

hospitals in Ghana have been found to have a custodial posture.

It is true that the psychiatric hospitals have for a time immemorial been maintaining a custodial posture but their services have not been static in nature; they have been improving and expanding with the passage of time as a result of improvements in medical technology.

The thrust of this section therefore is to explore the trends that have been emerging in the services of mental medicine in Ghana since its inception with a view to finding out the degree of the custodial character of the psychiatric hospitals. We are going to consider changes in both institutional and non-institutional forms of treatment and their results.

V: CHANGES IN INSTITUTIONAL METHODS OF TREATMENT.

As already noted, the first mental hospital in Ghana, the Accra Lunatic Asylum started as a purely custodial institution. It was manned by untrained ward attendants who offered no treatment to the patients.

According to Forster et al (op cit) treatment of patients started in the hospital when the first psychiatrist assumed duty as the head in 1929. The treatment he

provided was nothing more than first aid.

In the early 1930s, group therapy, an economical form of psychotherapy was introduced at the Lunatic Asylum. Its advantages include the provision of a protective environment by a group for the patient to try out new patterns of behaviour and the offer of opportunity for him to express his feelings before a group.

A major breakthrough in the treatment process occurred at the mental hospital in 1947. In that year the psychiatrist in charge of the hospital introduced the Electro-Convulsive Therapy (ECT). This machine is still in use and it has the advantage of re-arranging the brain cells and therefore cutting short the psychiatric symptoms (hallucinations, mood swings, delusions, flight of ideas etc.) of the mental patient.

Developments in the therapeutic front continued in the hospital and the decade beginning from 1951 witnessed the greatest achievements in psychiatric service in Ghana. These achievements occurred mostly during the headship of Dr. Forster. They included the establishment of an Outpatient Department, the construction of occupational therapy workshops, the introduction of recreational therapy, counselling and psychotropic drugs.

In 1954 modernisation of the consultation rooms began and an outpatient department was established together with seats for the patients. Now more outpatients can be accommodated than before. The other mental hospitals have similar outpatient departments. These departments are situated in front of the consultation rooms. Accra Psychiatric Hospital alone treated 20,796 outpatients in 1986, 19,152 in 1987 and 2,598 between January and July 1988.

The construction of the occupational therapy workshops began in Accra mental hospital in the same year. At Pantang and Ankaful these workshops were set up together with the other departments when the hospitals were being established. They are staffed by trained occupational therapists. Before the introduction of this therapy menial jobs associated with the maintenance of the hospital were organised for the patients from time to time to reduce their boredom. The jobs included the raking of leaves, scrubbing of the wards and the removal of cobwebs. Occupational therapy provides the patients with tasks of the art and craft type - weaving, door mat and basket making, sewing, carpentry etc. - which give the patients skills. It is very advantageous to the

short-stay acute group.

Recreational therapy comprising entertainments, games, reading and even annual get-togethers came into being in the mid 1950s. The therapy is meant to reduce the isolation of patients especially the depressed ones. The extent of a patient's activeness in his participation in this therapy is considered a measure of the state of his mental condition.

Counselling, offered by trained counsellors is important as a mechanism for finding a group solution to the individual problems of the patients. It also came into being during the mid 1950s.

One major product of medical technology is the psychotropic drug. The use of psychotropic drugs began at Accra Psychiatric Hospital in 1956 and valium and largactil were among the first to be used. As already stated, psychotropic drugs constitute the backbone of the treatment process in the hospitals. In the words of Forster et al (op cit) these drugs "share the property of quietening disturbed behaviour and lessening tension".

Spiritual therapy is organised for all the mental patients in the three psychiatric hospitals. It was began in 1967 at Accra Psychiatric Hospital by an Anglican Priestess. Now, a large variety of Churches, - both Syncretic and Orthodox - take part in the therapy in all the hospitals.

This type of therapy has become necessary because of the traditional notions that underlie the causation of this kind of sickness. The traditional notion holds that lesser Supernatural forces are responsible for the causation of the illness. It becomes necessary, therefore, for the supreme God, the Hero, All-powerful, the all-knowing, the Omnipresent who holds sway over all beings to be invited to cast out these lesser supernatural forces that might have inflicted the illness on the patients.

In 1972 another scientific method of treatment was introduced into the psychiatric service. This is psychotherapy. It has already been stated that the branch in use in Ghana is behaviour therapy. Its advantage lies in helping the patient to revise his attitude so as to enable him to move away from his emotional crisis.

VI: ADVANCES IN NON-INSTITUTIONAL METHODS OF TREATMENT.

The non-institutional treatment methods are those methods that take place outside the premises of the hospital. They have come about as a result of the practice of deinstitutionalization embarked upon by the hospitals. The deinstitutionalization itself has become possible because of the proliferation of psychotropic drugs which can be administered to patients outside the hospitals. By this practice patients whose conditions have improved are discharged into the community and are given aftercare treatment.

Under the term deinstitutionalization, we are going to consider community Psychiatry and Rehabilitation.

Community Psychiatry

Usually released patients from mental hospitals find themselves too far from the hospitals for supplementary care and as rightly observed by Grawunder and Steinmann (1980) they are too fragile to cope independently with the pressures of the outside world. If they are to make a successful return to the community, then the community has to provide some support for them.

The community must house them, feed them, give them

emotional and financial support. All what the therapists have to do is to provide aftercare service from the mental hospitals through follow-up visits to the patients' homes. This service is community psychiatry or what Shepherd (op cit) has dubbed "Upside down" psychiatry.

The community psychiatry facility in Ghana is about one and a half decades old now. In the mid 1970s a decision was taken in this country by the National Health authorities that society as a whole should accept a more moral and financial responsibility for the mentally disabled without distinction as to age, social class, religion, sex or form of disorder. There was a call for a trend towards the organization in the community of programmes which would, if possible, keep the patient out of the hospital, thus saving him from the disruption of his community and family ties. The call culminated in the establishment of community psychiatry as an integral part of psychiatric service in the country. It was started in 1974 and Mrs. Juliana Owusu, then a psychiatric nursing sister (but now a Principal Psychiatric Nursing Officer) at Accra Psychiatric Hospital was the principal architect of the Scheme. Initially, the

Scheme was made up of a team of nursing sisters, staff nurses, ward masters and social workers. Their activities were confined to the Greater Accra Region. At the moment the community psychiatric service is provided by the members of the senior eschelons of the psychiatric nursing service. They are attached to the Regional Hospitals.

Their functions include:

- (a) The provision of aftercare service for those patients, discharged from the mental hospitals through followup visits to their homes,
- (b) The provision of mental nursing care for patients in the community who may not require inpatient care.
- (c) The education of the public on mental health through such media as public lecturers, the press, the radio, symposia, conference and brochures. Emphasis is mainly on preventive measures - identification of psychosocial and physical factors that are likely to affect people's mental state, education on local belief systems underlying the causation of mental illness etc.

Rehabilitation Centres

As a result of their illness and consequent disability,

mental patients are rejected by society and placed in institutions which are remote from their communities so that they become socially isolated. Rehabilitation is a noninstitutional social treatment which aims at reversing the process of social isolation and the effects of institutionalization because as noticed by Denham (1967) people who spend a long time in the mental hospital develop defects of personality among which loss of initiative appears to be the most noxious. As a treatment process rehabilitation centre is a separate unit directed by a psychiatrist and staffed by nurses, occupational therapists and social workers. It is by convention, affiliated to the psychiatric hospital from which its inmates are drawn. It is fully residential.

In Ghana the rehabilitation centre currently in use is the Pantang Rehabilitation Scheme which provides crops and livestock. The ultimate objective of the scheme, according to the Psychiatric Specialist in Charge of the Pantang Hospital is to enable the hospital to achieve self-sufficiency in the hospital's food and meat requirements and to provide jobs for its discharged patients who do not want to return to their homes.



There is another rehabilitation centre at Elmina belonging to Ankaful Psychiatric Hospital. It was set up in 1981 and at the moment it is undergoing renovation. Rehabilitation courses at the centre include animal husbandry, farming, soap manufacturing, palm oil and palm kernel oil making, blacksmithing, tailoring and dress making.

Accra Psychiatric Hospital has acquired a plot of land at Amasaman on the Accra-Kumasi road where it intends building an integrated rehabilitation centre for its discharged patients.

As a therapeutic programme, rehabilitation enables the discharged patient to adapt himself to the outer community. We agree with Hir-Schberg et al (1976) that it shifts the outlook of the patient from one of despair and depression to an attitude of hopefulness accompanied by a desire to make a new start in life. It teaches him to give up the status of a sick person and provides him with work. In a word, it reduces his anxiety and doubts of ever making a successful living and fills him with the desire and the energy to make life more meaningful and enjoyable.

VII: ACHIEVEMENTS OF PSYCHIATRIC SERVICES IN GHANA.

Our objective in this section is to examine briefly the achievements of the psychiatric institutions in Ghana in recent years as a result of the increase in the number of and the improvement in the methods of treatment. The following seem to be the achievements so far made:

- (a) Increase in the range of services,
- (b) considerable decrease in the length of stay in the hospital,
- (c) considerable reduction in the number of resident patients,
- (d) rehabilitation of patients, and
- (e) Open door policy

Increase in the range of services.

Twumasi (op cit) has remarked that the present day mental hospital is an interdisciplinary complex organization with different branches. It comprises medical personnel all of whom are engaged in complex division of labour with each person being a specialist in his department. There are psychiatrists, psychologists, occupational therapists, religious leaders, nurses and counsellors. They all manipulate the patient's brain in various ways in order to control his disorder.

Before his discharge he is likely to have passed through majority of these departments. He might have undergone for example electro-convulsive therapy, psychological testing, occupational therapy, group therapy and spiritual therapy, on various occasions. All these services are synchronised and are available in Ghana. They are all backed by the most important treatment method, drug therapy.

Considerable decrease in the length of stay in the Hospital.

Doctors Asare and Koranteng have observed that as a result of improvement in medical science and technology, the psychiatric hospitals in Ghana have made tremendous advances in the course of treatment. These are reflected in the speed with which they discharge patients. In a hundred years' anniversary brochure issued by the medical staff of the three psychiatric hospitals in 1988, these doctors made a remark that this time between six and eight weeks majority of the mental patients recover their normal health, (Forster et al, (op cit)).

Considerable reduction in the number of resident patients.

Another progress made in psychiatric treatment in Ghana has been the reduction in the number of inpatients and the consequent increase in the number of outpatients. This has been achieved as a result of the existence of community psychiatry whose objectives are to provide aftercare service and to reduce the custodial characteristic of the hospitals. In 1987 the three hospitals together had an inpatient population of 4,455 and an outpatient population of 20,982. The outpatients numbered nearly five times the number of the inpatients.

In 1988, the hospitals' resident patients were 1,733 while their outpatients numbered 1,504. According to these data about three fourth of the patients were on outpatient status.

As already indicated in this chapter the first outpatient block came into being in Accra in the early 1950s. Now, emphasis is being placed on deinstitutionalisation. It seems convincing that the psychiatric hospitals are making attempts to reduce their custodial role.

Rehabilitation of Patients

The rehabilitation of the psychiatric patient as an aspect of deinstitutionalisation is another attempt being made by the Ghanaian mental hospitals to diminish their custodial nature. With one rehabilitation centre in operation, one being renovated and another one on the drawing board, the hospitals' primary objective in this field is to give their discharged patients vocational training in skills, security and independence. As suggested by Caplan (1964) the rehabilitation of the patients is going to help them to resume maximum activity in the community in accordance with their individual abilities and skills.

Open Door Policy

In all the three hospitals the doors of the wards are never locked except that of the special or criminal ward at Accra. This is an attempt to remove the physical and social isolation or the closed nature of the hospitals. At Pantang the psychiatric specialist in charge remarked in an interview:

"Our doors are never closed".

And at Ankaful, his counterpart stated:

"We are operating on the open ward system".

Several factors may be mentioned to explain the hospitals' rationale for adopting this policy. Through the application of tranquilizers they are able to tame their patients. It seems then that the period of the agitated noisy patient that characterised the Lunatic Asylum and necessitated the locking of doors is over.

It appears also that the hospitals want the public to have an idea about their improvement in treatment. It has been stated already that the therapists believe that their turnover of patients is now greater. It is a pride, we believe, that they want the public to understand. The unlocked doors enable visitors and even passers-by to have a quick and easy access to the patients.

Finally, as has been observed by Peter Hays (1964) the therapists want the slur cast on the discipline of psychiatry brought about by their isolation of their patients to be erased. This may explain why in addition to the open ward system, the two modern mental hospitals Pantang and Ankaful are not walled at all. The authorities of the hospitals believe that the

absence of walls gives the hospitals a home-like appearance so that the patients may not notice a well-marked departure from their actual homes.

We have already seen that as a result of the type of illness that they are required to treat and to some extent the interplay of certain social factors, the psychiatric hospitals in Ghana have been maintaining a custodial posture.

This posture is true only to some extent. This is because with the passage of time especially since the introduction of the first physical therapy, the electro-convulsive therapy in the late 1940s, the hospitals with the help of increasing application of medical science and technology, have been making systematic attempts to move away from their custodial position.

The attempts are mainly concentrated in the introduction of a large variety of institutional and non-institutional services directed towards improvement in their health care delivery. The visible effects of these developments include minimisation in the time that majority of patients spend on admission, tremendous

increase in the number of patients on outpatient status, increased aftercare and rehabilitation facilities and more exposure of the hospitals to public scrutiny.

The overall impact of these achievements is that they have contributed to a decrease in the period in which a large number of mental patients bear the inpatient status of their career. In this respect they have given rise to a reduction in the custodial functions of the mental hospitals. The achievements therefore confirm our second hypothesis:

"that the psychiatric hospitals in Ghana have partially renounced their custodial nature and have resorted to diagnosis, treatment and rehabilitation of patients as a result of the emergence of new ideas in the field of medicine".

What we have attempted to do in this Chapter has been to explain sociologically the similarities and differences between the services of the mental hospitals in Ghana and Erving Goffman's model. Like Goffman we have observed that the mental hospitals in Ghana are custodial in character and that the problems of inpatients cut across cultural barriers. On the other hand no system



of rewards and punishments and special initiation procedures that accompany admission are institutionalised in Ghana.

The next Chapter, which is the concluding Chapter summarises our findings in the study and offers some suggestions which we consider useful for future research.



CHAPTER FOUR

CONCLUSION.

I. SUMMARY

The thrust of this study has been to examine the extent to which Erving Goffman's theory of the mental hospital is relevant to the study of mental institutions in Ghana. The motivation for the study emerged as a result of the need to re-examine the concept because of new ideas and technological innovations that have come about in the field of psychiatry in recent years.

In chapter one the concept was thoroughly elaborated and seven major points which were considered to constitute the core areas were isolated to be investigated in relation to psychiatric service in Ghana. These core areas are largely related to therapy, inpatients' rights and problems and stigma.

The views of other writers who have discussed the mental hospital from the sociological point of view were similarly explored. Their contributions in principle confirmed Goffman's idea that the mental hospital is a custodial institution.

As typical of such research reports a problem was stated to provide guidelines for the investigation of the theory. The problem centred on the need to evaluate Goffman's typology of the mental hospital in the light of the performance of present-day psychiatry. It was backed by the establishment of two hypotheses to serve as inves-

tigatory tools and the spelling out of data collection methods. The methods comprised interviews, study of hospital documents related to patients and participant observation. They were required to enable us to have an idea of the hospitals' social environment and to facilitate the testing of the hypotheses.

In Chapter Two we briefly traced the historical growth of the psychiatric institutions in Ghana. This was followed by the review of the characteristics of the hospitals, with a particular attention to factors that give rise to their custodial nature and their treatment programmes.

In Chapter Three with the help of our field data, and the guidance of the seven propositions of Goffman, we related the activities and the characteristics of the psychiatric hospitals in Ghana to the theory. Our central objective in this regard was to find out those propositions that apply and those that do not apply to the Ghanaian cultural context. Congruencies and divergences were found and analytical explanations were sought for them.

Guided by our field data we tested our two proposed hypotheses and we found that all of them have validity in Ghana. The hospitals' role has been custodial with their inmates isolated from the main stream of social life since their establishment; however in recent years with the help of advancement in medical science they have progressed considerably by way of diagnosis, treatment and rehabilitation of patients.

In sum, this study has shown that Erving Goffman's typology of the mental hospital has relevance in the Ghanaian psychiatric service in spite of the critical observations of Scull, Siegler and Osmond and Shepherd already noted in our relevant background review. Stated briefly, Scull, Siegler and Osmond believe that the model is limited in its application because it resulted from an ethnographic study of only one institution. Shepherd also argues that the prevailing sentiments of the era in which the study was conducted was not favourable to the institution of psychiatric medicine and undoubtedly it had a profound influence on, Goffman's ideas.

Shepherd's point of view is that at that time the image of psychiatry was at a low ebb because of the poor performance of the then existing mental hospitals and the resemblance between such hospitals and concentration camps.

The validity of the model in Ghana is true but it is equally true that some progress in the area of the management of patients has been made in recent years as a result of new ideas in psychiatric medicine.

II: LIMITATIONS OF THE STUDY.

The following were problems to which the study could not address itself because of factors considered uncontrollable.

- (a) The views of the members of the public, especially mental patients' relatives, on the notion of stigma, were not solicited because of the limitations of time and financial resources. Such views might corroborate or disprove the existence of the phenomenon.
- (b) We are aware, from experience, that many mentally disordered persons are in the shrines of traditional healers and in the streets but since the research was confined to mental patients in psychiatric hospitals (in fulfillment of the requirement of our thesis) they could not be contacted. They might offer useful ideas related particularly to their problems which could be incorporated into this research report.
- (c) A large majority of this study's respondents were the mental patients who were found to be sober. Since some of them might not have insight, the truth in their information they provided could be suspicious.

III: SUGGESTIONS FOR FUTURE RESEARCH.

This study has suggested three areas of research that appear to be very meaningful in terms of their utility and practical significance. They include:

- (a) Chronicity
- (b) Integration between psychiatric hospitals and traditional healers.
- (c) The village system as an alternative to hospitalization.

CHRONICITY

We have already noted that Doctors Asare and Koranteng have shown that many patients are discharged between six and eight weeks after admission. However, the research revealed that there are several others who go beyond that and go into chronicity. It is these people who are more stigmatised. Little is, however, known about these chronic drug users. There is therefore the need to research into the socio-demographic characteristics of patients so as to identify patients at risk of becoming long term drug users.

INTEGRATION BETWEEN PSYCHIATRIC HOSPITALS AND TRADITIONAL HEALERS.

Twumasi, Forster and Swift and Asuni have on different occasions remarked that traditional healers are an integral part of the medical profession in Africa and that the medical doctor cannot close his eyes to their role. Since many mental patients are under the care of the traditional healers or go to them and come to the mental hospital as a result of

abortive cure offered by them, there is the need to investigate how best the two medical systems - the modern and the traditional - can come together to provide an integral treatment.

THE VILLAGE SYSTEM AS AN ALTERNATIVE TO HOSPITALIZATION

It is important to examine the feasibility of the village system in the treatment of psychiatric patients in Ghana. According to Swift and Asuni, this system is in operation in Nigeria. The patients live with their families in rented rooms in a number of villages near Abeokuta in Western Nigeria and receive medical treatment at Are Psychiatric Hospital in the vicinity. The system has been in use since 1964.

This facility has the advantages of enabling families between the patients and their relatives to be maintained; of avoiding the huge expenses associated with their housing and maintenance in the hospital and of enabling them to avoid stigmatization which accompanies institutionalisation.

The orientation of this Thesis has been mainly to evaluate the theory that in spite of the variety of therapeutic programmes in the mental hospital permanent cure for the mental patients since time immemorial has remained an



illusion. The theory has been tremendously supported by our field data. It seems therefore that since several patients are to live with the illness for the rest of their lives, as Cockerham (1986) has suggested, they are faced with the impossibility of resuming normal roles in life so they must be helped to manage their disorders to enable them to maintain a relatively normal pattern of physiological and social functioning. This may be done through the medium of rehabilitation. There is therefore the need for future research to be directed towards how best the rehabilitation programmes in this country can be expanded in order to absorb the discharged patients of the mental hospitals.

Sight should also not be lost of the need to find out the mental and physical capabilities of both male and female patients. These measures are likely not only to provide the patients with a means of earning a living but they will also enable them to maintain themselves physically and to be useful to their families and society as a whole since their dependence on society will be reduced.

Furthermore, they will be relieved of the immense boredom and isolation that most mental patients experience after their discharge from psychiatric institutions.

APPENDIXINTERVIEW SCHEDULEA. FOR THE STAFF

1. Are the patients allowed to go out of the hospital without restrictions?
2. Are the patients' visitors allowed to enter the hospital without restrictions?
3. Enumerate the hospital's rules that govern the behaviour of patients.
.....
4. Are the patients punished for contravening the hospital's rules?
5. Are there any rewards for obedient patients?
6. What are the admission formalities in the hospital?
.....
7. Are there any initiation formalities through which patients have to pass?
8. How many wards are therein the hospital?.....
9. How many patients occupy each ward?
10. In your opinion what are the problem areas of the patients.....
11. What are the treatment programmes in the hospital?
.....

- 12. What is the hospital's annual average discharge rate of patients?
- 13. In what ways are the discharged patients subjected to Stigma?
- 14. Name the achievements that have been made in the therapeutic processes since the establishment of the hospital.
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FOR INPATIENTS

1. What is your age?
2. How many times have you been on admission in a mental hospital?
3. Since when have you been on admission in this hospital?
4. Are you allowed to go out of the hospital without restrictions?
5. Are you allowed to receive visitors without restrictions?
6. What help do your visitors give to you?
7. As an inpatient have you been given a list of rules to abide by?
8. Are there any rewards that the staff give to patients who they think behave well?
9. Are you punished when you behave wrongly in the hospital?
10. As an inpatient enumerate your personal problems
11. What forms of treatment have you undergone since your admission?
12. Did you face some kind of discrimination from the public after your previous discharge, if any?

FOR OUTPATIENTS

1. What is your age?
2. In which town do you live?
.....
3. How many times have you been on admission in a mental hospital?
4. For how long were you on admission?
.....
5. Are you subjected to discrimination by the public as a result of your sickness?
6. Describe how and where you meet the discrimination
.....
.....
.....

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