



The experiences of providing caregiving for patients with schizophrenia in the Ghanaian context

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INTRODUCTION

Schizophrenia is a severe mental illness that is often characterized by significant distortions in thinking and perception, accompanied by the exhibition of inappropriate emotions (Zhai, Guo, Chen, Zhao, & Su, 2013). It alters one's perception of reality, often manifesting in the affected individual to think and act in ways that are strange or abnormal. It is estimated that schizophrenia affects approximately 1% of the global population (Fatemi, 2010). According to the World Health Organization (WHO), around 450 million people are suffering from a mental or behavioral disorder worldwide (WHO, 2003). Schizophrenia usually starts in late adolescence or early adulthood and follows a variable course, with complete symptomatic and social recovery in only one third of cases (Tandon, Keshavan, & Nasrallah, 2008). The impact of schizophrenia has multiple contexts. Awad and Voruganti (2012) classified the effect of schizophrenia at three levels: 1) the patient undergoing personal suffering, 2) the caregiver and/or families experiencing the burden of care along with the added responsibility of transitioning the relative from inpatient to outpatient treatment, and 3) society due to the strain on the health care delivery system (e.g., frequent hospitalizations), as well as long-term financial and psychosocial support. Globally, there has been a shift from institutionalized caregiving of patients with schizophrenia to informal caregiving primarily by family (Chan, 2011). Some of the positive outcomes of such a shift, as argued by Björkman and Hansson (2002), are reduced stigmatization and improved quality of life for individuals with schizophrenia.

It is estimated that 2.4 million people with mental health problems of which 67,780 (2.8%) received treatment in 2011. This however does not match the manpower crisis in the number of health workers in the country. Reports indicate that as at 2011, there were 18 psychiatrists, 1068 Registered Mental Health Nurses, 19 psychologists, 72 Community Mental Health Officers and 21 social workers working in

mental health which is an unbalanced staffing situation with an unbalanced emphasis on nurses compared to what would be expected (Roberts, Mogan, & Asare, 2014). There were 123 mental health outpatient facilities, 3 psychiatric hospitals, 7 community based psychiatric inpatient units, 4 community residential facilities and 1 day treatment centre, which are well below what would be expected for Ghana's economic status. The majority of patients were treated in outpatient facilities and psychiatric hospitals and most of the inpatient beds were provided by the latter. Mental health services are significantly underfunded with only 1.4% of the health budget allocated to mental health, and expenditure very much skewed towards urban areas (Roberts, Mogan, & Asare, 2014). There are no recent epidemiological data on schizophrenia in Ghana. From the 1960's and 1980's, researchers reported few cases of schizophrenia among various groups in Ghana. Field (1960) in her work in among the Akans in Southern Ghana studied 52 cases of Chronic Schizophrenic cases. Fortes and Mayer (1966) studied 17 cases of psychosis among the Tallensi in Northern Ghana. In 1984, Sikanartey and Eaton (1984) reported on 28 cases of diagnosed schizophrenia among the Gas, of Labadi, a suburb of Accra (the capital of Ghana). In a cross-cultural comparisons of the symptoms of schizophrenia in 7 countries, the researchers used DSM-V to conduct a structured clinical interview among 76 patients in Ghana, but the location on where the patients were drawn from was not reported (Bauer et al., 2011). In another recent randomised controlled trial studies, schizophrenia was predominantly diagnosed (52% of cases) among the primary target conditions (such as bipolar disorder or major depressive disorder) in prayer camp in the eastern region of Ghana (Ofori-Atta et al., 2018). These isolated studies do not show any clear prevalence rate of schizophrenia in Ghana. However, they do show that the condition has long been a commonplace in the country.

Ghana has passed a Mental Health Act (Act 846) in 2012. A key provision in the act is to de-institutionalize mental health care in the

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country, providing community-based care for people with mental disorders and reduce crowding at the three mental hospitals. Unfortunately, the Act continues to be in limbo as the legal frameworks which should govern its implementation are still not passed. In the absence of the implementation, families of the mentally ill continue to provide caregiving in Ghana (Doku, Wusu-Takyi, & Awakame, 2012). The central role of the family in the provision of care provides them much autonomy in decision making regarding health seeking for their suffering relatives. Faith healing, herbalists and traditional healers are constantly consulted for a cure (Ae-Ngibise et al., 2010). There are about 45,000 traditional healers registered in Ghana, with many churches providing some forms of syncretic spiritual healing to about 70–80% of people using them as frontline service personnel (Ministry of Health, 2005). A recent report on Ghana's mental health system indicates that a significant proportion of faith healers and traditional practitioners offer treatments such as medications, use mechanical shackles to restrain about 41–57% of patients but also refer mental illness cases to psychiatric services for attention (Roberts, Asare, Mogan, Adjase, & Osei, 2013).

Most patients with schizophrenia may end up in prayer camps in Ghana (Ofori-Atta et al., 2018) where family folks and staff of such sanatorium provide care. Generally, schizophrenia and other mental illness in Ghana are viewed by many persons as manifestation of diabolical manipulation. Family folks of such patients around the world have to struggle with various significant psychological burden of caregiving (Bevans & Sternberg, 2012; Robison, Fortinsky, Kleppinger, Shugrue, & Porter, 2009). In the developing world where family ties provide strong social support for people, most schizophrenic patients are supported by close relatives. For example, the WHO estimates that up to 90% of schizophrenic patients live with their families (WHO, 2008). There is, however, a paucity of research examining the experiences of unpaid (i.e., family) caregivers who provide care for relatives that have been diagnosed with schizophrenia in Ghana. There is thus the need to explore and better understand the experiences of informal caregiving (e.g., family) for people living with schizophrenia in Ghana. To this end, we conducted a qualitative study of caregivers for patients with schizophrenia in three public psychiatric hospitals in Ghana to examine the experiences and coping strategies of caregivers in this context.

METHODOLOGY

RESEARCH APPROACH

To gain a deeper and more complete understanding of the psychological burden experienced by informal caregivers providing care for schizophrenic patients, use of qualitative methods are informative and useful. It is an approach that is often used to explore a phenomenon that has not been previously well described (Risjord, Moloney, & Dunbar, 2001). To the best of our knowledge, this is the first attempt to conduct an in-depth examination of the experiences of informal caregivers of schizophrenic patients in Ghana.

INTERVIEW GUIDE

A semi-structured interview guide was developed and piloted for its appropriateness and clarity. The interview questions covered themes such as personal risk, family support, disruptions in personal/family life, role as caregiver, barriers/challenges of caregiving, overall physical health status, health condition, relationship with family and friends, emotional distress and coping strategy of caregivers. Two key questions on the interview guide that were analysed in the present study are 'Tell me about your experiences in caring for your relative with this mental difficulty' and 'How do you handle or cope with the challenges of caregiving?' The use of a semi-structured interview guide gives qualitative research a descriptive capability and flexibility in collecting,

analyzing, and interpreting data (Boodhoo & Purmessur, 2009; Pietkiewicz, Pietkiewicz, & Smith, 2012).

STUDY LOCATIONS

Ghana has three public psychiatric hospitals (all located in the southern part of the country) that provide services for its estimated population of 25 million (Accra, Pantang and Ankaful Psychiatric Hospitals). Though some public hospitals see patients with mental illness on an outpatient basis, most of those with severe mental conditions such as schizophrenia who report to public hospitals are referred to one of these three psychiatric hospitals. According to the World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS), these hospitals provide care for about 85% of all mental health cases in the country (Roberts, Mogan, & Asare, 2014).

INFORMANTS AND SAMPLING PROCEDURE

Using a purposive sampling frame, family caregivers who visited any of the three institutions during the study period were identified by the nurses on duty and approached for the study. After the study was introduced to participants and informed consent provided, face-to-face interviews were carried out using the semi-structured interview guide. Data collection was conducted within a four-week period. Sixty (60) primary family caregivers were sampled from the Accra Psychiatric Hospital, the Pantang Hospital and the Ankaful Hospital with 20 participants from each unit. Ages of the caregivers ranged from 25 years to 81 years. Twenty-nine (29) of them were males and thirty-one (31) females. Fifty-four (54) caregivers were Christians and six (6) Muslims. The interview lasted between 45 and 60 min and all were audio recorded. The majority of the caregivers were interviewed in a local language (Twi, the widely spoken Ghanaian language), by the first author. The responses were translated into English by a transcriber who is a professional translator.

ETHICS

Ethical clearance was received from Ethics Committee for Humanities (ECH) at the University of Ghana and Ethical Review Committee of the Ghana Health Service with protocol identification numbers ECH 041/15-16 and GHS-ERC: 22/11/15 respectively. Participants were fully informed about the study and assured of confidentiality. Their consent was sought before conducting any interview or administering the questionnaires. In this age of technology and social media outlets, participants were assured that their voice will not be heard on radio or any social media platform.

ANALYSIS

Interpretative Phenomenological Analysis (IPA), a commonly-used qualitative approach, was used to analyze study data. The main tenant of IPA is to elicit rich, detailed, and first-person accounts of experiences and phenomena under investigation and examine how participants make meaning of the of these personal experiences (Smith, Flowers, & Larkin, 2009). Use of semi-structured, in-depth, interviews provide flexibility for an IPA analysis (Pietkiewicz, Pietkiewicz, & Smith, 2012). Although this study has relatively large sample compared to typical IPA studies, the steps described by Smith, Flowers, and Larkin (2009) in analyzing large data using IPA were maintained. Data analysis started first by reading each transcript to gain an overall understanding of the data. Researchers took detailed notes of specific phrases and words related to the objective of the study. Since a majority of the transcripts were transcribed from the local language of Twi into English, the authors (who are all fluent in Twi and English) discussed thoroughly all statements which seemed incongruent with the transcriber's rendition and agreed before further analyses were done. The second step of the

analysis was to identify group level themes and illustrate them with typical narratives from individual participants. Such narratives were linked with other recurrent themes, if appropriate. The third step involved verifying, summarizing and drawing analytical connections across all the themes (Smith, Flowers, & Larkin, 2009).

VALIDITY ISSUES

The accuracy of the analysis and interpretations of the present study was ensured through the following steps. First, the first author always summarized the views of participants during the interviews to determine whether what had been reported was congruent with the recorded information. Second, through a peer-review process and group interpretation, the paper was drafted by the lead author and an opportunity was given to the rest of the group to discuss the results. Themes were discussed and agreed upon before analysis continued. Such group interpretation increases the credibility and validity of qualitative findings (Steinke, 2004).

FINDINGS

The age range of caregivers was from 25 to 81 years with a mean age of 46. Nearly half of the participants (29) were male. Majority of caregivers (54) were Christian, and there were six Muslim participants. Two main themes (with sub-themes) resulted from the analysis: 1) Illness perception, (sub-themes: *Spiritual attribution, psychosocial crisis and schizo-illiterate*), 2) and Caregiving burdens (sub-themes include *Supervision related burdens and Treatment related demands*).

Below is a table that briefly describes the themes and their corresponding sub-themes (Table 1):

ILLNESS PERCEPTIONS

This theme addresses the attributions caregivers have about the aetiology of the condition (schizophrenia) their relative suffers with daily. The cause ascribed to the illness generally included *spiritual attribution, Psychosocial factors* (e.g., drug abuse, excessive thinking (rumination), and postpartum experiences) and ‘*Schizo-illiterate*’ (i.e., they had no idea about the cause of illness) themes. Study findings are organized around these three sub-themes.

SPIRITUAL ATTRIBUTION

Majority of respondents (n = 36) attributed schizophrenia to spiritual forces. To some, it was new to the family and thus, they perceived the illness as spiritually determined as illustrated below:

We don't have a family history of it. There is a reason behind everything that happens and when you critically look at it, it could be spiritual to some extent. This is because we don't have a family history of it, so it could be spiritual.

(M, 37, brother to patient)

Based on the above quote, since the participant cannot trace any

Table 1
Relevant demographics of participants.

Variables	Frequency (F)	Percentage (%)
Sex		
Male	29	51.6
Female	31	54.8
Religion		
Christian	54	90.0
Muslim	6	40.0
Employment status		
Employed	43	71.6
Unemployed	17	28.3

familial connections for schizophrenia in the family, he has implicated a diabolical spiritual manipulation. From the view of others, spiritual gurus have diagnosed the aetiology as spiritual.

A lady pastor told me that my son's brain has been removed and kept at our village. He gave me directions to go to my hometown and pray. So I went to our village to pray. I saw in a dream what she asked me to go and do... I had another dream and saw that my son was not well in the dream and it confirmed to me that what is happening to him is spiritual.

(F, 50, mother to patient)

This informant perceives that the spiritual explanatory model of the illness as explained by a pastor was confirmed through self-experienced visions and dreams. Since such a model fits her explanatory model, she holds firm to this belief. Others added that the aetiology could be a response to meddling in black magic as explained by this 70-year-old caregiver:

I think it is spiritual. When he went to Nigeria he was involved in spiritual matters. He brought a lot of magical books. I think that is where the problem started from, he was acting abnormally. Sometimes he will burn his belongings and he will be talking about spiritual things and sometimes he will like to go naked.

(M, 70, brother to patient)

PSYCHOSOCIAL FACTORS

A substantial number of respondents implicated psychosocial factors such as substance abuse (n = 17), rumination (n = 8) and postpartum experiences (n = 5) in the aetiology of the condition of their relatives. Some caregivers attributed the illness to substance abuse as illustrated by this 69-year-old trader's view: *“It's the alcohol that is causing his condition. Well some people said it is spiritual but even after I took him to the church and he is still used alcohol, to me I think it is his own will”*. (F, 69, trader, mother to patient).

This caregiver confidently believes her son is responsible for his own predicaments. She discounted suggestions made by people that her son's illness may be spiritual due to lack of improvement following spiritual therapy and continued alcohol use. Rumination (or excessive thinking) was also identified as a cause of the schizophrenic condition. Eight (8) caregivers attributed the illness to ruminating and worrying as illustrated by this mother: *“She toils a lot in life and that makes her to think a lot, so it is thinking that made her go through this condition”* (F, 60, mother to the patient). This view was corroborated by a man who was a husband to another patient and explains how certain problematic emotional attributes and excessive thinking coalesce to lead to the present condition of her wife:

Since I have been with her she is quick and hot tempered, she cries a lot and keeps things within her. She really thinks and worries a lot. And to my knowledge these things really put strain on her mind'

(M, 39, husband to the patient)

Five (5) husband caregivers said their wives developed the disorder following the birth of a child as illustrated in this quote: *“One thing I know is that it happened after she had given birth to our last child. She handled the child anyhow and started acting in ways that were abnormal”* (M 54, husband to patient). This caregiver cannot identify a particular risk factor, yet the patient reported a warning sign: the mishandling of the baby. As this was observed only after the birth of their ‘last’ child, the caregiver had a basis for comparison of the patient's treatment of their previous children. This story is no different from that of a 53-year-old farmer who had been caring for his wife for 24 years now:

When I got married to her, everything was fine but after giving birth to her second child, she ran away and we had to look for her. She then started behaving strangely, talking to herself and causing problems”

(M, 53, husband to patient)

In both scenarios above, the caregivers make a direct link between

the birthing of a child and the subsequent change in behaviour of their wives.

'SCHIZO-ILLITERATE'

Four (4) caregivers could not provide any explanation with regard to what was happening to their relatives as illustrated in this quote: *As for this one, I don't know ooo... hmmm. It just happened and up 'til now I do not even understand.* (F, 43 wife to the patient). Another caregiver reports that he cannot implicate substance use, medical causes, or, spiritual and interpersonal problem as potential cause of the condition, as illustrated below:

Well he hasn't taken any substance before. If it is spiritual, we have prayed about it for a long time and if it is medical, too we have sought medical care. I am a pastor too so I have prayed about it, but God hasn't told me that it is spiritual. He has not offended anyone too and he is not stubborn. He completed senior high school and he was trying to apply for a teaching position for the interim then later he could continue his education, and this sickness started. So I cannot really say what is causing it
(M, 42, brother to patient)

CAREGIVING BURDENS

This theme addresses the burdens caregivers experience in their caring roles for their relatives. Analysis showed two major burdens—*supervision related burdens*, and *treatment related burdens*.

SUPERVISION RELATED BURDENS

This sub-theme addresses the need to be on guard due to the inclinations of patients to damage property and be violent towards others. The following voice is illustrative of this:

If he does not issue any threat, then it's not worrying. But now he is issuing threats, so we are scared. He is threatening of burning properties, that's why I have brought him here to Ankaful. When you are with him, you don't even know what to do because you cannot leave him at home and you cannot go with him too.

(M, 42, brother to patient)

From the narrative above, the caregiver's main concern is the patient's vocalized intent to cause damage to property. As a result of these threats, the caregiver's mobility has been considerably limited, as he is uncomfortable leaving the patient unsupervised.

Some patients may not vocalized their intention to destroy property, but their uncontrollable violent behaviours keep caregivers constantly vigilant. A father finds this stressful:

There was a stage when we came here he was wild and during odd hours he went out which wasn't normal for him. So it wasn't easy because you should always be vigilant on him since he may damage something...

(M, 63, Father to Patient)

Related to the above is the cost of damaged properties that is slammed on the caregiver. Some caregivers reported being apprehensive almost all the time; perhaps an indication of hyper-vigilance due to the patients' unpredictable destructive behaviour with its corollary economic implication:

My sister, hmmm, it is one trouble after the other. Today, he will go and cause this trouble, tomorrow, another one. I sometimes feel uneasy not knowing what to expect next. It is like I am always anxious! Always... because you will be there, and he will be reported to have destroyed someone's property which I will have to pay for

(F 35, sister to the patient)

In certain situations, the burden of payment of destroyed properties extended to the procurement of certain rituals for pacifications. Other times some community members were sympathetic with the caregiver and so did not demand payment for the destroyed properties. A 63-

year-old farmer who had been caring for his son for about five (5) years described these dynamics in the following quote:

'In the beginning, truthfully, when the sickness started, it was right here in Accra that he was learning a trade and he was destroying people's property and there were some of the properties he destroyed that I had to pay for. He went to... erhh ...destroy an Ewe's fetish priest's properties and the fetish priest ordered me to buy some items for pacification, even though I am a Christian. When it happens that way, I make losses! Some people were benevolent on me and allowed me to go scot free, but others will let me pay for the damages. I have suffered very much'

(M, 63, father to patient)

A similar narrative was given by a taxicab driver who had been providing care for his relative for six (6) years: *He will go and destroy people's property and it is our responsibility to pay for the damage. It is a serious situation and drains us a lot.* (M,46, brother-in-law to the patient).

The transfer of responsibility from the patient (who destroys other people's properties) to the family (and not government/social welfare systems) may reflect a certain cultural understanding of the family's primary role of taking care of their ill member.

Other participants also indicated that the critical need of keeping an eye on the patient distracts them from other important ventures for livelihood. For instance as expressed by this 40-year-old farmer who has been caring for his mother for two (2) years, he is no longer able to concentrate on his farming activities because of the illness. *Since her condition started, any time I go to the farm, I mostly feel uncomfortable and therefore return quickly because I don't want her to go and do anything nasty or something like that. When I go, I run quickly and come back'*

(M, 40, farmer, son to the patient)

The thought of his mother being home alone puts the farmer in an uncomfortable position. The caregiver does not spend the maximum time he needs on to the farm because of his mother's behaviour. It is this feeling of anxiety that makes him rush from the farm to the house to ensure that everything is under control.

A middle aged father also narrates how the condition distracts his attention from his farming activities. He has to leave the farm to attend to her:

Because of the situation of the child you can't even concentrate when you are on the farm, you would be called several times about things happening to her there so I have to leave all I am doing and come to her so because of that I can't do any meaningful thing at work

(M, 40, Father to the patient)

The patient's condition requires a full-time provision of attention which places extra demands on any the time needed for other engagements, in this case economic activity. As indicated, all other activities are secondary to the burden of providing attention to the patient.

Additionally, almost all the caregivers reported sleepless nights. The potentially violent behaviour of some of the patients required that caregivers remain awake most of the time to ensure that the patient is asleep and is not doing anything that might cause harm to themselves or other members of the household. This is what a 53-year-old caregiver expressed:

Yesterday, for instance, I slept around 2–3 am. She was making so much noise at home. You have to keep an eye on her and make sure she is calm before I am able to sleep'

(M 54, husband to patient)

TREATMENT RELATED BURDEN

Some caregivers described the burden of caregiving which are related to treatment of the patient. Such treatment related burdens ranged from 'healer shopping', monetary cost of care, ensuring

medication adherence, and difficulty accessing psychiatric centres.

Some caregivers had ‘healer shopped’- this refers to families embarking on a number of journeys in search for a cure for their relative's condition. The treatment trajectory usually began from seeking traditional healers guided by others, to other areas and then finally to an orthodox health centre as illustrated below:

When the sickness first started, some people directed me, and I took him to a place in Kwanyako (a town in Ghana). There was a fetish priest there. It was even my brother –in-law that gave me the directions to the place (the very place where his brother-in-law has sought a cure for an illness). But with time I could see that there was no way he was going to get healed. So, another person told me to take him to some pastor at Swedru (another town in Ghana). That place too, what I went through was stressful. Consultation fee was high, so I realized that I could not pay and therefore moved him from there and brought him back home! Then I took him to Pantang (a psychiatric hospital in Accra, the capital) again. And since then it is here I have been coming to and the medications are effective. Herh! I am tired very, very much'

(M, 63, father to patient)

The treatment trajectory was full of experimentations undergirded by testimonies of previous efficacious treatment of close relatives. Traditional treatment regimens appeared to be trusted more than orthodox therapies and yet eventually, the family returned to the orthodox centre for medical treatment which he attests as efficacious. Such a circuitous search for help could add additional strains to the caregivers' burden as indicated in the quote. Caregivers sometimes must take days off from work to bring the ill relative to the hospital for routine check-ups and other emergencies:

At the moment I have to be at work, but I can't 'til he has been taken care of by the doctor. I sometimes loose client since some of them want me to work on their hair and not my apprentices

(F, 43, niece to patient)

From this quote, the caregiver left her duties to be in the hospital with the ill relative, thereby losing her customers.

Another aspect of the treatment related burdens included the monetary cost of patient care. Most of the patients are unable to maintain their jobs, and as a result, the caregivers have the stress of competing responsibilities of self-care and the patient's care as described below:

The only worry is that he is no more working, so we have to work and take care of him. If there is anything to be paid, we have to do that, my auntie and I. So it has brought some financial problem to us all

(F, 43, niece to patient)

In the above narration, the cost can be seen to be collateral, as it exacts further demands on another family member.

A further treatment related demand is the stress related to ensuring patient's medication compliance. A caregiver expresses the following.

If I don't do well to put his medicines in his food for him to eat, he won't take it. So, I decided to look for ways to get him better. For his drug, I usually dissolve it in water and mix it with the tea for him. Sometimes I fry it with the egg for him' otherwise you have to worry and virtually struggle with him to let him take it

(F, 62, mother to patient)

As explained, the caregiver administers the medication through the patient's meals. This might be the most innovative way to manage the struggle she has had to endure in managing the patient's adherence behaviour.

Travelling a distance for medication and the related difficulties of searching for out-of-stock medication was also reported as a treatment related demand:

My main worry is that I come from the village just as others come

from afar for medications and they are told they can't get the medicine from here, so they have to go outside and go look for some. If they don't get the medicine too, the patient will not be well. That is our main worry as at now

(M, 40, son to patient)

Here, the caregiver alludes to two structural stressors. Caregivers and patients from rural and remote areas traverse long distances to receive needed treatment. This challenge is aggravated by the fact that the health care facilities tend to be under stocked with the required medication, creating further stress of having to search for medications from private sources.

DISCUSSION

The purpose of this study was to explore the experiences of family caregivers of people living with schizophrenia and how they cope in Ghana. The analysis focused on two main areas under two themes: perceptions about schizophrenia and caregiving burdens.

Illness perception is an important dimension of attitudes and health seeking behaviour globally, but specifically important in African settings where health is perceived to be multi-determined (van den Bosch-Heij, 2012). Consistent with other studies, majority (36 out of 60) of the caregivers in this study perceived schizophrenia as spiritually determined and accordingly, sought spiritual care. Religion and spirituality is a major cultural dimension of the worldview of Ghanaians (Gyekye, 2010). Its impact can be observed in values, beliefs, health seeking behaviours, treatment regimen, coping and several other areas of life (Osafu, Agyapong, & Asamoah, 2015; Salifu Yendork & Somhlaba, 2016). The spiritual determinism of mental illness in Ghana has a corresponding conceptualization about spiritual treatments for such illnesses (Salifu Yendork, Kpobi, & Sarfo, 2016). Usually, spiritual determinism and the corollary of seeking spiritual treatment is reported to account for the poor adherence to psychotropic medication management (Mensah & Yeboah, 2003). The primary treatment of schizophrenia, is antipsychotic medications (Miyamoto, Duncan, Marx & Lieberman, 2005), but about 25% of people with schizophrenia are resistant to this type of treatment. In essence, although medications are able to deal with the symptoms of the illness in most cases, they are not effective in all cases. There is evidence in Ghana indicating that perceived inefficacy of psychotropic medication management of mental illnesses also reinforces the spiritual determinism and management of the illness (Read & Doku, 2012). In other studies however, the over 98% of patients who poorly adhered to their medication was as a result of economic challenges, forgetfulness, and the feeling of wellness and not spiritual beliefs (Ashong, Kretchy, Afrane, & deGraft Aikins, 2018).

Thus, the belief and use of spiritual care in the treatment and management of mental illnesses in Ghana continue to exist side-by-side that of orthodox approaches. As mental health management expands, people are searching for other innovative ways of infusing orthodox practices with cultural forms of treatment. For example, some churches in the United Kingdom currently retain the services of faith healers (Friedli, 2000), with the task of expelling the demons in cases of real possession. There is also evidence of recommendation from Turkey of the potential to engage the services of religious leaders in the management of schizophrenia (Irmak, 2014). Such recommendations might come with suspicions of abuse, but the limitation of psychotropic medication, the abundance of religious/spiritualized services and manpower crisis in the mental health landscape in Ghana, might provide strong basis to consider alternative treatment. However, the caution of the double-edged role of spirituality or religion in the management of schizophrenia has been proffered (Gearing et al., 2011).

A related implication following the spiritualized perception of schizophrenia and its management in this study was healer shopping. ‘Healer shopping’ is a term that was derived from the concept of ‘doctor shopping’, where the use of a second healer without referral from the

first for a single episode of illness is sought (de-Graft Aikins, 2005). In their quest to get their relatives cured, caregivers often 'healer shopped' in the hope of helping the patients regain their sanity. The practice of healer shopping, according to de-Graft Aikins (2005), is driven by widespread spiritual causal theories of chronic illness, the need for cures, and the endorsement of ethno-medical professionals — in particular traditional religious healers — as experts in treating and curing spiritually caused illnesses. The study found this to be the case among many caregivers of patients with schizophrenia who explored several options of healing including going to prayer camps, fetish priests or alternative medical practitioners in order to find permanent cure for their relative's schizophrenia. Invariably, however, the roaming from healer to healer eventually brought them back to the hospital after being drained both physically and financially and finding no solution. Consistently, healing traditions are often associated with inhumane acts such as beatings, starving, chaining and smearing of unknown substances on the patients by the healers. Some of these inhumane treatments have often been implicated as reasons for poor collaboration between faith healers and mental health professionals in Ghana (Osafo, 2016; Osafo, Agyapong, & Asamoah, 2015). However, some faith healers have begun to show readiness for collaboration, (Arias, Taylor, Ofori-Atta, & Bradley, 2016) and a recent RCT study has demonstrated the viability of combining psychiatric treatment with spiritual healing in a prayer camp in the country (Ofori-Atta et al., 2018).

Respondents also indicated that they observed a link between the specific biopsychosocial factors such as birth related complications, drug abuse and excessive thinking in the lives of their relatives and the onset of schizophrenia. Generally, lay beliefs about the cause of mental illness have been reported to be varied and some studies in Africa have showed that apart from spiritual factors, biopsychosocial factors are largely implicated (Adewuya & Makanjuola, 2008). There are indications of risks of schizophrenia following obstetric complications such as prolonged labour, gestational age and complicated caesarean delivery (Buoli et al., 2016; Kotlicka-Antczak, Gmitrowicz, Sobów & Rabe-Jabłonska, 2001), drug abuse (Adewuya & Makanjuola, 2008; Nimwegen, Haan, Beveren, Brink, & Linszen, 2005; Parshotam & Joubert, 2015) and a host of other psychosocial conditions. Mental stress or overthinking has been reported as one of the perceived psychosocial factors leading to mental illness (Choudhry, Mani, Ming, & Khan, 2016). Some reports in Ethiopia (Hailemariam, 2015), Nigeria (Okpalauwaekwe, Mela, & Oji, 2017) and Uganda (Okello & Ekblad, 2006) show that people perceive mental stress or over thinking about daily life experiences, limited economic opportunities and future prospects as potential causes of mental illness. The views about the cause of schizophrenia as found in this study is generally consistent with the multidimensional views about the condition and as such might need a multifaceted approach in dealing with it (Park, Lee, Furnham, Jeon, & Ko, 2017).

Specific burdens experienced by caregivers of person living with schizophrenia have also emerged in the present study: supervision and treatment related burdens. Schene, Tessler, and Gamache (1996) reported that there are four main domains of structural difficulties in providing care for patients with schizophrenia: 1) tension, 2) supervision, 3) worrying and 4) urging. Most caregivers indicated fear of being harmed by patients, as reported Pusey-Murray and Miller (2013). The apprehension over potential violence from the patients on both caregivers or others reflect supervision related difficulties. Consistent with a large hospital-based cross-sectional study ($N = 444$) among family caregivers of patients with schizophrenia attending psychiatric hospitals in Ghana, caregivers were stressed from supervision related burdens (Kretchy, Osafo, Agyemang, Appiah & Nonvignon, 2018). Other supervision related burdens such as disruption of family routines, interaction and economic have also been reported among caregivers in Nigeria (Adeosun, 2013; Igberase, Morakinyo, Lawani, James, & Omoaregba, 2012). In South Africa, similar burdens such as violence and food insecurity have been reported among caregivers (Sibeko et al.,

2016). Sleeplessness was also reported among the caregivers. We could view this as supervision related burden; that caregivers lack sleep because they have to considerably keep awake in the night to be sure their wards don't pose any danger before they sleep. This robs them of the require time to take care of their own daily needs (Kheng, 2005). This finding is also consistent with a study in France in which caregivers of patients with schizophrenia reported higher scores on sleeplessness and insomnia compared with non-caregivers of patients with schizophrenics (Guillon, Van Impe, & Gupta, 2015).

Antipsychotic medications have been found to be effective in treating the acute episodes of schizophrenia and preventing relapse of some patients (Ginovart & Kapur, 2012). In this study however family caregivers described the financial commitment in acquiring the medications and the process of ensuring that the patients adhered to these medications as burdensome. Our finding that caregivers experience treatment related burden is consistent with a recent study in Ghana, in which caregivers reported high scores on anxiety, stress and depression related to non-adherence of patients. Thus when caregiver was unwell, time and commitment to supervise patients adherence behaviour was poor (Kretchy et al., 2018). The fact that most of these patients were unable to work posed both treatment and supervision related challenges. In terms of supervision, they were distracted by the amount of time they needed to provide care and supervision. In terms of treatment, they needed extra income to augment the physical and medical needs of the patients and other family members. The financial drain on family members with a chronically ill relative was common, especially when the family member had to leave the workforce to care for the ill family member (Niazi, Basheer, Minhas, & Najam, 2004). Csoboth, Witt, Villa, and O'Gorman (2015) have reported that essentially, the distress of caregivers of patients of schizophrenia reflect both humanistic and economic burdens. We opine in this study that both supervision and treatment related burdens are consistent with their postulation.

LIMITATIONS

Data were collected from the three main psychiatric facilities in the country, Accra Psychiatry, Ankaful and Pantang, which are all located in the southern part of the country. Care for schizophrenic patients, however, is not limited to these institutions. Some of the caregivers resort to private facilities as well as prayer camps and traditional healers to seek spiritual healing. Exploring these areas may have provided additional findings of the experiences of caregivers.

IMPLICATIONS

Nevertheless, the findings of the present study have implications for both clinical practice and policy. In terms of practice the findings indicate that caregivers are faced with a number of burdens- supervision and treatment related. Attention ought to be paid to caregivers whenever they send their ill relative to any facilities. Provisions must be made for caregivers to express themselves freely based on the challenges they encounter in their day-to-day discharge of their caregiving duties. Caregivers need to be educated about the illness to keep things in perspective rather than seeking care at inappropriate healing locations for their relative. There is a need for clinical interventions for family caregivers experiencing some forms of distress for the purpose of improving their quality of life. Public understanding of the illness will help to reduce the stress caregivers face as they may have the opportunity to freely express their problems and worries to social support outlets that are available to them.

In terms of policy, government's intervention is key by ensuring that mental healthcare services are readily available and proximate. Some caregivers had to travel long distances to access mental healthcare which increases the level and amount of stress they experience. Existing laws on mental health should consider the informal caregiver role as

important resource in the management of mental illness and structured to provide some financial support to ease the burden of caregivers.

In conclusion, caregiver perceptions of the cause of schizophrenia in Ghana requires an important educational intervention to improve early detection and provision of appropriate care. Further, caregivers are experiencing essentially, humanistic and financial burdens in Ghana, which will require both innovation in clinical practice and government policy intervention to address.

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CONFLICT OF INTEREST

The authors declare no conflicts of interest in relation to the study, authorship, or publication of this article.

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