UNIVERSITY OF GHANA

PERCEPTIONS AND ATTITUDES TOWARDS MENTAL ILLNESS: THE CASE OF PANTANG COMMUNITY

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DECLARATION

I, Florence Adeeku hereby declare that the work presented herein, with exception of the quotations and references contained in published works, which have all been duly acknowledged, is entirely my own original work. Additionally, this work has not been submitted to any institution either in part or whole for the award of another degree.

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DEDICATION

This work is dedicated to all mental health patients, there is light at the end of the tunnel; also to Edem Rexford Kwame Axadzi for being a true friend through and through.

ABSTRACT

Despite an increase in the number of individuals affected by mental illness, mental health facilities in Ghana are few and ill resourced, leading to stress on the few facilitates available. Alternatively, community-based care is being proposed by Ghana's Mental Health sector to reduce stress on mental health facilities. Societal attitudes and perceptions towards mental illness and mental health, however, affect the effectiveness of community -based care. The main goal of this study was to determine how members of the Pantang community in Accra, perceived mental illness and their attitudes towards the mentally ill. Using in-depth interviews and focus group discussions, data was collected from twenty-eight participants from two communities in Pantang. The results reveal that participants believe mental illness is caused by a curse from supernatural beings, stress from relationship problems, drug use, overindulgence in certain habits and having a dubious character. Participants indicate that alternative treatment with the use of herbs and prayers, is best for treating mental illness since they believe hospitals only manage symptoms and do not provide treatment. Despite this belief, some participants are of the view that, some patients need to be permanently kept at a psychiatric facility to protect them and society. Participants were willing to have the mentally ill as neighbours and were willing to live in the same house and take care of relatives who were mentally ill. Community members' support for the mentally ill was basically influenced among other things by perception of the causes, relationship to the person and religious duty. Based on these findings, communities must be educated on the causes of mental illness to do away with misconceptions about the illness. Psychiatric social workers must be trained to form, facilitate and monitor support groups in the community and to assist families with the skills needed to care for the mentally ill.

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CHAPTER ONE

INTRODUCTION

1.0 Background of the Study

Over the years, studies have revealed rapid increase in the number of people who have developed mental illness. The World Health Organisation (WHO), in its 2007 report estimated that globally, 13 per cent of the total population of 6.6 billion suffered from mental illness. Furthermore, between 2007 and 2014, the percentage of the world population suffering from mental illness increased to 25 per cent of the global population (WHO, 2014). In 2012, Out Patient Departments (OPD) in both Accra and Pantang psychiatric hospitals recorded a total of 39,536 and 23, 331 patients respectively; this was against 35,898 and 23,360 in 2013. A holistic assessment of the health sector by the Ministry of Health (MOH) from 2012 to 2013 indicated that whereas Accra did not record any increase in reported OPD cases, Pantang experienced an increase of 29 patients (MOH, 2013).

The rise of about 25 per cent cases in mental illness globally, has both social and economic implications. Socially, people suffering from mental illness often face stigmatisation such as rejection from their own relatives and friends, whereas economically, the human resource of the country diminishes (WHO, 2007). With about 35,898 OPD reported cases of mental illness in the Accra psychiatric hospital alone, the implications are that there will be pressure on the few facilities available at the hospital and also the few hospital workers, as against the bed capacity of 800 intended to accommodate 1,200 patients (Asare, cited in WHO, 2007 p. 26). The emphasis is now being placed on the community's role of accepting the mentally ill and providing community support base in addition to out-patient services as part of efforts in dealing with issues of mental illness. According to Gala (2012), communities must serve as

conduit through which the mentally ill should be helped to recover and must do away with negative beliefs that are potentially harmful to the mentally ill.

In Africa, perceptions about mental illness are derived from cultural and religious beliefs about its origin. In a study on perceptions of mental and physical illnesses in North-western Ethiopia, most people attributed the origin of mental illness to the work of a supernatural being (Mulatu, 1999). The belief was that this supernatural being had the ability to punish those who do wrong by afflicting them with mental illness. The study again revealed that mental illness could occur when an individual or a family breaks a taboo. In a different study conducted in Northern Nigeria, most individuals share similar views on mental illness (Kabir, Illiyasu , Abubakar and Aliyu, 2004). Beliefs about mental illness and the mentally ill in Ghana, is not different from those held in Ethiopia and Nigeria. People suffering from mental illness are therefore treated as outcasts. This may perhaps explain the increasing number of people with mental illness living on the street instead of being cared for by their relations.

Perceptions about mental illness will always exist because beliefs, customs and norms are the lenses through which society interact (Chen, 2002). These customs and beliefs dictate how members should relate with one another. Belief systems are humanly constructed and when there are indications that they may not promote healthy communal living, there is the need for change. Most beliefs about mental illness may be the results of tales handed over by one generation to the next and may not have any scientific proofs. But the beliefs have been accepted because they have stayed over time and individuals tend to believe them as the truth.

It has been established that perceptions about mental illness has both direct and indirect impact on the mentally ill and the immediate families (Segal, Baumohl & Moyles, 1980), and has the potential to either foster or mar the help seeking behaviour of the mentally ill. There is therefore the need to explore what informs such perceptions and recommend appropriate measures to reorient individuals' perceptions about mental illness especially when these perceptions are in bad taste.

1.1 Statement of the Problem

There is an increase in the number of individuals affected by mental illness which has implications for the nation as a whole (WHO, 2014). Meanwhile, there are not enough mental health facilities to address the rising problems associated with mental illness, thus leading to stress on the little facilitates available. Alternatively, community-based care is being proposed by Ghana's Mental Health sector to reduce stress on mental health facilities. This move calls on communities to accept people affected by mental illness and offer support. However, the community which is expected to offer support to the mentally ill has some misgivings about the mentally ill and mental illness. Some people perceive mental illness as a transferable illness and do all they can to avoid close contact with those affected by mental illness. Others also believe that mental illness is a curse from a supreme being –God, Allah or Waqa (Mulatu, 1999). It was against this background that the researcher sought to explore the attitudes and perceptions about mental illness in the Pantang Community and to determine how supportive communities would be towards community-based care for the mentally ill.

1.2 Objectives of the Study

The general objective of this study was to find out how members of the Pantang community perceive mental illness**.** Specifically, the study sought to:

1. Find out the beliefs members of the Pantang community hold about mental illness and the mentally ill.
2. Explore the attitudes of people in the Pantang community towards the mentally ill.
3. Find out the forms of assistance available in the Pantang community to people suffering from mental illness.

1.3 Research Questions

The research attempted to answer the following questions:

1. What are the beliefs about mental illness in the Pantang community?
2. How do people relate with the mentally ill in the Pantang Community?
3. What forms of assistance does the Pantang Community have for people suffering from mental illness?

1.4 Significance of the Study

The study provides relevant information on how the Pantang Community perceives mental illness and the ways in which they assist the mentally ill. This knowledge will inform the need for programmes to be tailored along the line of these perceptions to reorient communities' perceptions about mental illness. Furthermore, the study provides information that will hopefully serve as a guide to generate effective community programmes towards

addressing mental health issues. Finally, provides a basis on which further research on mental illness and community response to mental health issues could be carried out.

1.5 Organisation of Chapters

The study is organised into five chapters. Chapter one of the study provides a general understanding of the research topic. It is composed of the background, statement of problem, and the objectives of the study which informed the research questions. The chapter also looks at the significance of the study in relation to programmes and research. It concludes by defining terms used in the study. Chapter two explores relevant literature on the research area. The literature review is divided into sub sections for easy understanding. The section also discusses the theoretical framework within which the study was conducted.

Chapter three discusses the research methodology used in the study. It outlines the research design and provides a justification for adopting a qualitative approach. Furthermore, the chapter discusses the study area and the study population. Additionally, the sampling technique used and the data collection tools process are also discussed. The fourth chapter presents and discusses the findings and relates the findings to existing literature. The last chapter summarises the findings, draws conclusions and makes recommendation.

1.6 Definition of terms

For better understanding of this study, the following terms have been defined:

Attitudes: The expression of like or a dislike for an individual based on marriage, friendship and residential patterns.

Perceptions: A belief about something as a result of how the thing is viewed.

Alijeni: The belief that 'bad air' or spirits are linked to mental illness. 'Bad air' refers to evil spirits that travel at night and afflict persons with mental illness.

1.7 Conclusion

Mental illnesses have been on the increase and about 25 per cent of the global population is affected. The increase in mental illness has implications for the socio-economic conditions of every country. This rise presupposes that, people suffering from mental illness will attract compassion from the general public; however, this is not the case. This chapter sets the background for the study which is to find out how members of the Pantang community perceive mental illness. The next chapter reviews relevant literature on mental illness, specifically on societal perceptions about mental illness and attitudes towards the mentally ill and discusses the theoretical framework within which the study is situated.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

The chapter reviews related literature on the perception of mental illness. It looks at the history of Ghana's mental health care and various beliefs about mental illness. The chapter continues by examining attitudes towards the mentally ill and discuses the role of care givers and the motivating factor for providing care. Furthermore, the chapter examines the ways in which mental illness is cured or managed. Finally, the chapter concludes by identifying the gaps in literature reviewed.

2.1History of Ghana's Mental Health Care

The history of Ghana's Mental Health care system can be traced to 1888 when the Lunatic Asylum Ordinance, Cap 79 became law and institutional care for the mentally ill was introduced. By then, people with mental health conditions were referred to as " lunatics"; a term that was derogatory. The mentally ill were put in prisons. With time, the prisons became overcrowded, hence the need for another institution to house them.

The issue of overcrowding in the prisons brought about the building of the Accra Psychiatry Hospital in 1960, with Dr. E. F. B. Foster, a Gambian working at the Accra Psychiatric Hospital becoming the first psychiatrist at the institution. Foster brought many developments to the hospital and placed the hospital at par with what pertained in other countries. He initiated the training of doctors as specialists in the field of psychiatry which complimented the efforts of Higgison, a British national who had initiated the training of registered mental

health nurses in 1952. The training of these professionals led to a rise in the attendance of patients to the Accra psychiatric hospital as quality services were provided.

The Ankaful psychiatric hospital was built in the Central Region in 1965. Even though, there were now two hospitals, the pressure on them was still profound. This situation led to the building of Pantang psychiatry hospital in 1975 in the Greater Accra Region to complement the efforts of the first two hospitals. In 1972, the Mental Health Act (National Redemption Council Decree –NRCD 30) was enacted. The Act focused on providing care within the confines of an institution and served as an abridged version to the Ordinance, Cap 72. Meanwhile, since its introduction, the NRCD 30 has never been amended although attempts were made to revise the law in 1996.

Efforts and attempts to revise the law continued until 2012 when the Mental Health Act was passed. This law outlined clear guiding principles to regulate the mental health system of Ghana. Currently, there are only three public psychiatry hospitals in the country serving a population of about 24 million people (Ghana Statistical Service, 2010). However, there are few privately owned psychiatry clinics like, Valley View at Dzorwulo, Alberto clinic at Tema, Pankrono Neuro-Psychiatric clinic and Adom clinic in Kumasi (WHO, 2007). There is also Keep Smiling clinic at Mambrobi. Aside these conventional treatment centres, there are also charismatic churches who specialize in healing mental health conditions (Mental Health Profile - MHP, 2012).

2.2 Beliefs About Mental Illness

In order to fully appreciate issues of mental illness, there is the need to understand the basis of attitudes about mental illness. There abound several beliefs about mental illness and these beliefs dictate the help seeking behaviour of the mentally ill or relations of those affected with mental illness. Beliefs about mental illness can best be termed assumptions. According to Laungan (1989), assumptions are the held beliefs, attitudes and values shared by people in a given culture. The assumptions about mental illness are shaped by cultural, biological, social and psychological views. He went on to say that often, the assumptions have been accepted as truths even though they may not have plausible explanations. The assumptions dictate how mental illness is perceived and the kind of help offered the affected person. The implication is that individuals may relate to an individual with mentally illness based on the idea he/she may have about the illness.

Stanley (2010) as well as Barry (2010) believe that mental illness has biomedical explanations. Scholars of the biomedical view believe that mental illness is caused by factors that are purely biological. With this standpoint, mental illness is believed to be caused by neurotransmitter deregulation, genetic anomalies, and defects in brain structure and function among other biological factors. Scholars of the biomedical model placed emphasis on the dysfunction of the brain as the footing on which they provided an understanding to mental illness. There are others who also believe that mental illness is "down the line" from a parent to a child (Hales, 1996). Thus, individuals are likely to develop mental illness if either parent suffered from mental illness.

Biologically, mental illness can also be traced to stress. Stress is "the heightened mind-body reaction to stimuli including fear or anxiety in an individual" (Cockerham, 2007, p.75). Stress

alters the brain's circuitry in ways that can have long term effects on thoughts and behaviours (Cockerham, 2007). As part of biological explanations to mental illness, infectious diseases are also believed to cause mental illness. The biomedical explanation to mental illness is strongly expressed in most of the Western World. Further studies have come out to debunk biomedical explanations, Studies by Carlat (2010) and Kirsch (2010) have concluded that there is the need to consider factors like the environment in an attempt to understand mental illness (Lopez-Ibor & Christodoulou, 2005).

Scholars like Sue and Sue (1990) as well as Chowdury, Chakraboty and Weisis (2001) are of the view that mental illness could best be explained from cultural perspective. According to these groups of writers, individuals perceive mental illness as a cultural phenomenon and may seek help not from the health system. Rather they may seek help from a medicine man, herbalist or voodoo priest when they are confronted with mental health disorders (Sue & Sue, 1990).

Mental illness is also believed to have social and economic underpinnings. For instance, Peplow (2004) attributed the lack of tryptophan (a nutrient) in food to mental illness. Peplow based his argument on the belief that when individuals are poor their purchasing power decreases, as such they may not be able to afford a balanced diet. Thus poverty could trigger mental illness. Also, some poor people in an attempt to reduce depression may find solace in taking drugs.

Furthermore, the National Alliance on Mental Health (NAMH) in its 2012 report stated that poverty may sometimes be linked to depression. And for these depressed individuals, the belief is that the best way to deal with the depression is to abuse drugs. This eventually leads

to mental illness (NAMH, 2012). Feldman and Papalia (2012) believe that persons who live in poverty stricken areas (slums) experience depression and anxiety. Other studies have concluded that poverty could not be traced to mental illness (Jenkins, Mbatia and Singleton, 2009). However, regardless of the position an individual takes, the debate is likely to continue for some time.

Psychologically, an individual's thoughts have implication for his mental wellbeing. When an individual frequently conceives negative thoughts, the brain tells the body to transmit negative actions (WHO, 2007). Studies indicate that psychological factors account for a significant number of mental health cases in Ghana (Mathews & MacLeod, 2004), the majority of which were recorded at Pantang psychiatric hospital in 2012 (PHAPR, 2012-2013). Beliefs about mental illness affect attitudes towards the mentally ill and inform help seeking behaviour.

2.3 Attitudes towards the Mentally Ill

Public attitudes towards mental illness are of great importance mainly because they inform the help seeking behaviour of the mentally ill, and relations of the patient (Schomerus & Angermeyer, 2008). In most societies, the degree to which individuals exhibit negative attitudes towards the mentally ill is dependent on the nature of the illness (Mulatu, 1999).In effect, the more severe the mental illness, the greater the exhibition of the negative attitude towards the mentally ill.

Generally, mental illness evokes a sense of shame from friends and families of those affected. The feelings evoked by mental illness can be felt in two ways (directly and indirectly). Directly, the mentally ill is shunned by his friends and his family. In severe cases the

mentally ill are not only shunned but are believed to be dangerous (Segal, Coolidge, Mincic & O'riley, 2004). Indirectly, the family members and friends of the mentally ill are also shunned by the larger society. The introduction of the media as a form of communication also helped to propagate some of the negative attitudes towards mental health patients. As noted by Asumang (2012) the media's portrayal of mental illness is usually negative and this goes to entrench the negative attitudes thus making communities have strong aversion towards the mentally ill and mental illness in general.

It is often said that the media is the fourth arm of government because of the power it wields. This power has made the media to be seen as credible source of information even in the face of half truths. The media is highly influential in shaping individual and societal views about mental illness. Sometimes there are inaccurate depictions of schizophrenia (which is often confused in the media with multiple personality disorder) which can lead to false beliefs and confusion about mental illness (Baum, 2009). Often times these perceptions are negatively skewed (Baum, 2009; Asumang, 2012) and since the media shapes our understanding of issues around us, we tend to accept these perceptions. However, for those suffering from mental illness, the implications are grievous since they bear the brunt of cruel actions which result from the perceptions created by the media. Such negative highlights of mental illness complicate the already delicate situation of the mentally ill who are pushed to the periphery of society.

2. 4 Persons Caring for the Mentally Ill

The onset of any illness makes an individual vulnerable. The vulnerability of any individual could make the person rely on others to even carry out basic daily tasks like bathing. More so

when faced with mental illness, persons affected tend to rely more on others since mental illness is presented with a loss of self-consciousness. Families and friends usually become the shoulders on which the mentally ill fall (Horwitz, Richard, Tessler, Fisher, & Gamache, 1992). Even though different groups of persons are involved in the provision of care, the overriding factor that underlined the care is the intensity of the relationship between the mentally ill and care giver. In effect Horwitz et al., (1992) noted that families and spouses are usually the ones who provided the needed care. Sometimes, closely knitted family members may feel obliged to care for their mentally ill relative because of the rewards they will gain. Horwitz et al., (1992) termed this, instrumental rewards. Instrumental rewards may be the bequeathing of a property such as a house or a car. In addition, spouses and families provide care based on reciprocity. Furthermore, significant others provided care as a sense of duty (Horwitz, et al., 1992). By saying this, Horwitz et al., (1992) meant that the significant other has no choice but to provide care.

2.5 Forms of Assistance

As with all ailments, there are various options available to either manage the particular ailment or cure it. Mental illness is no exception since there continue to be studies on how to treat mental illness. To effectively and efficiently assist mental health patients, Frisch and Frisch (2009) outlined two principles. The first principle is that there is the need to know the particular belief about mental illness. The second principle is that individuals offering care are expected to know more about the belief system of the patient. When mental disorder is perceived as a religious issue, treatment most probably will be from the religious point of view. Frisch and Frisch (2009) concluded that most patients recovered faster when professionals had knowledge about the belief system of patients. As a means of caring for the

mentally ill, there is an array of options available to professionals. Whereas some of the assistance may be formal (that is, through hospitals), others could be done through spiritual means (Gelder, Andreasen & Lopez, 2003).

Institutional care is among a host of assistance that can be provided to the mentally ill. Once confined to the institutions, persons with mental illness receive care and other services that the institutions provide (Gove, 2004). The care institutions are mainly residential and are governed by rules and regulations to guide both patients and the professionals. Within the institutions there are psychiatric social workers, counsellors, rehabilitation officers among others. Meanwhile, nurses are usually the first point of call at any institution (Ho, Rasheed & Rasheed, 2013). Many of these professionals have the tendency of playing overlapping roles which may lead to conflicts.

According to Munch (1994), there are mainly two kinds of institutional care; these are institutions established for persons felt to be incapable and who are considered harmless. The blind, aged and the orphans are among the first category that are believed to incapable of caring for themselves and considered to be harmless. The second groups consist of those who are thought to be both incapable of caring for themselves and also considered a threat to the community. Individuals who make up the second group are the mentally ill and lepers. In Much's (1994) view, individuals considered to be harmful to society must be placed under institutional care where, appropriate care can be provided. He believed that institutions are totalitarian in nature, in that persons who lived in the institutions live a life separated from the outside world. Additionally, administration is strictly authoritative and the mentally ill are

expected to adjust to the set rules and regulations that govern the institutions. Traditionally, institutional care for the mentally ill was the preserve of the state; however, private individuals and organizations have also stepped in to provide the needed care.

Institutionalised care may be suitable for some categories of the mentally ill; since it affords the effective monitoring of patient's progress in terms of recovery. It is however bedevilled with some challenges. Among the challenges are when institutions become overburdened with patients, the result is the provision of substandard services. The over populated hospitals may not have enough resources (material, professionals and financial) to provide the needed care. Kramers-Olen (2014) concluded that institutionalisation of the mentally ill, made patients more depressed. The conclusion was drawn based on the fact that the restrictive nature of the institutions curtailed the freedom of the patients. In addition to the disadvantage mentioned above, there is also the issue of lumping together people suffering from all kinds of mental illnesses. In this case all patients are considered to be suffering from the same ailment and are provided the same assistance (Hughes & Gove 1981). The danger here is that, even patients that do not need drugs will be given medication alongside the severe ones. Practices such as these go a long way to affect the physical health of the particular patient because of the adverse effects of medication. Meanwhile, Sue, Sue and Sue (2009), have pointed out the need to explore the social background of patients when discussing care for the mentally ill. Furthermore, once individuals are put into institutions, the perception may be created that the mentally ill are a danger to society hence, the need for the patients to be "housed'' in institutions.

Over the years, the growth in population has significantly impacted the increase in mental illness. With regards to Ghana, the development had brought untold hardship on the three

public facilities namely, Accra, Pantang and Ankuful psychiatric hospitals. For instance, in 2012, the Accra Psychiatric hospital had a population of about 860 against a bed capacity of 200. However, in a decongestion exercise carried out in 2013, there are a little over 480 in terms of the hospital's population (HAHSP, 2012-2013). The reduction in the number of admissions made it possible for the hospital to provide more efficient services to the mentally ill with its little resources.

The presentation of some of the disadvantages of institutional care called for alternative assistance for the mentally ill. Even in the face of the enumerated disadvantages to institutional care, some still believe that there is the need to hospitalize some categories of the mentally ill in order to provide the best form of care (Sue & Sue, 1990). Generally, there has been the call for deinstitutionalisation since it can worsen the plight of the mentally ill. Additionally, institutionalisation can deepen the gap between the community's negative perceptions about mental illness and the mentally ill in general. In addressing the shortfall inherent in institutional care, community care was introduced, specifically in Ghana.

The idea of community care is regarded as the ideal since it focused on caring for the mentally ill within the community (Gala, 2012). Community care appealed to majority especially some family members whose relations may be suffering from mental illness. In the researcher's view, this assertion may be based on the fact that some family members will not have to travel from afar to seek help. With community care, care is administered at the doorstep of the patient. And where there is the need both refer patients and their families to the psychiatric institutions (WHO, 2007; GHS, 2005; MHA, 2012). By visiting the homes of discharged patients and providing counselling on daily living, both nurses and social workers provide care through this means. The introduction of community care does not defeat the

concept of institutional care, rather it added to it by playing complementary roles. As, there may be some patients who will require institutional care.

As part of efforts at providing care for the mentally ill, the services of traditional healers may also be sought. The services of traditional healers are on high demand that, there has been an increase in their numbers. In Ghana, there are about 45,000 traditional healers, (Roberts, 2001) who provide care for the mentally ill. There are some traditional healers who blend the use of herbs and spiritual means to provide care for the mentally disabled. The importance attached to the traditional healers made their services the most sought after (WHO, 2007) hereby making the traditional healer the first point of call in the provision of care for the mentally ill.

Barke, Nyarko and Klecha (2011) reported that between 70 -80 per cent of Ghanaians use the services of traditionalists as the first frontline of services before reporting at the hospitals. The statement echoed the earlier point raised by Roberts (2001) that much importance is attached to traditional healers as the first point of call, hence the increase in their numbers. Patients who patronized the services of traditional healers are of the view that, there is a spiritual underpinning to mental illness, especially, in cases where unexplained psychological symptoms of mental illness cannot be sought (Endrawes, O'Brien & Wilkes, 2007). Also in some parts of Egypt, individuals believed that being provided the opportunity to confess sins, make a sacrifice, or be cleansed heals an individual of mental illness (Hales, 1996). The spiritual means of providing care to the mentally ill, is not only limited to the African, indeed Sue et al. (2009), concluded that in America, some individuals reported healing after visiting the Voodoo.

Sometimes, assistance could be provided the mentally ill through psycho-social rehabilitation. In psycho social rehabilitation, mental health patients are taught how to live independent lives within their families and the community after suffering from mental illness (B, Woezuame [1] personal communication, October 4, 2014). In psycho social rehabilitation, there must be the onset of mental illness in which the particular patient can no longer perform the tasks that were initially performed (B, Woezuame personal communication, October 4, 2014). As part of providing psycho social rehabilitation, patients may be taught how to sew, farm or do carpentry work. The provisions of skills are meant to make patients capable of living independent lives once they are discharged from the institution (Farkas & Anthony, 2010). In a nutshell, the importance of psycho social rehabilitation cannot be overemphasised since this has led to the establishment of psycho social units in the three governments psychiatric hospitals in Ghana (MHA, 2012).

As an aspect of rehabilitation, vocational training is provided to enable the mentally ill find reasonable and competitive employment in their respective communities (Bond, 2004). The ability to find work is believed to make the mental health patient able to live a meaningful life, making it possible for the patient to have a sense of self-worth. In other words, providing care for the mentally ill through vocational training goes a long way to facilitate recovery. Rehabilitation care for the mentally ill has been advocated since, there is large evidence supporting its efficacy (Escamilla, & Saracco, 2013).

Debates within the field of mental illness have focused on the use of medication. Medication as one of the methods of caring for the mentally ill started in the 1950s (Norfleet, 2000).

[1](Benedictus Woezuame is a former Director of the Pantang Hospital).

Even though medication was introduced in the 1950s, the practice is still the most widely used in caring for the mentally ill (Norfleet, 2000; Levinthal, 2005). The wide use of medication does not imply that all patients must be administered with medication. Once taken, these drugs work on the brain by altering the brain's processes which cause changes in thought process and behaviours of individuals. Even so, Ehlers, Maercker and Boos (2000), contended that sometimes medication is necessary for some mental health patients who may not respond to psycho social care**.** Out of the patients who may not respond to psycho social care, women may form the majority because through their study on Clinical Drug Therapy: Rationales for Nursing Practice, Abrams, Pennington and Lammon (2009) concluded that women responded more to drugs than, men. The danger in administering medication to all patients called for alternative ways of providing care for the mentally ill (David, Barlow & Durand, 2002).

Therapy is another method of care that can be provided for the mentally ill. In therapy, the aim is to 'control' mental health disorders (Sue et al., 2009). In the use of this method of care, the social world of the mentally ill is taken into consideration. Kottler (1992) concluded that the therapy process builds a relationship with the client and also helps establish a relationship with families which foster early recovery. Therapy could be at the individual, family and community levels. Sometimes therapy groups can be formed by social bonding groups like parents whose children suffer from a mental illness. The groups once formed could act as a therapy group by providing care for the mentally ill. The American Psychiatric Association (1994) recommended the forming of social bonding groups as a model for caring for the mentally ill. Social bonding groups which can be classified under community level therapy,

are also very helpful in addressing issues of mental health (Keltner, Schweck & Bostrom, 2007).

Furthermore, peer support groups as a subset of the social support group could also be relied upon to provide assistance to the mentally ill. According to Kopelowicz, Wallace and Liberman (2007), peer support group is an integral part of the recovery process. Peer support groups come in various forms; self-help groups, family support group. In Ghana, the former Chief Psychiatrist, J.B. Asare, formed one of the first of such groups. Most peer groups are not composed of professionals from the various fields who are passionate about mental health issues. The peer groups are also made up of individuals who may be directly or indirectly affected by mental illness. However, in certain cases professionals may be invited to provide education on mental illness as well as act as political advocates for the mentally ill (Solomon, 2004).

2.6 Summary

The section has reviewed the history of Ghana's mental health care system and looked at various studies on beliefs about mental illness. The chapter discussed the various care options for the management and treatment of mental illness, the role of care givers and the motivating factor for providing care. In reviewing literature, very few qualitative studies have been found on mental health; this study is qualitative and therefore brings more in-depth perspectives to the subject under study. The next section discusses the theoretical framework within which the study was carried out.

2.7 Theoretical Framework

The study makes use of the labeling theory because the work focuses on how individuals with mental illness just like any other ailment derive their self-identity; and how persons relate with the mentally ill based on the terms used to describe or classify them. Labeling theory posits that individuals receive labels based on how others perceive their behaviours, thereby making these individuals act out the labels placed on them. For example, when individuals are not able to perform certain functions, society places labels on them and such individuals end up living out these labels. The theory is closely associated with Merton's (1949) theory of Self-fulfilling prophecy and Stereotyping linked to Coffman's theory on Stigma. Goffman (1963) states that stigma is an identity a person has due to societal belief that the particular individual's behaviour is a deviation from normality. The underlying theme of the three theories (labeling, stigma and stereotyping) is the subjective meanings attached to individuals who may be different from other members of society. The root of the labeling theory is grounded in the work of French sociologist, Emile Durkheim, in his book Suicide". When Durkheim **(**cited in Much, 1994 p. 201) proposed this theory, he referred to deviant

behaviours and how labels make individuals more deviant. Later George Herbert Mead (1963) popularised the theory by saying that, the self is socially constructed, and reconstructed through the interactions which each person has with his or her community.

Through social interaction every individual is aware of the fact that other people in the community judge them because of their inability to perform certain roles and functions. This leads to the forming of perceptions about those who are not able to perform the societal expectation. The result of the judgment is the subjective meaning attached to the self of the labeled individuals which may lead to the expressions of attitudes (negative or positive) towards these individuals. Hence, Mead (cited in Munch, 1994 p.1) stresses the revaluation of these perceptions in order to bring out an objective outcome.

Building further on Mead's work, Munch (1994) outlined the ways in which individuals are labeled. In the view of Munch, human beings interact among themselves in order to continue and maintain societal survival. Through interactions, individuals form their views about others and relate to them based on the views they have formed. Consequently, individuals are defined based on the formed views and are labeled as such. The results of the views are that they may be usually subjective and may not reflect the true self of the individuals so labeled. Moreover, the individual views become the general perception of the community. According to Munch (1994), in the process of interaction, individuals are categorised into two groups. These are the "we group" and the "them group". The classification brings about the feeling that some individuals are better than others based on some unique characteristics which explain the concept of the "we group" and the "them group." For instance, when individuals

have problems with brain function, they are classified as being below the characteristics of the ‟normal'' individual who can make use of the intellect. Once labeled, individuals eternally accept the labels and consequently act out the labels (Camp, Finlay & Lyons, 2012).

Despite its wide use in academia, debates have evolved in the theory's application. Scheff in 1947 published a paper, 'Being Mentally Ill: A Sociological Theory' (cited in Gove, 1999) and challenged the notion that when labeled, individuals acted out the labels. According to him, individuals act not because of the labels placed on them but because of innate triggers. His argument is based on the idea that there may be biological explanations to mental illness and not necessarily the result of societal labels. He argued that society views certain actions of individuals as not conforming to the general rule and, in order to come to terms with and understand these actions, there is the need to explore the biological makeup of the individual concerned that made him act out the label. Scheff laid emphasis on the use of medication in order to control the actions of the mentally ill. His work even though has contributed to the theory, has equally received some critique.

Notable among those who have critiqued Scheff's work is Gove who asserted that the view that biological makeup accounted for the acting out of labels lacked merit. Gove (1999) indicated that sometimes the inability of some individuals to psychologically find a balance between their thoughts make them act out certain characteristics. For example, when an individual does not relate well with the spouse, the affected individual is likely to throw up tantrums at the least provocation. When this happens, the conclusion cannot be drawn that these individuals are acting out characters based on their biological makeup.

2.9 Conclusion

The chapter has reviewed literature on the topic under investigation focusing mainly on beliefs and attitudes towards the mentally ill as well as care and support. It has also discussed the theoretical framework that underpins the study along with the views of critics of the theory. The next chapter looks at the methods used in the collection and analysis of data for the study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

The chapter presents in detail the procedures used in gathering data for the study. Specifically, the chapter provides a description of the study area and discuses the research design adopted for the study. The section further elaborates on the population from which participants were selected for the study and discusses the processes used in selecting participants from the population. Furthermore, there is a detailed elaboration on the way in which data was collected and analysed. Finally, the chapter presents and discusses the ethical issues that were observed and some limitations that were encountered in the conduct of this study.

3.1 Study Area

The Pantang Community was the study area of this research. Pantang is located in the Ga East District of the Greater Accra Region and has its capital as Abokobi (L. I. 2030). It is about 24.4 kilometres from Accra and 7.5 kilometres off the Adentan- Abokobi road. According to projected data from the Municipal Planning Coordinating Unit-MPCU (2013) there are about 21,105 people living within the Pantang community, with the dominant tribes being Akan, Ga and Ewe. There are numerous suburbs that make up the Pantang Community. Some of the communities are Hospital Staff Quarters, Sampeni, Kofi Mathew and Simon Kofi (L.I. 2030).

The Pantang community was chosen for the study because of the location of the psychiatric hospital and Doctor Friday (a herbalist and Imam) in the community. Residents of the

community may have encountered the mentally ill on a daily basis which may have had an impact on how the community members view and relate with the mentally ill. Additionally, the residents of Pantang Community were more capable of providing firsthand information on mental health issues compared to residents in other communities. Nyamekrom is a relatively small rural suburb that is located on the Southern part of the Pantang community. Most of the residents are petty traders and artisans who were of Ewe origin. According to an elderly man who had lived in the community for over 4 decades, his father told him that, the land on which Nyamekrom was located was originally owned by the Gas. However, the first man –Nyame who hailed from Togo was not allowed by the Gas to settle among them when he made the request. The Gas therefore gave him a parcel of land to settle on. Upon settling on the land, the man named the place Nyamekrom which means God's town. With the passage of time, other people migrated from Ewe speaking communities to settle in Nyamekrom. This perhaps explains the reason why Ewes constituted the majority of the population compared to other tribes in the community.

Shalom Estate, on the other hand, is also a small suburb with most of the residents being staff of the Standard Chartered Bank. The land on which the Estate is situated was acquired by the Bank in 1996 and developed to serve the accommodation needs of its workers. Over the years, there has been the development of other residential facilities and a big soap making factory within the Shalom Estate community. The two communities are close to the Pantang psychiatric hospital while Nyamekrom is unique because it has an Imam who doubles as a herbalist and a spiritualist; by providing care for the mentally ill. Shalom Estate is a modern community with more beautiful houses that have been fitted with gates. The houses are semidetached in nature and the community has been well planned. Nyamekrom on the other

hand, is rural in nature and lacks modern facilities like water closets and bath houses. There alleys in the community are not properly demarcated with most of houses built of thatch and mud.

The reason for specifically selecting the two suburbs from among other communities within the Pantang community was based on closeness of the two communities to the Pantang Psychiatric hospital compared to the others. Thus, the proximity of the communities to the hospital provided an opportunity for the residents in these two communities to be confronted with the realities of mental illness and the plight of the mentally ill which may influence how they perceive and act towards persons with mental illness.

3.2 Research Design

The study adopted a qualitative research design to engage the residents of the Pantang community on their attitudes and perceptions towards mental illness. Qualitative studies, according to Bryman (1988), aim at the understanding and interpreting of social reality. Social realities include among others actions, decisions, beliefs and values of individuals (Bryman, 1988). The difficulty in measuring such social reality makes qualitative design not to rely on findings drawn from statistical procedures or other methods of measure (Badu, 1998). Furthermore, findings from qualitative designs are mostly analysed through detailed descriptions of the units. In lieu of this, qualitative methods rely on prescription for framework analysis as one of the most suitable research techniques in the field of social sciences (Krippendof, 2004). Thus in conducting this study, qualitative methods were used to gain an in-depth understanding of the attitudes and perceptions of the Pantang community towards mental illness and the mentally ill in general.

3.3 Study Population

The study population was adult heads of households who had lived in Nyamekrom and Shalom Estate for five years. The households' heads were used because they were the breadwinners of the homes and wield much authority, hence, their views were taken as representing that of a particular household.

3.4 Sampling Technique

The impossibility in using a whole population for a study, necessitated the use of a sample of the population. Sampling involves the selection of a sample from the target population (Kumekpor, 1999). Purposive sampling was used to select participants who were capable of providing the needed data for the study, based on their unique characteristics, experiences and knowledge (Ritchie and Lewis, 2003). The unique characteristics of the participants include among others regular encounter with persons with mental illness and living closer to a psychiatric hospital.

The purposive sampling method was used to sample participants for individual interviews and participants for the focus group discussions. Purposive sampling was used to select adult household heads, who were not suffering from mental illness and had been residents in the Pantang community for five years. The selection criteria became necessary because, the adult household heads were the breadwinners of the homes and wielded much authority over other members of the household. Hence, their views were likely to affect views of other members of the particular household. Moreover, the choice also allowed more coverage of other households, instead of using all members of a particular house for the study. Secondly, the

researcher was of the view that selecting participants with a history of mental illness may not produce the needed data for the study.

In order to select a sample from the population, the researcher went into the homes within the selected communities. Where household heads were not willing to be part of the study, the next house was visited. The process was repeated until the total number of sample required for the study was arrived at. For the focus group, participants were sampled from the pre-existing groups (Nyamekrom youth and Shalom Estate resident association groups). This made it easy to get all participants at one place. There was a scheduled meeting with the groups during which members were briefed about the study and the number of participants needed for the study. Individuals who opted to be part of the study became the sample that was used.

3.5 Sample Size

The sample size for the study was twenty eight. There were sixteen individual participants from both Nyamekrom and Shalom Estate. The focus groups were made up of six individuals from each community. In effect, in each community, there was one focus group. The researcher had an initial intention of selecting three men and three women in each of the communities for the focus group but the men were mostly not willing to be part of the study. The inability of getting the gender balance for the focus group led to the use of the few men that were available. Furthermore, the sample size of twenty eight was conveniently used because of the difficulty in working with a larger sample size in qualitative studies (Ritchie and Lewis, 2003).

3.6 Methods of Data Collection

Primary data formed the basic information used for the study. Primary data for the study was collected through in-depth interviews. The in-depth interviews paved the way for participants to share their knowledge on attitudes and perceptions about mental illness. In addition, participants were also able to state the various services that were available to the mentally ill in the Pantang community.

The interview sessions were carried out in the homes of participants. Participants were asked to select a private place in the home where the interview process could be carried out. Once a place had been indentified, participants and the researcher sat down to collect data. A recorder was placed on a table in-between the participant and the researcher. The interviews were informal and conversational in nature which allowed participants the flexibility to say more, while allowing the researcher to delve more into information provided. In addition, the informal setting also allowed the researcher to seek clarification for answers that were already provided. In addition, field-notes were taken to support the data gathered. During the interview process, the facial expressions, gestures and how participants reacted to the questions posed to them were noted. Each interview section lasted between a period of 30 - 45 minutes. On the whole, individual interviews were collected over a period of one month. At the end of each interview section data was transcribed.

Focus Group Discussions

The strength of focus group is its ability to illicit more data from participants as they interact among themselves (Ritchie and Lewis, 2003) while making the individual participants also share their personal views. In the view of the researcher, as participants interacted among themselves, they were able to make meaningful contributions as they examined other contributions in the light of theirs. This formed the basis for using the focus group discussions.

In Nyamekrom, there was a youth group which was used as focus group. A letter was written to the president of the youth group seeking audience to speak with the group members. Within a week consent was received from the president. At the first meeting with the youth group, it became clear that the population was large. The members were informed that only six participants were needed. Only heads of households who were resident in the community were asked to volunteer for the study. A sheet was sent around and participants wrote down their names and contact numbers.

An appointment was booked with the participants who later met the researcher at their meeting grounds on the day of appointment. On the day of the interview with the focused group, a consent form was given to each individual member of the group. The content of the form was read out and explained to the participants. Subsequently, participants were also given the opportunity to ask questions. Thereafter participants were asked to append their

signatures to the consent form to signify their consent. Participants were informed about their ability to withdraw from the discussions at any point during the interview process.

Vignette was used to facilitate the FGDs. The vignette consisted of presenting a short story on mental illness which touched on attitudes, perceptions and ways of supporting persons with mental health challenges. The aim of the vignette was to make the focus group share ideas on the short story while the interviewer facilitated the process. The whole process was tape recorded while field notes were also taken, particularly, notes of the non-verbal communication aspect of group participants. The data was later transcribed and stored.

With regards to Shalom Estate, the neighbourhood association group was used as a focus group. The Shalom Estate area is a well demarcated area unlike that of Nyamekrom. A letter was written to the President of association about the research and the intention of the researcher to use them as focus group. An invitation was extended to the researcher to come and make further explanations to the members on a set date. At the meeting, members were briefed on the study and what was required from participants. The president selected the six participants who were heads of households and resident in the community. The names of the focus group participants were written down.

Due to the busy schedules of most of the members, there was an agreement to conduct the interviews during the group's next meeting which was two weeks away. The same vignette that was used in Nyamekrom was also used for this focus group. The focus group discussions

were carried out within a period of one hour. A recorder was used to record the data that was collected. In addition, field notes were also taken. The facial expressions of participants, tone of voices and gestures were all noted while also maintaining eye contact with all participants during the interview process. The focus group context provided a key opportunity to explore difference and diversity of individual participants.

3.7 Data Handling and Analysis

In order to manage and analyse data effectively, the Framework method was used. The intention of using the framework technique was to provide deeper meaning to the findings. There are stages in the framework method that help in the analyses of data. These are made up of the familiarisation stage, in which data is read until one becomes conversant with data. At the second stage, data was transcribed; the transcriptions were read through a number of times to become thoroughly familiar with them and to generate themes from them. Thereafter, numbers were assigned to identified themes and sub themes. Some of the themes developed were concepts and others were phrases. The themes generated were based on the research objectives. The numbered themes were placed under the particular research objective they fell. In order to provide further detail, the major themes were further divided into sub-themes in order to get a deeper meaning of the themes.

The themes were later discussed per each research objective and related to literature reviewed**.** At the beginning of the analytic process, the researcher was faced with a mass of tangled data, which needed to be sorted out. The first task was to sort and reduce the data to make it more manageable. Themes from the focus group were analysed as participant- based group analysis; in this case, findings from individual participants in the focus group were

mostly discussed as single units. These were later discussed in relation to the literature reviewed. Field notes taken were placed under appropriate themes discussed.

3.8 Ethical Consideration

As part of conducting every study, there are rules and guidelines to be followed. With regards to this study, informed consent was sought from all participants. It was ensured that participants had clear understanding of the purpose of the study, about the interviewer conducting it, how the data will be used, and what participation will mean for them. Sometimes, the consent form was given to participants who could understand the English language. At other times, the form was read out to participants who could not read them. Thereafter, participants were asked to append their signatures or thumbprints to the form after they had agreed to be part of the study. Another ethical consideration that was observed was the voluntary participation of participants. Participants were not coerced in any way to part take in the study and they were given the opportunity to decline at anytime they wanted to.

Furthermore, anonymity and confidentiality were observed. Anonymity meant the identities of participants were not known to outsiders. Confidentiality of participants was observed as part of the ethical consideration. Participants were assured that the information provided will not be disclosed to any individual. Additionally, their names and identity would not be revealed, instead pseudonyms were used. Plagiarism was avoided by citing all references that were used in the study.

3.9 Credibility and Trustworthiness

Credibility and trustworthiness of every research cannot be overemphasised. This is because the adherence of these two principles makes the study valid. Credibility refers to the truthfulness or otherwise of the data (Brink, 1993). It could also mean the correctness or precision of a research reading (Ritchie and Lewis, 2003). Looking at these two definitions, the conclusion can safely be drawn that both lay emphasis on truth.

Trustworthiness on the other hand, is the ability to produce the same research findings using the same or similar methods (Brink, 1993). In the attempt to ensure credibility, the main instruments used for the collection of primary data were face to face interview and vignette. The face- to- face- in-depth interview allowed participants to vividly describe their responses which questionnaires will not have provided, it also helped the researcher to grasp participants' point of view (Burgess, cited in Ritchie and Lewis, 2003 p.335).

The use of vignette provided a common basis for discussion in the focus group as compared the former. Additionally, it allowed other group members to add up to what had already been said by other group members. In the pursuit of making the study credible, the researcher visited the homes of individual participants. The two focus groups were also visited several times. The purpose was to identify with all categories of participants, establish rapport with them in order to gain their trust. However, the researcher was also careful not to be too close with participants else risked being objective. In all these visits, the researcher reminded participants that the study was purely an academic exercise. Hence, there was the need to be as truth as possible since wrong responses has a bearing on the data. The researcher also took cognisance of the two categories of participants and had to dress appropriately whenever an interaction was made. For example, when researcher had to meet participants in Nyamekrom,

the dress code was very causal so as not to intimidate them. The dress code was based on the rural characteristics of participants. The opposite was the case of Shalom Estate participants. This group of participants could be classified as the upper class in society since they were into white colour jobs. The observation necessitated a change in the dress code for the participants from Shalom Estate.

To ensure for credibility and trustworthiness of the study, the researcher employed member checking. Member checking was carried out during the interviewing process by restating or summarising responses of participants to validate their responses. The aim was to determine the accuracy of data collected. Creswell (1998) provides eight lists of ensuring credibility and trustworthiness of a study. These are prolonged engagement and persistent observation of the research phenomenon, triangulation, peer review and debriefing. Furthermore, Creswell (1998) adds negative case analysis, clarification of research bias, member- checking, rich-thick description as well as external audits. Even though he provides the eight lists, he suggests that the use of any two of the above is enough to ensure credibility and trustworthiness of a study. Consequently, the use of prolonged engagement and persistent observation and member checking by the researcher has ensured that the findings from the study credible and trustworthy. Additionally, the similarities of responses given by the former director of the Pantang hospital during a personal conversation and participants add to the study's validity and reliability.

3.10 Limitations of the Study

Some limitations were encountered during the conduct of the study. The study was conducted in an environment where the setting of the Pantang psychiatric hospital may have had some

influence on the outcome of results, of which the case might be different if the study was conducted at Aburi or any other community.

Secondly**,** the sensitive nature of the research topic may have made some participants not to reveal their past experiences with mental illness to the researcher. This may have led to some participants with mental illness becoming part of the study. Furthermore, there was the challenge of translating some of the words from the data into the English language since it was difficult to translate such words without losing their meaning. The researcher tried to replace such words with the nearest word with similar meanings.

3.11Conclusion

This chapter has provided a justification for the selection of the qualitative design employed for this study, explored the setting in which the study was conducted and discussed the sample used for the study. In addition, the chapter looked at the data collection processes and discussing the ethical considerations observed while conducting this study. It also touched on the processes employed in ensuring credibility and trustworthiness of the study. The next chapter presents and discusses the findings of the study.

CHAPTER FOUR

DATA ANALYSIS AND DISCUSSIONS OF THE FINDINGS

4.0 Introduction

The chapter presents the findings from participants' interviews. The chapter is divided into two sections. The first segment consists of demographic characteristics of participants. The demographic characteristics were developed to shed light on the background of the participants. Data from the focus group discussions was analysed as participant based group analysis. Here the contributions of individual participants were separately analysed within the context of the discussion as a whole. This allowed the information of each participant to be retained. In order to throw more light on the demography of participants, the characteristics of age, sex and religious affiliations of participants were assessed. The voices of the participants and the field-notes were shared to support the themes and pseudonyms were used instead of real names. These pseudonyms have also been labelled either focused group discussion (FGD) or individual participant (ID). The second section provided the discussions of the findings in relation to the literature reviewed.

4.1 Demographic Characteristics of Participants

In order to appreciate the background of participants and its influence on the findings, the sex, age and religious background of the participants were sought. A total number of twenty eight participants were interviewed, out of this figure, twelve were males and sixteen were females. With regards to the individual interviews in Nyamekrom, there were three male and five female participants. Shalom Estate on the other hand had four males and four females who participated in the study. The focus group interview produced three male and three

female participants in Shalom Estate, while Nyamekrom saw two men and four female participants respectively.

The ages of the participants ranged from twenty five to sixty-seven years. Of all the twenty-eight participants interviewed, Nyamekrom had a greater number of individual participants who were between the age range of twenty-five years and forty-five. The outcome of the findings revealed that Shalom Estate had all individual participants in the age range of twenty-nine and sixty-seven years. The findings also showed that there were younger persons who headed households in Nyamekrom compared to Shalom Estate. The focus group participants for Nyamekrom were between the ages of twenty-eight and forty, while Shalom Estate produced age ranges from forty to fifty years.

On participants' religious background, there were twenty-one Christians, six Muslims and one Hindu. On the educational level of participants, all of them have had at least basic education. However, most participants in Shalom Estate had tertiary education. The exposure to formal education helped the participants to communicate with the researcher in the English language.

4.2 Perceptions about the Causes of Mental Illness

This section throws light on the views of participants in Nyamekrom and Shalom Estate about the causes of mental illness. Perceptions about the causes of mental have been categorised under supernatural, biological, psychological and social causes. Below, some voices of participants have been presented to reflect participants' views.

4.2.1 Beliefs about Supernatural Causes

Findings showed that participants perceive mental illness to be a curse from voodoo or other deities. Persons suffering from mental illness are therefore believed to have been bewitched by a god. Sometimes the belief is that individuals who hate others can bewitch them and make them become mentally ill. This belief associates mental illness with spiritual forces.

> *Sometimes a family member who does not like you can bewitch you... anytime he* (the bewitched) *gets money he uses all his money to seek treatment. His family has given him to Voodoo. That is what happens* - (Madam Yɔm, Shalom Estate, FGD).
>
> *Sometimes the gods can punish you, if you do the wrong thing*- **(**Madam Awo, Nyamekrom, IP).
>
> *For me I strongly believe that Voodoo is behind it, because when you visit the hospital, the doctors can tell you that this illness is not a hospital one so take it somewhere* - (Madam Eli Shalom Estate, IP).

Participants often mentioned the name of the deity with reverence signifying how strongly they adhered to such beliefs. Participants were of the view that sometimes God or Allah can afflict an individual with mental health illness. The following are quotes from some participants in support of this:

> *My child, it is in the Bible, a certain king was made mad by the Lord, he was punished* - (Madam Ekua, Nyamekrom, IP).
>
> *It is in the Q'uran somebody was made mad by Allah* - (Mr.Abu, Nyamekrom, FGD).

The findings from the study showed that participants believed that Alijeni (bad air) can cause mental illness. Alijeni, they said, presents itself in two ways. The Alijeni or bad airs are evil spirits that travel at night and afflict night travellers. When an individual frequently travels at night such individuals may encounter these spirits who possess the body of the individual and afflict him/her with mental illness. Secondly, the Alijeni could also accidentally possess an

individual. When this happens, the Alijeni can be cast out and the spirit will confess that it possessed the person accidently. The second Alijeni can make the individual to lose consciousness temporarily. This type of Alijeni also presents itself in ways such as refusing to smile at people, making sudden loud noises or eating dirty food. This is what Nafisa and Rabi had to say;

> *... Alijeni is believed to cause mental illness. When bad airs enter you, you can behave abnormally* - (Madam Nafisa, Nyamekrom, FGD).
>
> *Alijeni can also cause it, especially for those who frequently travel at night, sometimes it borrows the body and after using it leaves the body* - (Madam Rabi, Nyamekrom, FGD).
>
> *Sometimes people become moody without any provocation, or shout all of a sudden all these things are examples of Alijeni* - (Mr. Baba, Shalom Estate, FGD).

During interaction with participants, they showed with gestures how a person believed to be afflicted by Alijeni behaves.

In addition to the above findings, individuals who suffer from mental illness were perceived by participants to have done something good or bad in their previous life, and their current status is the direct outcome of their previous existence. The belief is that every individual on this earth has lived before and the present state of mind in which any individual finds himself/ herself is based on his/her karma. The karma is therefore the destiny of any individual. The findings show that sometimes certain individuals may have done good deeds in their previous life but because their karma is to suffer mental illness, they will develop mental illness in their current life. The following is what a participant said during individual interview to support the findings:

For some people it is their Karma to be mentally ill, sometimes when you had been bad in your previous life, you can be punished by becoming mad in your present life. That is your Karma. Sometimes you may have done good but it is your Karma - (Mr. Fifi, Nyamekrom, IP).

4.2.2 Biological and Psychological Causes

The findings from the study revealed that participants are of the view that biologically parents can pass down mental illness to their children. They believe that when a parent suffers from mental illness, it can be easily passed on to a child. The voices below buttressed the findings. Additionally, others are also of the view that psychological causes such as stress may be involved.

I believe it is passed down from a parent to a child - (Sir Dzormor, Shalom Estate, FGD).

Parents can give it to their children - (Madam Eno, Shalom Estate, FGD).

Ooo they give birth to it - (Madam Afi, Shalom Estate, IP).

Madam as you see me, when you talk of stress that is me, I am stressed. Sometimes I act abnormally because of stress. This bank work is not easy - (Madam Afi, Shalom Estate, IP).

It's not very easy these days, life can take a toll on you if you are not careful, you will become mental, I know what stress can do, I have seen it before - (Madam Eno, Shalom Estate, FGD).

Young lady, I believe even your work is stressful, I believe stress leads to plenty diseases - (Mr. Dromor, Shalom Estate, FGD).

4.2.3 Social/Interpersonal Causes

Participants were also of the belief that mental illness is the result of strain in relationship with a significant other. The significant member could be a spouse, child, parents or siblings.

> *I believe that disappointment is a cause, sometimes when a woman disappoints a man, it can happen* - (Mr. Etor, Shalom Estate, IP).
>
> *For us men sometimes a woman is to be blamed for this, when they disappoint you* - (Mr. Kojo, Shalom Estate, IP).
>
> *I know of a woman who took very good care of her children when they were young but in her old age the children neglected her. It passed through her head, now she is on the streets. If the children had loved and cared for her do you think it will be that way? For me I believe the bad relationship is to be blamed* - (Madam Oba, Nyamekrom, FGD).

Some participants also hold the belief that individuals who suffer from the mental illness are the cause of the illness. Examples given related to going in for someone else' wife, or having a dubious character. This is what some members in the focus group and individual interviews had to say:

> *We were once told that Mr. Abu brought the illness unto himself, he went in for someone's wife. That was what his family told Doctor Friday. When he recovered he used to visit us in the community because we lived near the hospital. He also told us he brought the illness unto himself* - (Mr. Kwame and Madam Eno Shalom Estate, FGD).
>
> *My uncle had a bad character, he brought the illness unto himself, if he had left the room for the landlord we the family believe he would not have developed the illness. That my uncle is very stubborn. He thinks bad all the time, always thinking of how to dupe people* - (Madam Aseye, Nyamekrom, IP).

4.2.4 Illicit Drug Use and Overindulgence

Participants believed that mental illness could also be the result of indulging in drugs and overindulgence such as gluttony and excessive sex. According to the findings, there are various kinds of drugs that are believed to spark off mental illness. Below are some of the voices of the participants on this belief:

> *... he told me his food was laced with Ojomi, before he knew it, he was on admission at Accra psychiatric* - (Mr. Kwame, Nyamekrom, FGD).
>
> *Nowadays there is something called Ojomi, it is Wee, they add it to food or drink and it works on the mind* - (Mr. Kojo, Shalom Estate, IP).
>
> *That is what is done now they smoke drugs, I believe that it can also result in that* - (Madam Afi, Shalom Estate, IP).

One participant believed that too much sex, eating meat, and gluttony can lead to mental illness:

> *You stop to eat meat, will you like anybody to eat you. Meat is not good for human beings. The animal is like you....How to control yourself about sex. Too much sex can reduce the brain, too much sex is not good for you. I don't want to go deeper into it just the surface.....Control your food, I believe too much food can result in that* - (Mr. Fifi, Nyamekrom, IP).

4.3 Perceptions about the Mentally Ill and Mental Illness

Findings from the study showed that participants believe that the mentally ill should not be part of the larger society while others thought otherwise. Participants who did not believe such persons are part of the larger society were of the view that when an individual suffers from mental illness, she/he no longer functions as other members of the society. Therefore,

society need not see the particular individual as being a part of the larger group. The following were some of the voices of participants:

> *For me, I see them as not one of us, because they are not normal* - (Madam Adjoa, Shalom Estate IP).
>
> *For me I see it like it is abnormal, I act normal and the person acts abnormal, they must be locked up for good* - (Madam Abra, Nyamekrom, IP).

While others saw mental illness as an abnormality, some participants viewed mental illness as any other disease, hence, felt there was no need to treat sufferers differently.

> *We see it as any ordinary disease like malaria* - (Mr. Kwame and Madam Naa, Shalom Estate, FGD).

Some participants are of the view that persons suffering from mental illness are aggressive as such that there must not be any contact with them. The belief is shared by some of the participants who in their words said:

> *People with mental illness are aggressive... we must all avoid them* - (Mr. Raja, Shalom Estate, FGD).
>
> *When I see them coming I pass a different way* - (Mr. Noi Nyamekrom IP).

The findings indicated that participants feared the mentally ill. The fear is informed by the unpredictable nature of the mentally ill. Participants expressed the emotion of fear through facial expressions. There were others who gestured with their arms to signify fear towards the mentally ill. Some participants expressed their fear in the following words:

> *I believe I must fear them because I cannot tell what he or she will do to me* - (Madam Araba, Shalom Estate, IP).
>
> *We must always be on the lookout because they can do anything to you when you are not aware* - (Madam Aseye Nyamekrom IP).

> *I remember when I was at Nima, a mad man struck a lady because he said the lady did not speak well to him, when they took the woman to the hospital, she died, but you see they couldn't do anything to him because he was mad, so me, I fear them* - -- **(**Madam Naa, Shalom Estate, FGD).

According to some participants, persons with mental illness have some level of sanity and are fully aware of their actions and inactions. To buttress this point Mr. Fifi stated:

> *Look I personally believe a madman is conscious of what he does otherwise what will prompt him to rape a woman. Who tells him that there is something between the thighs of a woman. So you think that because he is mad it means he did not enjoy raping the woman? He has feelings* - (Mr. Fifi, Nyamekrom IP).

Participants were of the view that psychiatric hospitals are not able to cure mental illness. The hospitals are only able to manage symptoms of mental illness. For this reason, when an individual suffers from mental illness it is best to pray for the person or use herbs if one wants to be completely cured:

> *I believe that hospitals are not the right places to seek treatment, if you want to cure mental illness, you must use herbs or be prayed for, the hospitals only manage the symptoms. They do not cure mental illness* - (Mr. Nii, Shalom Estate, IP).
>
> *When my Akuvi fell sick we took her to the hospital but there was no improvement. It was Doctor Friday that cured her* - (Mr. Noi, Nyamekrom IP).

Surprisingly, the findings revealed that even though participants believe the psychiatric hospital only manages symptoms of mental illness but does not provide cure, some participants were of the view that, some patients need to be permanently kept at the hospital.

> *The hospital is good for them, for their own safety so they don't go about drinking dirty water* - (Madam Oba, Nyamekrom, FGD).

The home is hostile and causes them to relapse. For example Agbedefu even though he died long ago, anytime he came home he relapsed. And he used all his money seeking treatment. So for such a man the best place for him is to be kept in the hospital because there was something in his home - (Madam Sika and Madam Oba Nyamekrom, FGD).

Some of the participants believed that mental illness could be completely cured. Once there is complete healing, individuals will never relapse or rely on medication for the rest of their lives. These are what some participants had to say:

Personally, I believe that mental illness can be cured because I have seen it before. When they come to Doctor Friday they are completely healed. We have seen it with our own eyes, they live with us in the community - (Mr. Kojo, Nyamekrom IP).

I remember when they come into the community they are not themselves but once they visit Doctor Friday, they become okay - (Mr. Dzormor, Shalom Estate,FGD).

I know Doctor Friday cures mental illness, I have seen it on several occasions - (Madam Sika, Nyamekrom, FGD).

4.4 Perceptions Relating to Treatment of the Mentally Ill

Perceptions about mental illness informed the kind of treatment meted out to them. These are voices relating to how participants believe individuals with mental illness must be treated.

We must lock them up in chains, they must not be roaming in town - (Mr. Isaka, Nyamekrom, FGD).

For their own good they must be locked up - (Mr.Kofi, Nyamekrom IP).

A unique feature about the findings was that in Nyamekrom almost all participants either had relations who were suffering from mental illness or had suffered from mental illness.

4.5 Attitudes towards the Mentally Ill.

Attitude was limited to three major areas namely, marriage, friendship and residential pattern. The intention was to find out how participants would relate to persons with mental illness.

4.5.1 Marriage

Participants showed a strong dislike for marrying someone with mental illness. However, they were of the view that when a partner develops mental illness in the course of the marriage, they will not part ways with the partner. The belief that mental illness could befall anyone at any particular time reinforced the reason why couples would stay in marriages where a spouse develops mental illness. Secondly, research participants were of the view that marriage was a life time commitment so there was no need to separate or divorce because the other had developed mental illness:

> *I will never leave my wife because that was not how she was before I married her* - (Madam Eli, Shalom Estate, IP).
>
> ooo, *I will not divorce him because he is my husband for better or for worse* - (Madam Aseye, Nyamekrom IP).
>
> *I will speak for most of the people, it will be difficult but we will not divorce* - (Madam Eno and Yɔm, Shalom Estate, FGD).

Participants preferred not marrying someone with mental illness. Their reasons were based on the fact that mental illness called for financial resources. Additionally, there is the need to have enough emotional capacity to care for the partner:

> *If I know that the man is mentally challenged, I will not marry him, nobody will like to marry someone with mental illness* - (Madam Naa and Mr. Baba, Shalom Estate, FGD).

No way, how can you marry such a person, you yourself will you like to marry such a person? - (Mr. Fifi, Nyamekrom, IP).

The findings further revealed that participants may allow family members with mental illness to marry someone without the illness, provided the partner is prepared to properly care for their relation. All participants were of the view that individuals must disclose their health status to their prospective partners before they finally get married:

As for marriage, it is [a life-long commitment] so you must tell the person so that the person becomes aware else there is no trust in the marriage - (Mr. Baba, Shalom Estate, FGD).

Participants also indicated that even though they will not marry an individual with mental health challenge, they can rescind their decision based on the level of the illness. Thus marriage may be considered when the illness is less severe.

I will only marry him when I know the level of his madness. If it is not severe, I will consider him - (Madam Sika, Nyamekrom, FGD).

Ooo the ones who are not completely off can be married but not the bad ones. Those ones nobody will marry them - (Madam Nafisa, Nyamekrom FGD).

We have some called Nyanunɔwer, those ones you can marry them - (Mr. Dormor and Madam Yɔm, Nyamekrom, FGD).

The term "Nyanunɔwer" is an Ewe term which refers to individuals whose illness are not severe and have a higher level of normalcy.

The general findings regarding marriage was that, spouses with mental illness will not face divorce or separation from their partners. However, participants will not marry persons suffering from mental illness although they would allow family members with mental illness to marry individuals without mental illness provided there is the disclosure of the mental state of health of the prospective suitors.

4.5.2 Friendship

Participants indicated that they would be friends with a mentally ill person provided the person comports himself:

> *As for this community if you come here and you comport yourself we will leave with you in harmony but if you chase children or try to rape women or throw stones, we will be unfriendly to you, We may even drive you away* - (Mr. Isaka and Madam Eno, Nyamekrom, FGD).
>
> *I will not mind having someone like that for a friend* - (Madam Abra, Nyamekrom, IP).

4.5.3 Residential Pattern

The outcome of the study showed that male participants would be willing to live in the same house with the mentally ill or have him/her for a neighbour. The findings revealed the opposite for the female participants. Female participants would only live in the same house if they were related to the patient; they were however willing to have the mentally ill as neighbours.

> *How can one live with a mad person in the same house, it cannot happen* (Madam Awo, Nyamekrom, IP).
>
> *I will live with a mentally ill on condition, if there is a relationship. If I am related to the person I have no choice but to live with her* - (Madam Rabi, Shalom Estate IP).
>
> *I am willing to be a neighbour to such a person, or live in the same house* - (Mr. Isaka and Mr. Abu Nyamekrom, FGD).
>
> *I can live in the same house with him provided he is not too violent* - (Mr. Kwame, Shalom Estate, FGD).

What if the person is your relative, you have no option than to live with the person - (Madam Araba, Shalom Estate IP).

Female participants were more likely to have verbal encounters with the mentally ill. For instance, a female participant who lived in the same house with her rival who suffered from mental illness retorted that she cast insinuations at her rival whenever she (rival) misbehaved towards her:

The other day she insulted me, and I responded by casting insinuations at her. I even referred to her illness because I was hurt when she insulted me. She likes insulting people - (Madam Rabi, Nyamekrom, FGD).

I am human so if you annoy me, I will insult you with your illness, I know it is not good to do it - (Madam Ekua, Nyamekrom, IP).

Why should you insult or cast insinuations at someone who you know is sick through no fault of theirs. It's not good I will not do it and I know we men will not do that. It is the women, they may do that - (Mr. Nii, Shalom Estate, IP).

The findings brought to the fore that, fear of social rejection was one of the reasons why some participants put up negative attitudes towards the mentally ill. This is a phrase from

... if I am nice to them, the neighbours will shun me. I don't want that - (Madam Oba, Nyamekrom, FGD).

I fear the reaction from other people so I also do what others do..... When I was growing up, my parents used to provide shelter for patients who visited them. They never drove them away. So I have grown up imbibing this knowledge. But when I came here I didn't want to be seen as 'too known' so I also showed dislike for them - (Madam Adjoa, Shalom Estate IP).

4.6 Forms of Assistance Available

The study revealed that in the study area there are various forms of assistance available to people suffering from mental illness. These assistances which are discussed below are available and are sometimes provided by the community members.

4.6.1 Community Support Groups

The findings from the study showed that community support was provided for persons with mental illness. Community support in this context meant that families with mental health patients come together to educate each other on how to care for their mentally ill relations.

> *Sometimes, parents with same problems can come together to help each other. When I lived at my former place, there was a group in my area, mothers especially met on weekends to share ideas on how to train and care for their sick children* - (Madam Naa, Shalom Estate, FGD).

> *Sometimes I hear the youth group are having discussions on mental illness, they announce it* - (Madam Awo, Nyamekrom, IP).

> *There is an association that work with persons suffering from mental illness in the community. I do know that some parents attend .It is for children with mental illness* - (Mr. Dromor, Shalom Estate, FGD).

4.6.2 Welfare Services

Findings revealed that at Nyamekrom and Shalom Estates, individuals with mental illness were sometimes cared for through donations, namely, cash, clothing, food and assistance with activities of daily living.

We Hindus do it a lot, through social welfare but we don't announce it the way most people do it when they come in front of TVs and newspapers, we do it on the quiet - (Mr. Fifi, Nyamekrom, IP).

We give them clothes whenever they came to us. Sometimes when they run away from the hospital, they don't wear their hospital clothes because they don't want to be identified - (Madam Nafisa and Sika, Nyammekrom, FGD).

They come to us frequently from the hospital, we give them a place to stay, we don't drive them away - (Mr. Isaka and Abu, Nyamekrom, FGD).

Food is nothing, if you cannot give your fellow human being food irrespective of his madness then it is not good - (Mr. Fifi, Nyamekrom, IP).

My other uncles take care of my sick uncle, the family rotate who cares for him at a particular time - (Madam Afi, Shalom Estate, IP).

Some families whose members have mental illness provided support on rotational basis in order that the burden will not be on only one person

My other uncles take care of my sick uncle, the family rotate who cares for him at a Particular time - (Madam Afi, Shalom Estate, IP).

Furthermore, findings indicated that community members who had not at the time of data collection provided any assistance to the mentally ill were willing to provide assistance when given the opportunity.

Food is a basic need of life so I will provide this basic assistance. It is basic as for this one everyone must be able to do it. In my own small way, I will give them food - (Madam Naa, Shalom Estate, FGD).

... I will assist in daily activities if I can, once I live close by - (Madam Ama, Nyamekrom, IP).

Sometimes, they can do many things for themselves, when I leave with her in the same

house I will help her maybe I will take her children to school or buy her things from the market whenever I visit the market - (Madam Ekua, Nyamekrom, IP).

Because I am related to him, I can bathe her - (Madam Abra, Nyamekrom, IP).

4.6.3 Healing Camps/ Prayers Services and Herbal Services

The findings showed that healing camps and prayers as forms of assistance are available to persons with mental illness in the study communities. In this case, participants believed offering prayers on behalf of the mentally ill is good sources of support. Below are the voices of Madam Awo and Madam Araba:

We believe in prayers, it works so we will pray for the person, there are prayer warriors who will help - (Madam Araba, Shalom Estate, IP).

Nowadays there are so many prayer camps, so I will help by sending the person to one of them, of course once they get there they will be taken care of. I believe when I am able to do this I have provided some form of assistance - (Madam Awo, Nyamekrom, IP).

Participants mentioned that herbal services were also available within the community which also provided alternative treatment to persons with mental illness.

We the people here are blessed to have Doctor Friday around so we will take the man to Doctor Friday. The man is very good. This help that we will give is the best. Look when you want to cure mental illness don't go to the hospital, hospital only manages the symptoms, but will not cure. Doctor Friday will cure you - (Madam Naa, Shalom Estate, FGD).

Our fathers use to help people with mental illness with herbs that is what I learnt so I will also help them with herbs. Thankfully, I know the herbs to use - (Mr. Kojo, Shalom Estate, IP).

It was observed that there was a Mosque near Doctor Friday's house. One participant stated that sometimes the Mosque and Doctor Friday become prayer camps where patients are housed and prayed for. There were churches in the two communities as well.

4.7 Motivation for Supporting the Mentally Ill

Participants mentioned different reasons why they would assist people suffering from mental illness. Some believe it is the humane thing to do, for others it is for reciprocity purposes. Other factors include relationship with the person, the person's willingness to accept help and the perceived cause of the illness.

> *We are all human, so I have to help my fellow man*-(Madam Ama, Nyamekrom, IP).
>
> *Why not, we have to help each other, we are all human we need to help when your brother is in need* - (Madam Oba, Nyamekrom, FGD).
>
> *Do unto others what you will want others to do unto you. Put yourself in the situation of the person and help* - (Madam Araba, Shalom Estate, IP).

Religion was also a driving force behind whether or not participants offer support to the mentally ill.

> *I have to consult my Guru or Master whatever he tells me I will do. I cannot do anything without consulting my Guru* - (Mr. Fifi, Nyamekrom, IP).
>
> *As a Christian I must help, if only you call yourself a Christian you must help* - (Mr. Noi, Nyamekrom, IP).
>
> *For us Muslims, the Holy book Quran advises us to help our brothers, so I will help, if you don't help then I believe you are not a true Muslim. You must help* - (Mr. Raja, Shalom Estate, IP).

The findings from the study showed that participants in Pantang community were more likely to assist persons suffering from mental illness who were related to them than those who are not. In other words the closer the bond, the more likely an individual suffering from mental illness will be assisted:

> *If you love the person, you must help*-(Mr. Baba, Shalom Estate, FGD).
>
> *Love is the greatest, where there is love you will by all means help the person, unless you don't love the person* - (Mr. Isaka, Nyamekrom, FGD).
>
> *When you are not related to a madman, you find his behaviours funny but when you are related to him you will do all you can to help him* - (Mr. Etor, Shalom Estate, IP).
>
> *My sister's blood is my blood, even if you don't want to help, something in you will push you. Maybe your sibling has helped you before so this is the time you also have to help back* - (Madam Eno, Shalom Estate, FGD).

Some assisted family members basically out of respect. In this case, age was the determining factor:

> *I used to call him efo, because he was older than me, I could wash for him, buy him food, run errands for him. In fact, I did all that because he was older than me. Looking back I will not have done all that if we were of the same age* - (Mr. Kofi, Nyamekrom, IP).

The findings also showed that the willingness of the individual with mental illness to accept help also has a role to play. When patients rejected the help being offered, it became difficult for participants to assist them.

When you want to help somebody and the person refuses to be helped, what do you do? You stop, so you end up not helping. Oga not your fault, when my family member was sick I wanted to take her to the hospital but she refused even though she knew she was sick - (Madam Aseye, Nyamekrom, IP).

There is a saying that you don't refuse help because the one helping you has delayed in coming, when you do that you hurt yourself - (Madam Oba, Shalom Estate, IP)

The findings showed that the willingness of family members to assist depended on the attitude of the some individuals before the onset of the illness.

It depends on how the person was with you before you can also help. So people when they were rich they refused to help their family members so when they are sick you can also not help them - (Mr. Kofi, Nyamekrom, IP).

My uncle was a very difficult man, I believe his difficulty had driven some of his friends from him. Me, I only send him money when they say we should help - (Madam Araba, Shalom Estate, IP).

Some people are very bad, so when you want to help, you find it difficult to help them. They brought the illness unto themselves by their evils ways - (Madam Aseye, Nyamekrom, IP).

The findings depicted that participants would want to know more about the cause of the ailment before providing the needed assistance. This may be done through mediums like consulting soothsayers or prayers to the Supreme God.

Sometimes, it's good to know the cause of the illness before you help, else in the attempt to help you end up falling sick - (Madam Awo, Nyamekrom, IP).

> *Look before you help someone with mental illness, you have to know that cause. We are spirit beings we cannot underestimate the power of evil forces* - (Madam Naa, and Madam Yɔm, Shalom Estate, FGD).

From the findings of the study, it was clear that finance determined whether or not to assist individuals with mental illness. The availability of money or otherwise either facilitated or marred the provision of support. According to Mr. Kofi money is used for everything; It tells one how to live and what to do:

> *... when Agbedefu was sick it was his money that made the family to care for him. Sometimes you will want to help but you don't have the money* - (Mr. Kofi, Nyamekrom IP).

> *Money does everything, my sister, how can you help someone when you yourself don't have any money to even take the person to hospital? Even just here Doctor Friday, he will take something so how do you send the person there when there is no money* - (Mr. Dromor, Shalom Estate, FGD).

Some offered assistance because of the perceived rewards they would receive in the future when the person recovers:

> *Maybe you see, she is rich who knows when she gets well she can help me stand on my feet. For example, I know of a man when he fell sick all his families cared for him because they knew he was rich so when he gets better he will help them* - (Madam Aseye, Nyamekrom, IP).

4.8 Discussion of Findings

In line with the labelling theory, the study shows how individuals relate to the mentally ill based on the subjective meanings attached to their behaviours. For this reason when people hold onto certain beliefs as being real, the beliefs become real in themselves. When these subjective beliefs are formed about mental illness and the mentally ill, there is little regard for the impact that biological, environmental and other factors have on the behaviour of the mentally ill (Scheff, 1974). Once armed with these subjective beliefs, people treat patients with mental illness subjectively and mental health patients are seen as different from other members of the society. Munch (1994) recognised this pattern and said this gave birth to the catergorisation of individuals into "We" and "Them" group. The categorisation of individuals leads to stigmatisation and isolation. The result of such negative treatments towards the mentally ill may have dire consequences for their family members as well. The theory therefore becomes useful to the study as it exposed the need to be objective in understanding the behaviours of the mentally ill; while in the long term, exposing the need to care for them.

The findings also revealed several perceptions about the causes of mental illness such as gluttony, and eating certain foods , curse by a supernatural being and others, which implies a lack of understanding about the causes of mental illness. The perception about supernatural forces and mental illness is consistent with Mulatu's (1999) assertion that there are perceptions that sometimes supreme beings may inflict mental illness on people. The findings also revealed that some participants are of the view that the destiny (karma) of people predisposes them to the development of mental illness. Karma works in two ways. Firstly, individuals who had mental illness may have lived a bad life in their previous life, such that when they reincarnated, there is the need to atone for their sins in the present life. Secondly,

there are times when individuals may not have necessarily done any wrong in their previous life, but because their destiny dictated that they develop mental illness, they become mentally ill.

Participants however believed that strain in relationships with significant others also cause mental illness. Every human being depends on others for survival. As part of surviving there is the need to build strong relationships with others. The relationship serves as a form of support to lean on during good and trying times. In the event that there are no strong bond between individuals and their significant others such as spouses and parents; individuals will be emotionally broken when they face crises. Obviously, such breakdown has the potential to trigger mental illness as indicated by Lopez-Ibor and Christodoulou (2005) that sometimes environmental factors like weak family ties can be linked to mental illness.

Participants also believed that, when people abuse drugs like marijuana, it has biological effects on the brain by altering the brain's functions. When this happens, individuals may behave abnormally. Additionally, participants believed stress has direct implications on mental illness. When individuals experience stress, the brain may be affected and this may lead to the altering of behaviours. When this happens, most individuals may not be able to function as expected of them. Cockerham in 2007 indicated that stress, negatively impairs the brain’s functioning.

The findings revealed that female participants who lived in the same house with persons with mental illness were more likely to have verbal confrontations with them than their male counterparts. Furthermore, female participants were also at the forefront of caring for the mentally ill than their male counterparts who were not directly involved. Male participants

provided material support such as monies to be used in caring for them. In Africa, women are often the carers for family members who are ill and men are expected to provide financial and material support (Cook & Wang, 2010).

Religion, which shapes the belief system of individuals, portrayed that participants felt compelled by their religious belief to provide support to the mentally ill. This expression by Mr. Noi - "As a Christian I must help, if only you call yourself a Christian you must help" in a way suggests that participants feel obliged to accommodate persons with mental illness because of their religion. Conversely, this could also mean that when participants do not adhere to any religion they may not feel compelled to be accommodating of persons with mental illness.

From the study, some participants are of the view that persons with mental illness are not to be regarded as part of the larger society. This idea is based on the fact that persons affected by mental illness cannot function as other members in the society. Many participants believed persons with mental illness are to be feared because they are aggressive and unpredictable. Despite being unpredictable, some participants believed that persons with mental illness have some level of sanity and are fully aware of their actions and inactions. According to this belief, persons with mental illness have a sound judgement such that they are able to decipher right from wrong. For these participants, persons with mental illness should not be excused from being held responsible for their actions or inactions.

A few participants regarded mental illness as any other disease. If mental illness was like any other disease then there was the need for participants not to treat the mentally ill with scorn. By implication, the mentally ill should be treated as individuals suffering from malaria of which they would be treated. Some participants also had contrary views and stated that hospitals were not capable of curing mental illness but only managed the symptoms. For this reason, they believe it is always best to resort to prayers or the use of herbs in order to be completely cured from mental illness. The finding that participants would resort to prayers confirmed Roberts, Asare, Morgan Adjase and Osei's (2013) assertion that some persons may resort to prayers as a means of seeking help.

On the issue of marriage, the study's findings revealed that participants will not seek separation or divorce their spouses in the event they developed mental illness. Even though participants would not divorce their spouses, most of them would not like to marry a mentally ill person because of the supposed unpredictable nature of the mentally ill. For the few who were prepared to marry someone with mental illness, they will only do so after considering the severity of the ailment. Such views can fairly be linked to Segal et al. (2004) as well as Mulatu's (1999) findings that the more severe the mental illness, the more stigma people experience.

Participants, especially males, were willing to live in the same house with individuals suffering from mental illness. On the contrary, females would only live with them provided the ailment was not severe enough or based on the existence of a relationship. Participants were willing to have a mentally ill person as a neighbour.

Furthermore, the findings revealed that community support services were available to the mentally ill. Participants either provided or were willing to provide assistance to the mentally ill in the form of cash donations, clothing and helping with activities of daily living, among others. Religious leaders (Guru or Imam) were instrumental in getting their followers to assist the mentally ill. In Nyamekrom, the Imam doubled as herbalist who operated the 'Doctor Friday' centre that provided services to the mentally ill and led worship at the mosque as well. This revelation corroborated Roberts (2001) conclusion that traditional healers were sometimes in the forefront in providing care to the mentally ill.

The findings indicated that there are some factors that influence participants' support of the mentally ill. The relationship between the care giver and the individual with mental illness played a role in the assistance offered by participants. According to Horwitz et al. (1992), individuals are apt to provide assistance to persons with mental illness when there is a strong bond between them, especially when they are related by blood. The above relationship between assistance and bond has also been confirmed by the findings. Whereas the findings from this study cannot be generalised, there is similarity in these two findings.

Furthermore, participants' religious belief was linked to support provided. Religion was therefore a pivot around which participants decided whether or not to help a person with mental health illness. The conclusion can therefore be drawn that when participants are less religious, there is the tendency that they may not help persons with mental illness. It was also found that participants may want to know the cause of the illness before providing assistance, due to fear of being punished by supernatural beings for offering assistance to someone who has been cursed.

Finally, it is often said that money is the purchasing power that people have and it determines the actions of individuals at a particular time. Thus, the availability of money determines whether or not support will be provided.

4.9. Conclusion

The chapter has presented and discussed findings to answer the research questions set out at the beginning of the study. The chapter has therefore looked at what the beliefs about mental illness are in the Pantang community; how people relate with the mentally ill in the Pantang Community; and the forms of assistance available in the Pantang Community for people suffering from mental illness. The chapter, among other things, looked at issues that inform participants' readiness to help persons with mental illness. The next chapter summarises the findings and draws conclusions based on the findings. Finally, recommendations are made based on the conclusions drawn.

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

The main goal of the study was to find out the perception and attitudes of residents of the Pantang community towards the mentally ill. Specifically, it aimed at finding out the beliefs members of the Pantang community hold about mental illness and the mentally ill; exploring the attitudes of people in the Pantang community towards the mentally ill; and determining the forms of assistance available in the Pantang community to people suffering from mental illness. The study was carried in Nyamekrom and Shalom Estate which are found in the Pantang community. The chapter presents a summary of the findings, followed by conclusions drawn from the findings and recommendations for action.

5.1 Perceptions about the Causes of Mental Illness

Participants believe that supernatural beings can afflict individuals with mental illness when they offend these deities. In addition, persons with mental illness can be bewitched by friends or foes to serve as a form of punishment for wrongs done them. Participants also believed that indulgence in too much sex, gluttony and the intake of meat could result in mental illness. Furthermore, participants believed that parents with a history of mental illness may pass on the illness to their unborn babies. Stress in relationships was also implicated.

5.2 Perceptions Relating to Treatment of the Mentally Ill

The findings exposed the perceptions study participants have about the treatment of the mentally ill. Some believe they need to be chained because of their unpredictable behaviour.

However, not all participants had such negative perceptions about the mentally ill regarding treatment. Some believed that persons who suffered from mental illness were also human beings who deserved to be care for and loved. There were also other participants who believed that mental illness was like any ordinary illness such as malaria.

5.3 Attitudes towards the Mentally Ill

Participants in Nyamekrom and Shalom Estate would not divorce their spouses in the event that they develop mental illness. All participants were of the view that prospective partners must disclose their mental health status to each other since marriage was a lifelong commitment. There were other participants who believed that they would allow family members with mental illness to get married. Another finding that came up was the fact that some participants will not divorce their spouses, in the event they developed mental illness in the course of their union. On friendship, some participants would be friends with the mentally ill, would have no problems with living under the same roof with a person with mental illness or having them as neighbours. However, female participants were willing to live with a mentally ill person only if that person was a relation. The study's findings brought to bear the knowledge that the fear of social rejection prevented participants from expressing likeness for the mentally ill.

5.4 Forms of Assistance Available

With regards to the provision of assistance to the mentally ill, participants mentioned the use of community support groups and the use of herbs and prayers. Herbs may be used alone or combined with prayers by the one providing the care. Additionally, there was the provision of food, money and clothes to persons with mental illness. The provision of support by

participants however was dependent on factors like finance, bond between the provider and the person with mental illness and the cause of the illness.

5.5 Conclusions

In conclusion, the study found that misconceptions about the causes of mental illness continue to persist and this feeds stigma and treatment options. On the positive side however, there are people who are willing to live in the same community with persons with mental illness and many are willing to provide care for family members who become mentally ill. Reciprocity, religion and family bonds appear to play a central role in participants' willingness to care for the mentally ill. On the downside, lack of resources and lack of knowledge, appear to be an impediment to providing the needed support to the mentally ill.

5.6 Recommendations

In order to eradicate the misconceptions associated with the mentally ill and mentally illness, social workers must be in the lead in educating community members on issues of mental illness. This may be done through dramatisation of the causes of mental illness and the dangers associated with stigmatising persons with mental illness in the various communities. Secondly, persons must be educated to know that no one is immune from developing mental illness, hence there is the need to treat people who develop mental illness with all the respect they deserve so that in the event one falls sick, the same treatment would be provided. Additionally, Metropolitan, Municipal and District Assemblies (MMDAs) must also complement the services of decentralised agencies like the Department of Social Welfare by providing them with logistics to carry out their mandate.

Prayer and herbal centres are often the first point of contact for people suffering from mental illness because of the beliefs about the causes. It is therefore recommended that government in collaboration with the psychiatric institutions must identify prayer camps and herbal centres to train them so they can work with psychiatric facilities to provide referral services. . This move would help the hospitals to monitor and evaluate the activities of such centres by making sure standard practices are followed.

The finding on herbal use in mental illness showed that, some participants were of the view that herbs can be effective in treating the illness. There is therefore the need for the Ghana Health Service (GHS) to fully roll out its programme on herbal use in the field of mental health. Although, there seems to be some minimal level of herbal use in medicine in Ghana, the GHS in practice does not really approve its use in the treatment of mental illness.

Governments must resource all public health facilities to provide psychiatric wings to make it easier for people with mental illness to access orthodox medicine. Social Workers must be used to assist communities to form and facilitate mental health community support groups as well as train communities on how to care for the mentally ill. This can be done by training psychiatric social workers who can facilitate and monitor such support groups in the community. This will enable the provision of quality care for the mentally ill at their door-step and reduce residential care which feeds stigma. Additionally, government must make pragmatic efforts at implementing the Legislative Instrument of the Mental Health Act to enable the smooth operationalisation of the Act since merely constituting the Mental Health Board is not enough. Also social workers must act as advocates to put pressure on governments to quickly pass the legislative instrument. These recommendations, even though they are not exhaustive in themselves, can help improve care for the mentally ill.

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APPENDIX 1

INFORMED CONSENT

My name is Florence Adeeku an MPhil student from the University of Ghana Legon. I am conducting a research titled "Perceptions and Attitudes towards Mental Illness: The Case of Pantang Community". This is purely an academic exercise which aims at exploring attitudes and perceptions towards mental illness and the services available to the mentally ill in Pantang community. Your participation in this study will be much appreciated since it will help me to gather the needed data. You will be interviewed by me and the interview will be recorded with the aid of a tape recorder. I will also take field notes during the interview sessions. As part of observing ethical considerations relating to the conduct of research you are kindly required to read, understand and sign this form before you participate in the study.

Voluntary participation: I understand that my participation is voluntary and that I may refuse to participate and/or withdraw my consent and discontinue participation in the study at any time if I choose to.

Confidentiality/Anonymity: I understand that the researcher will take all reasonable measures to protect the confidentiality of my interview session and my identity will not be revealed in any publication that may result from this study. Pseudonyms will be used in cases where there is the need to refer to the names of participants. By signing below, I agree to partake in the study.

Name of participant: Signature/ Thumbprint:

Date:

Witnessed by

Researcher's name: Signature:

Date:

Contact number: 0242173458

APPENDIX 2
INTERVIEW GUIDES FOR PARTICIPANTS

Section A- bio data of participants

1. Sex of participant.

2. What is your religious affiliation?

3. Can you please tell me your age?

Section B

4. How will you define mental illness?

5. What are your views about mental illness?

6. What do you think about the mentally ill?

7. What informs the views about mental illness and the mentally ill?

8. Would you have a mentally ill person as a friend? Why/why not

9. What will your reaction be if a person with mental illness wants to be your friend?

10. What about marriage to a mentally ill person?

11. Do you think your relative with mental illness should marry someone without mental illness? Why/why not?

12. Would you live in the same house with a mentally ill person?

13. Would you live in the same neighbourhood with a mentally ill person? Why/Why not?

14. What services are available to the mentally ill in this community?

15. Any comments or contribution on mental health issues?

APPENDIX 3

Vignette for Focus Group Discussions

Mr. Olam a wealthy, happily married man with two kids develops mental illness all of a sudden. Olam is of the view that he cannot possibly be suffering from mental illness. His reason is that no one from his family has ever suffered from mental illness, and that the problem he is experiencing is caused by evil eyes from people who do not like him. He has visited the hospital twice and has seen little improvement in his condition but still maintains his busy schedule. Mr. Olam's illness has driven away his wife, family members and some of his friends who used to live with him in his house. Some neighbours have also moved from the vicinity because they do not want his regular visits to their homes. Currently, some family members want to take him to the prayer camp, while others say he must seek herbal care.

Questions:

- Can one say that Mr. Olam has mental illness? Why/Why not
- What do you believe causes mental illness?
- Were the behaviours exhibited towards him appropriate- Marriage, friendship and neighbours?
- Why did his wife leave him?
- What will prevent people from being friends with him? What about neighbours?
- Can any of us live in the same house with Mr. Olam- Why/why not?
- What services are available to him in this community /What resources are available in the community that can help Mr. Olam?
- What suggestions or comments do we have about mental health issues?