

**UNIVERSITY OF GHANA
SCHOOL OF PUBLIC HEALTH
COLLEGE OF HEALTH SCIENCES**

**HOUSEHOLD AND COMMUNITY PERCEPTIONS ON THE INTEGRATION
OF PERSONS WITH MENTAL ILLNESS IN THE TEMA METROPLIS**

BY

BERTHA SMITH

10636164

**THIS DISSERTATION IS SUBMITTED TO THE UNIVERSITY OF GHANA,
LEGON IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE
AWARD OF MASTER OF PUBLIC HEALTH DEGREE**

JULY, 2018

DECLARATION

I do hereby declare that apart from people's knowledge that I have acknowledged, this research proposal is the result of my dedication hard work under supervision

I take full responsibility for this work.

.....

BERTHA SMITH (Student)

.....

DATE:

.....

GENEVIEVE C. ARYEETEY (Supervisor)

.....

DATE:

DEDICATION

This thesis is dedicated to God almighty for his enormous mercies upon my life.

Also to my husband and children, David, Michelle, Ornella and Annabella, for their constant support and encouragement during the challenges of graduate school and life. I am thankful for having them in my life.

This work is also dedicated to my mum, Faustina, brother, Frank, Aunty Vida and my mother in-law Mrs. Beatrice Odonkor who have always loved and supported myself and my children whose good selfless dedication have brought me this far.

ACKNOWLEDGEMENT

I thank God almighty for giving me the strength to go through a successful completion of this project.

My sincere gratitude also goes to my supervisor Dr. Genevieve Cecilia Aryeteey and the entire staff of school of public health for their immense contribution and dedication towards this project.

I also want to thank the entire staff of Tema Polyclinic specifically the Psychiatric unit for their enormous support that was given to me to conduct my research at their facility.

In addition, I would like to thank my work colleagues for their understanding and support during that period.

Finally, I would like to thank my husband Mr. David N. Odonkor for his wise counsel and sympathetic ear and also for all the financial assistance that you gave me.

ABSTRACT

Background: Household and Community Care has increasingly been recognized by the Ghana Health Service and the mental health sector as a means of promoting mental health in Ghana. However, household and community attitudes and perceptions towards mental illness and mental health affect the effectiveness of community-based care.

Objective: The main objective of this study was to assess household and community perceptions on the integration of persons with mental illness in the Tema Metropolis.

Data collection: Using in-depth interviews and focus group discussions, data was collected from thirty-eight (which comprised 10 IDIs and 4FGD of 7 participants each) consented participants whose family members or relatives had visited the psychiatric unit of Tema polyclinic and also from community members living with persons with mental conditions.

Data analysis: Data collected was coded and themes generated. The succinct themes that was relevant to answering the research question was analyzed. Based on the data gathered after the in-depth interviews and focus group discussions four themes were generated. These themes comprised: description of mental health, individual perception on mental health, community/household perception of health, mental health integration and coping strategies.

Results: The connotation of mental health is diverse and fraught with stigmatization because of cultural and societal belief about the disease. The condition is also perceived to be spiritual and lifestyle related. The relationship individuals have with mentally ill patients is one of fear. Due misconception about mental illness, persons with mental illness are robbed of the opportunities that define quality life, which include affiliation with friends and community members. Generally, mental illness evokes a sense of shame

from friends and families of those affected, such as; they are entirely not accepted as part of the community.

Conclusion: The results indicate a mixed reaction of attitude towards mental illness among participant. Though there is knowledge on mental illness, people always have drawbacks to integrating or mingling with persons with mental illness into society. Notwithstanding, some are also willing to accept them into society

TABLE OF CONTENTS

DECLARATION	iii
DEDICATION	iv
ACKNOWLEDGEMENT	v
ABSTRACT.....	vi
LIST OF FIGURES	iv
LIST OF ABBREVIATION.....	v
DEFINITION OF TERMS IN CONTEXT	vi
CHAPTER ONE.....	1
INTRODUCTION	1
1.0 Background.....	1
1.1 Problem Statement	3
1.2. Objectives.....	4
1.2.1. General Objective	4
1.2.2. Specific Objectives	4
1.3.2. Research Questions.....	4
1.3. Justification of the Study.....	5
CONCEPTUAL FRAMEWORK.....	6
CHAPTER TWO	7
LITERATURE REVIEW.....	7
2.1 Mental health and mental illness.....	7
2.2 Historical Antecedent of Ghana’s Mental Health Care.....	8
2.3 Social context of mental health	10
2.4 Effects of Stigma and Discrimination	11
2.5 Coping strategies for mental illness	12

2.6 Beliefs about Mental Illness	13
2.7 Attitude towards mentally ill persons	15
2.8 Chapter summary and conclusion	16
METHODS	17
3.0 Introduction	17
3.1 Study Design	17
3.2 Study Location	17
3.3 Study Population	18
3.4 Sampling Technique.....	18
3.4.1 Inclusion Criteria	19
3.4.2 Exclusion Criteria.....	20
3.5 Sample size.....	20
3.7 Data Analysis	22
3.8 Ethical consideration.....	22
3.9 Participant consent	22
3.10 Privacy & Confidentiality	23
3.11 Risk and Benefit.....	23
CHAPTER FOUR.....	24
RESULTS	24
4.0 Introduction	24
4.1 Demographic information	24
4.2 Organization of themes	25
4.3 Description of mental illness.....	25
4.4 Individual perception on mental illness	27
4.5 Community/household perception on mental illness	30

4.6 Mental illness integration	33
4.6 Coping strategies	35
CHAPTER FIVE	37
DISCUSSION.....	37
5.0 Introduction	37
5.1 Individual perception on mental illness	37
5.2 Community/household perception on mental health.....	38
5.3 Mentally ill integration.....	39
5.4 Coping strategies	40
5.5 Limitations of the study.....	41
CHAPTER SIX.....	43
CONCLUSION AND RECOMMENDATION.....	43
6.1 Conclusion.....	43
6.2 Recommendations	43
REFERENCES	44

LIST OF FIGURES

Figure 1.1 Conceptual framework.....6

LIST OF ABBREVIATION

PHC	Population Household Census
WHO	World Health Organization
IDI	In-depth Interview
FGD	Focus Group Discussion
GHS-ERC Committee	Ghana Health Service Ethics Review

DEFINITION OF TERMS IN CONTEXT

Mental Illness: Any condition that makes it difficult for an individual to cope with normal stresses of life or a state of mental and social disequilibrium.

Community: A locality inhabited by a group of people who share common characteristic or interest.

Community members: Means persons in close proximity.

Integration: Combining community members to live or mingle with mentally ill persons in the community

CHAPTER ONE

INTRODUCTION

1.0 Background

Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community (WHO, 2014). In recent times, mental illness is increasingly being recognized among health professionals, psychologists and the general public as a major contributor to the global burden of disease worldwide (Shrivastava, Bureau, & Johnston, 2012). The World Health Organization reports that one in four people in the world will be affected by mental or neurological disorders at some point in their lives (WHO, 2015).

Mental illness is treatable and the symptoms of mental illness often can be controlled effectively through medication and psychotherapy. That notwithstanding, the symptoms of mental illness may go into remission, and for some people it causes continuous episodes that require prolonged treatment. Untreated mental illness can disrupt an individual's personal, social, educational and work activities and in some cases it may lead to suicide (Todor, 2013).

In Sub-Saharan Africa, perceptions about mental illness are defined within the context of cultural and religious beliefs. As such, people attribute the origin of mental illness to supernatural powers (Atilola, 2016). Community attitudes influence the health seeking behaviour of mental health sufferers. Ignorance about advances in the diagnosis and management of mental illness, the availability of effective treatment, and the fear of

stigmatization may prevent people with mental disorders from seeking professional help (Benedicto, Mndeme, Mwakagile, & Mwansisya, 2016). Poor understanding of the nature and dynamics of mental disorders has been described as a major challenge to household and community integration in Sub-Saharan Africa.(Egbe et al., 2014).

Stigma, lack of awareness misconceptions and false perceptions about mental illness has also been found to create a barrier between mentally ill patients and the society. Mentally ill patients are labelled as “strange” and are viewed negatively by others. They are often perceived with more negative attributes and are more likely to be rejected and subject to ridicule regardless of their behaviour (Verelst, De Schryver, De Haene, Broekaert, & Derluyn, 2014).

The role of the family and hence, the society as a whole is vital in mental health. Integrating persons affected with mental illness in the community has been found to better the lives of mentally challenged. The provision of emotional and physical support, creating a sense of belongingness for the mentally ill patient improves their recovery and their well-being (Tibebe & Tesfay, 2015). In most parts of Sub-Saharan Africa, having a family or relative affected by the consequence of a mental illness is accompanied with stigma and discrimination (Atilola, 2016).

The call for social integration to be incorporated as a key outcome of mental health services creates a pressing need to better mental health outcomes. Community integration is recognized as a crucial component of recovery from serious mental illness. Community integration can be measured with structured instruments, little is known about the

subjective and experiential meaning of community and community involvement for persons with serious mental illness (Pahwa, Daly, Brekke, & Ph, 2013).

1.1 Problem Statement

About 450 million people suffer from mental or behavioral disorders worldwide. Mental disorders are recognized as one of the major contributors (14%) to the global burden of disease worldwide (Mariam & A, 2016). Untreated mental illness can disrupt an individual's personal, social, educational and work activities and in most cases lead to suicide. According to the World Health Organization the cost of not treating mental illness may be high both in personal and financial terms (WHO, 2014).

The Accra Psychiatric and Pantang Hospitals recorded a total of 39,536 and 23,331 patients respectively in 2012; this was against 35,898 and 23,360 in 2013 (MOH, 2013). Meanwhile, there are not enough health facilities and the existing health facilities are under resourced. To curb this menace, community-based care has been proposed by the Ghana's Mental Health Sector to help reduce the pressure on the few under-resourced mental health facilities available. The communities are expected to offer support to the mentally ill by applying very positive attitudes that seek to reduce stigmatization and accept these people as part of the society (Ofori-Atta, Read, & Lund, 2010).

Studies have shown that people have limited knowledge and negative perception about mental illnesses in the community, and whenever there is any knowledge, it is based on prevailing local understanding of the nature and causation of mental illnesses (Vos et al., 2009). In some cases, most people attribute mental illness to be a curse from a deity or a punishment from the Supreme Being (Atilola, 2016). It is in this light that the researcher

seeks to explore the household's perception, role and challenges of family members with mental illness in the Tema metropolis.

1.2. Objectives

1.2.1. General Objective

To assess household and community perceptions on the integration of persons with mental illness in the Tema Metropolis.

1.2.2. Specific Objectives

1. To describe the concept of mental illness in the community.
2. To explore household's perceptions towards integration of persons with mental illness.
3. To explore community perceptions towards integration of persons with mental illness.
4. To describe the coping strategies on integration of persons with mental illness.

1.3.2. Research Questions

1. How do community members understand the concept of mental health?
2. What are household's perceptions towards integration of persons with mental illness?
3. What are community perceptions towards integration of persons with mental illness?
4. What forms of coping strategies on integration of persons with mental illness exist in the Tema Metropolis?

1.3. Justification of the Study

The promotion of mental health that is actions to create living conditions and environments that support mental health and allow people to adopt and maintain healthy lifestyles is a responsibility of all stakeholders in the society; family, friends, social clubs and organizations and government among others. In Africa and particularly Ghana, the high influence of our cultural system and collectivism (i.e. sense of belonging) makes the role of families and the community key in the personal development and orientation of individuals into the society. Therefore, family members including friends and close associates play important role in the reintegration of persons with mental conditions who have been discharged. This study however, will go a long way to inform policy makers on the best policies and guidelines that will facilitate integration of persons living with mental illnesses in our communities.

CONCEPTUAL FRAMEWORK

The conceptual framework presented in Figure 1.1 presents factors influencing perception on mental illness. Environmental factors such as an individual's past and present surroundings, experiences, hearsays and knowledge affects an individual's perception on mental illness

Individual attributes and behavior such as misconceptions, cultural beliefs, personal experiences and encounters have an effect on perception on mental illness.

Social and economic status, such as rehabilitation centers, adequate, availability and accessibility of essential drugs, communal support, financial soundness, companionship ect influence perception of mental illness.

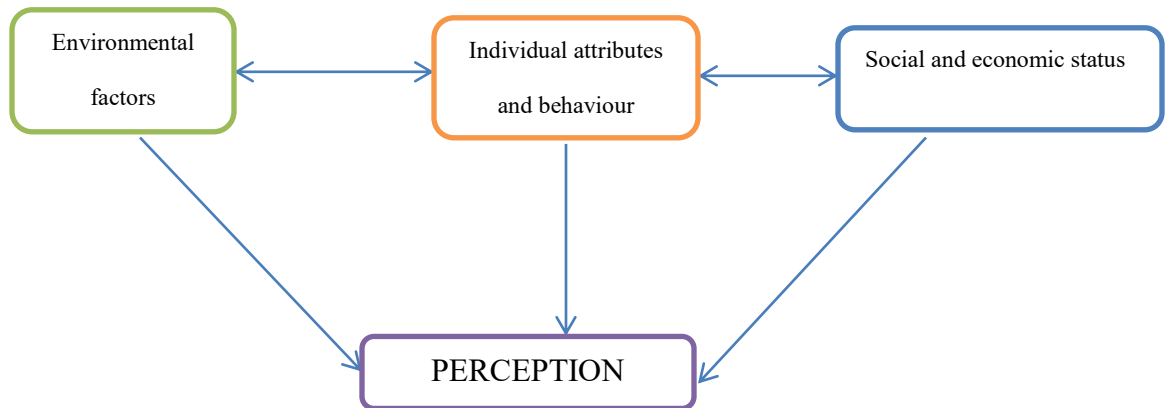


Figure 1.1 Conceptual framework showing factors that influence perception on mental illness

CHAPTER TWO

LITERATURE REVIEW

2.1 Mental health and mental illness

Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to her or his community (WHO, 2015). From the definition, mental illness therefore is viewed as any condition that makes it difficult for an individual to cope with normal stresses of life, or state of mental and social disequilibrium (Tawiah, Adongo, & Aikins, 2015). Mental illnesses has been identified to account for at least 160 million lost years of healthy life, of which about 30% could be averted with existing interventions (Mariam & A, 2016).

It has been estimated that 1 in 5 people will experience some sort of mental illness in their lifetime and 1 in 4 people will know someone with mental illness according to the National Institute of Mental Health (NIMH, 2014). Mental illness is treatable and the symptoms of mental illnesses can be controlled effectively through medication and psychotherapy (Salve, Goswami, Sagar, Nongkynrih, & Sreenivas, 2013).

In recent times, mental health is being considered an indicator of the social life of a given population. Morbidities and mortalities are a sign of social as well as disease burden. That notwithstanding, most countries have ignored mental health and mental illness to a very large extend. The result however, is the increased burden of mental disorders in communities and the widened „treatment gap“ that exists (Salve et al., 2013).

Most studies have revealed that the wider treatment gap that exists is largely due to community perception and social stigma (Benti, Ebrahim, Awoke, Yohannis, & Bedaso, 2016;).

Negative narratives and stigmatizing attitudes against mentally ill persons have powerful historical roots in many cultures. The common perception of these persons, who are unable to defend their rights, is that they are dangerous, violent and unpredictable (Todor, 2013).

Persons living with mental illness have been stigmatized throughout history in any community, and this stigmatisation is beyond just “labelling” the person. The condition is perceived as frightening, shameful, imaginary, feigned, and incurable, while the victims are characterized as dangerous, unpredictable, untrustworthy, unstable, lazy, weak, worthless, and/or helpless in the community (Salve et al., 2013).

2.2 Historical Antecedent of Ghana’s Mental Health Care

Ghana’s Mental Health care system can be traced to 1888 when the Lunatic Asylum Ordinance, Cap 79 was made law. It was with this that 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 and highly debatable among human rights experts. Mentally ill persons were put behind bars (prison). With time, the prisons became densely populated and there was the need for decongestion. This, however created the need for another institution to house them.

The issue of congestion and 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 became the first psychiatrist at that institution. Foster brought many developments and reformations 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 instituted in the Central Region in 1965. Despite the two institutions available at that time, there was still some pressure on them. This situation called for the building of Pantang psychiatry hospital in 1975 in the Greater Accra Region to compliment the efforts of the first two hospitals.

However, 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 Mamprobi. Aside these conventional treatment centres, there are also charismatic churches who specialize in healing mental health conditions (Mental Health Profile -MHP, 2012).

2.3 Social context of mental health

A social context to illness can be defined from the widely recognized conceptual distinction between disease (the biological condition) and illness (the social meaning of the condition). The WHO (2004) reports that individuals stand the risk of being discriminated against if they are identified to be suffering from a mental problem.

In countries where mental health care is provided for free, underutilization of mental health services continues to remain as a problem (Tibebe & Tesfay, 2015). Undoubtedly, the social context of illness has direct effect on whether the condition will be stigmatized or otherwise (Griffiths et al., 2006).

The general misconception about mental illness – for instance that they cannot be cured or the inefficiency of drug treatment is what remains in the minds of many people in populations (Todor, 2013). Kleinman in (1995), studied the stigma of epilepsy in China. In that study, he critically reviewed concepts of stigma, emphasizing the importance of considering broader social contexts of illness experience. His analysis emphasized the role of stigma as a force both shaped by and influencing the character of local communities (Florence, 2015).

Stigma remains a powerful negative attribute in all social contexts all social relations. It is considered an amalgamation of 3 related problems: a lack of knowledge (ignorance), negative attitudes (prejudice), and exclusion or avoidance behaviours (discrimination) (Ganesh, 2011).

Scheff (1986), reported that people who are labelled as mentally ill associate themselves with society's negative conceptions of mental illness and that society's negative reactions contribute to the incidence of mental disorder. The social rejection resulting from this may handicap mentally ill people even further.

2.4 Effects of Stigma and Discrimination

The principal effects in developing countries are social isolation of persons living with mental illness, where the person may be avoided by former friends and acquaintances.

Persons with mental illness often isolate themselves to avoid uncomfortable situations such as being shunned, ridiculed or made subject to gossip. Being either a patient or an ex-patient is likely to affect employment and employment prospects.

Unmarried women often find it difficult to get married, due to discrimination by prospective husbands and in-laws, while married women may find they are divorced because they have mental illness or mental illness is subsequently revealed. In Ghana for instance, families usually investigate each other prior to a marriage ceremony to ascertain whether there is a history of mental illness in their family (Tawiah et al., 2015).

Stigma and consequent discrimination have a double impact on TB control. First, concerns about being identified as a person with TB make it more difficult for people with a cough of long duration who suspect they may have TB to seek care, because of the

public nature of the TB diagnostic process (Baral, Karki & Newell, 2007). A study of leprosy counseling groups in Nepal from 1994 to 1998 showed that perceived stigma prevented individuals with leprosy from seeking care and resulted in lower compliance with treatments. HIV-positive women in Chile reported that they avoided necessary health services, or delayed seeking services until their condition had deteriorated, because they had been discriminated against in the past and so feared mistreatment in the future (Floyd-Richard and Guring, 2000).

Subjective perceptions of stigmatization is as important as objective exposure to discrimination in predicting adverse health-relevant outcomes among the stigmatized (Finch *et al.*, 2000).

Subjective social status is positively related to health-related outcomes, even controlling for objective indicators of social status (Ofori-Atta *et al.*, 2010). Self-reported experiences of discrimination are positively associated with psychological distress, and with self-reported physical health problems (Sebastian & Richards, 2017).

2.5 Coping strategies for mental illness

Mental illnesses expose victims to stigma-induced identity threats. People cope with this threat in a number of ways. While some of the efforts in coping with this stress are primarily problem focused, others focus on their emotions. Coping strategies are in most cases expressed as „engaging“ and „disengaging“. The engaging strategy involves fighting the stigma-induced identity threat whereas the disengaging strategy involves avoiding the source of stigma-induced identity threat (Verelst *et al.*, 2014).

Groups of people who suffer stigmatization, one way or the other may cope with the threat to their self-esteem by blaming the outcome. Another way in which the stigmatized

cope with identity threat is by withdrawing their efforts and or disengaging their self-esteem from domains in which they are negatively stereotyped or fear being a target of discrimination (Kazantzis, Wakefield, Deane, Ronan, & Johnson, 2009). They sometimes cope with identity threat by approaching, or identifying more closely with their group (Egbe et al., 2014). Groups can provide emotional, informational, and instrumental support, social validation for one's perceptions, social consensus for one's attributions, and a sense of belonging. Group identification is positively correlated with self-esteem among stigmatized groups (Ofori-Atta et al., 2010).

2.6 Beliefs about Mental Illness

To gain a better understanding of mental illness, there is the need to understand the basis of attitudes about mental illness. The existence of the many beliefs about mental illness determine the health seeking behaviour of persons living with mental illness. Families and relations are not left out of this direction to which the several beliefs cause their health seeking behaviour. These beliefs about mental illness can best be described as assumptions. According to Laungan (1989), "assumptions are the held beliefs, attitudes and values shared by people in a given culture." He further explained that assumptions about mental illness are shaped by cultural, biological and psycho-social views. These assumptions have unfortunately been accepted as truths even though they may not have scientific explanations.

These assumptions direct how mental illness is perceived and the kind of intervention required for the affected person and their family (Shrivastava et al., 2012).

In effect, individuals may relate to another individual with mental illness depending on the idea that he or she may have about the illness (Jupe, Elezi, Zenelaj, & Myslimi, 2017).

Some schools of thoughts believe that mental illness has biomedical explanations. Scholars of the biomedical view believe that mental illness is caused by factors that are purely biological (Tibebe & Tesfay, 2015). On the other hand, some schools of thought believe that mental illness has spiritual and divine explanations (Sadik, Bradley, Al-Hasoon, & Jenkins, 2010).

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. 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 (Trikkas & Zafirakopoulou, 1996).

Biologically, stress has been identified to be linked to mental illness. Cockerham (2007) defined stress as “heightened mind-body reaction to stimuli including fear or anxiety in an individual”. Stress alters brain function in ways that can have long term effects on thoughts and behaviours.

The biomedical explanation to mental illness has been the emphasis for intervention 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 (Mariam & A, 2016).

Scholars like Sue and Sue (1990) as well as Chowdury, Chakraborty 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 (Page, 2014).

2.7 Attitude towards mentally ill persons

Public attitudes towards mental illness are of great significance mainly because they inform the help seeking behaviour of the mentally ill and his relations (Mariam & A, 2016). In some societies, the manner to which people exhibit negative attitude towards the mentally depends on the nature of the illness. In effect, the severe the mental illness, the greater the negative attitude exhibited towards the mentally ill (Roberts, Mogan, & Asare, 2014).

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 extreme cases, not only are the mentally ill shunned, they are tagged as dangerous (Salve et al., 2013). Indirectly, the larger society extends this attitude of shunning and ridicule to friends and family of the mentally ill person.

2.8 Chapter summary and conclusion

Most of the literature revealed that the wider treatment gap that exists is largely due to community perception and social stigma (Benti, Ebrahim, Awoke, Yohannis, & Bedaso, 2016). However, these studies were done quantitatively and at the community level. The present sought to add to literature by assessing household and community perception on the integration of persons with mental illness in the Tema Metropolis.

CHAPTER THREE

METHODS

3.0 Introduction

This chapter outlines the steps and procedures that was followed in obtaining data and analyzed for the study. These included; research design, target and study population, sampling technique, research instrument, data handling and finally ethical consideration.

3.1 Study Design

This study employed exploratory cross-sectional qualitative approach. According to Creswell (2009), qualitative research method provides a means for exploring and understanding the meaning individuals give to a social problem. This approach was therefore adopted to provide subjective responses to the research questions of this study. It provided an in-depth understanding of the behaviours and perceptions of the community towards mental illness.

3.2 Study Location

The study was carried out at Tema Community-Two (Podoku). The community is located in the Tema Metropolis. The Tema Metropolis is a coastal district situated about 30 kilometers East of Accra, the Capital City of Ghana. It shares boundaries in the northeast with the Dangme West District, southwest by Ledzokuku Krowor Municipal, north-west by Adentan Municipal and Ga East Municipal, north by the Akuapim South District and south by the Gulf of Guinea. The Metropolis covers an area of about 87.8 km² with Tema as its capital. Tema community two is amongst the many suburbs within the metropolis. According to statistics data from Population Housing Census PHC (2010) there are about 22,547 people living within the Tema Community two area, with majority of the tribes

being Akans(Fantes),Ga and Moslems. There are various suburbs that make up the community such as Mangoase, A lang, BBC, Italian Flat, J Country, and Kasadjan.

The Community Two was chosen for the study because of the location of the polyclinic with a community psychiatric unit that sees about 5-12 client in a day. In 2016 the unit saw 85 new cases and 98 new cases in 2017. Old and new cases for 2016 and 2017 were 170 and 165 respectively. Usually family members accompany their relatives to the facility for medication and consultation.

3.3 Study Population

A target population comprises a group of individuals or subjects which serve as the main focus of a scientific query from which a sample is selected for a study (Castillo, 2009). For this study, it consisted inhabitants of community Two who were aged 18 and above who had relatives with mental illness and visit the Tema Polyclinic. In addition, community members who lived in the same neighborhood with the persons with mental illness were also included for the community perceptions.

3.4 Sampling Technique

Purposive sampling was used to select the participants who could provide the relevant information for the study, based on their unique characteristics, experiences and knowledge. The unique characteristics of the participants included persons who had regular encounter with persons with mental illness. 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 (care takers), who were not suffering from mental illness and had been residents in the Two Community. The selection

criteria became necessary because, the adult household heads were the care takers of these clients. Hence, their views were likely to affect views of other members of the particular household. Secondly, the researcher also selected participants from the community that are close neighbors to persons with mental illness.

In order to select a sample from the population, the researcher went to Tema Polyclinic (Psychiatric Unit) where mentally ill persons visit together with their relatives and the nurses at the facility led me into the homes where these clients lived, within the selected community. Every household heads were willing to be part in the study. This made it easier for number of sample required for the study was arrived at. For the focus group, participants were sampled from the neighborhood that was closer to the client's (those with mental illness) houses and various individuals approached were willing to part take in the study. This made it easier to get all participants at one place. The venue was scheduled for meeting during which members of the group were briefed about the study and the number of participants needed for the study. Most of the interviews were held at the participant homes and neighborhoods. Individuals who opted to be part of the study became the sample that was used.

3.4.1 Inclusion Criteria

All residents within the Tema Community Two area who accompany the mentally ill relatives to the clinic who were above age 18, and persons within the community who had regular encounter with persons with mental illness and were of sound mind were included in the study.

3.4.2 Exclusion Criteria

All residents of Community Two who were below age 18, mentally not stable to communicate.

All residents of Community Two who did not have any relative and/or ally with mental illness were excluded from the study.

3.5 Sample size

Given that this study was qualitative, the sample size was not pre-determined. However, those that fell within the inclusion criteria and consented to participate were included till a saturation point was reached where responses become repetitive. There were ten individual participants from the community who were interviewed both house hold heads and community members. The focus groups were made up of community members where these client lived, there were four focus group in all with seven participant in each group in all thirty eight people were interviewed.

3.6 Data Collection

The primary data for this study were collected through in-depth interviews. In-depth interviews provide a platform for participants to share their experiences, knowledge, attitudes and perception about mental illness as well as integrating persons with mental illnesses back into the community.

The in-depth interview was carried out in the homes of the participants. Household heads were approached to seek their participation in the study. Participants were given the privilege to choose a place of convenience within their home environment where the interview was carried out. Once a place was identified, participants sat comfortably with

the researcher. A recorder was placed on a table in-between the participant and the researcher. The interviews were made informal and conversational as possible so as to allow the participants the flexibility to say more, while the researcher delves into information provided. Field notes were taken in the course of the interview process. Facial expressions, gestures and how participants react to the questions posed was noted and interpreted. Each of the interview process lasted between a periods of 20-45 minutes. A focused group discussion was conducted among members of community groups. An introductory letter was presented to the leader of the youth groups spelling out the intention of the researcher and the objectives of the study. Once the letter was received, a date was set for the meeting where the members of the groups were briefed on the study. Seven group members were selected in each of the focus groups with their names and contact details written down. A date and time of convenience was agreed upon for the focus group discussion which was carried out. A recorder was used to record the data that was collected. In addition, field notes were collected. Gestures, facial expressions, tone of voices were well taken notice of while maintaining eye contact with all participants in the course of the interview. The focus group context provided a key opportunity to explore difference and diversity of individual participants. Questions such as how many times relatives visit the health facility, what are some of the challenges they face from the community members, and where these people stay. Data were collected for a period of one month and at end each interview section data was transcribed.

3.7 Data Analysis

Data from the FDGs and IDIs were analyzed thematically. This involved familiarization with the transcribed data. Information transcribed were read over repeatedly to become immersed and familiar with its content and to generate themes.

Coding was done by generating succinct labels that identify important features of the data that might be relevant to answering the research question. Themes from the focus group discussions were analysed with Nvivo 11, 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. The themes used to code data from the FDGs and IDI was coded and copied into Microsoft excel. Codes such as F which represented female, M which describes males and FGRESP which also represent Focus group participant or respondent were all use in the spreadsheet for further analysis.

3.8 Ethical consideration

Approval of the study was sought from Ghana Health Service Ethics Review Committee (GHS-ERC). Following this, permission was sought from the District Authorities including the assembly heads in the community before undertaking the study.

3.9 Participant consent

Similarly, every respondent was approached to express consent prior to participation. Before participants were interviewed, each was given a consent form to read and sign. For those who cannot read and sign, consent was read to them in the language that they prefer data were collected.

3.10 Privacy & Confidentiality

All respondents were given assurance that any information they provide was strictly to be used solely for academic purposes and information collected was handled with the strictest confidentiality. It will not be shared with third parties not directly involved in the research. Also, they were identified by numbers instead of their names.

3.11 Risk and Benefit

Respondents were assured that although there are no risks associated in participating in this study, they had the liberty to withdraw from participating if they desire to do so. They were assured that there was no foreseeable harm that may arise as a result of this study. It was explained to them that the result of the study will be beneficial in two main ways: adding to knowledge and serving as a guide to policies on stress management in Ghana as a whole.

CHAPTER FOUR

RESULTS

4.0 Introduction

The chapter presents the findings for the study. Based on the research questions, three main themes emerged. These included understanding mental health, relationship building with mental health patients, mental health integration and coping strategies. Understanding of mental health emerged as a theme through content analysis. The background information of respondents is presented, followed by the themes.

4.1 Demographic information

Thirty eight participants were selected for the study. Out of the thirty eight participants, twenty-eight participated in the focus group discussion and ten participated in the in-depth interviews. Participants were residents within the Tema Community Two area, had relations with a mentally ill patient and persons who had regular encounter with persons with mental illness.

The participants were aged between twenty and seventy-nine years. Most of the participants spoke Twi and were twenty-eight females and ten males. All participants had some form of basic education with four of the interviewees being university graduates. Apart from the students, the remaining participants were employed. Most of the participants had relations suffering with mental disorder. Majority of the participants were Christians but not married. The interviews as well as the focus group discussion were transcribed verbatim.

4.2 Organization of themes

Based on the data gathered after the in-depth interview and focus group discussions, four themes were generated. These themes comprised; description of mental illness; individual perception on mental illness; community/household perception of mental illness; mental illness integration and coping strategies.

4.3 Description of mental illness

The connotation of mental health is diverse and fraught with stigmatization because of the cultural and societal belief about the disease. Not everyone will associate with a mentally ill patient and even those who associate with them do so with extreme caution. More often than not the condition is likened to „mad“ persons on the streets. Some responses from participants about the concept of mental illness are described as follows;

“It a condition that do not allow a person to control his/herself and in his mind he does things that a normal person would not do” (F, 79yrs).

“Someone who has a brain problem that is how I understand mental illness” (F, 69 yrs)

“Someone who has been affected in the brain and it also a sickness” (F, 56yrs).

“It a condition where by the person is not able to think well compare to a normal person” (F, 34yrs).

“Let say the person’s brain is not functioning properly, for instance he or she is doing something and he thinks what he is doing is right but in actual sense what he or she is doing could be the wrong thing” (F, 21yrs).

“It means that the person is not psychologically sound or mentally fit and the person behaves abnormally” (M, 30yrs).

“Aaah to me like someone who is mentally challenged, or someone who cannot think straight for him or herself, this is my idea about mental illness” (M, 28 yrs).

“It is a disease condition that affects the functioning of the brain” (F, 25 yrs).

“Hmmm, someone who act abnormally and looks differently from the original world” (F, 24 yrs)

“It has to do with the brain for instance if there is malfunction or disorder with the brain that they do things that they are not supposed to do” (F, 20 yrs)

From the focus group discussion, some participants’ connotation of mental health after presenting them with a case scenario said;

“Yes, because he is being avoided by his friends and some relatives due to his current reactions and behaves that he puts across, makes him a mental person” (FGRESP 1)

“Yes, I think he is suffering from mental illness because some of the people in the community as moved away from the vicinity due to his regular visit to their house” (FGRESP 2)

“He has mental illness because if the people who normally visit him are all gone, then they have to send him to the psychiatric hospital (laughing)” (FGRESP 3)

“Yes, he has mental illness because his reaction towards his friend and family members shows that he is suffering from mental illness” (FGRESP 4)

“He is suffering from mental illness because he is exhibiting some traits, that are in line with people who have mental illness, and if his neighbors are moving away from him, then it means that there is something that he is doing that they are not satisfied with him, and also considering the fact that his wife and kids have all left for their safety according to the scenario” (FGRESP 5)

4.4 Individual perception on mental illness

Often times, discrimination and stigmatization emanating from the causes of mental health are as a result of negative perceptions against persons living with the mental disorders. The condition is also perceived to be spiritual and lifestyle related. The relationship individuals have with mentally ill patients is one of fear. As such, most people are likely to withdraw from building personal relationship with such persons. However, not every individual would build personal relationship with mentally ill persons. Some responses from participants during the IDI are presented below as;

“My view is that, is a big worry to the family, to the individual who is sick and also to the community in which the person stays, and the government as a whole. Sometimes is from the family, and also sickness such as Malaria, Hereditary, injuries and Trauma such as accident can cause mental illness. We Africans we have superstition because we believe that one can be attacked spiritually and that influences that one can get mental illness” (F, 79).

“My son used to follow his friends to have fun in town and by the time he returns you will see that his eyes have become reddish and when you talk to him the least thing will provoke him and he will try to hurt you. I remember he hurting my eyes

with his hands after one of his usual outings with his friends and he also started behaving abnormally, and when you talk to him he wouldn't understand or reason with you on anything. Then I started suspecting him of smoking (wee) so any time he goes out and come I would ask whether he went to smoke and he would answer NO then I would respond- you are lying you went to smoke. So I started getting worried and I discussed the issue with a police friend who then suggested I take him to the hospital for assessment and when we went we were referred to Pantang Hospital where he was seen and admitted and treated and since then he has been on medication and I have seen improvement in his behavior. It a condition that put financial burden on the family. For my son I realize he was behaving abnormally and the least thing provoked him” (F, 69)

“I think it is not a contagious disease and besides my brother does not worry at all. I think we have to help them because not all of them are dangerous. They are also human being like us” (F, 56).

“People tend to neglect people who have mental illness and the stigmatization is high. I think there should be education and people should be taught about the condition. They are also human being like us” (F, 34).

“Most often we see them as people who can harm you and they do not do the right things. Like “adwene a sei”, to wit “someone who's brain is malfunctioned or spoilt”. Well, most often when you see them, they are dirty, and even the way the talk and eat and also the way they dress can let you know that this person is mentally ill. Notwithstanding, there are others who also put on suit or even dress

neatly and nicely and go to work or office that also have mental problem” (M, 28).

“I see them as people who are crazy. They do things that any how and they do not have a mind to think about the things they do” (F, 24).

“It is not a good illness and they are seen as mad people, which is sometimes attributed to spiritual believe. I see them as people who are sick. They do things anyhow and they do not have a mind to think about the things they do” (F, 20)

From the focus group discussion, some participants’ views/perception on mental illness after presenting them with a case scenario. The case scenario asked whether the behaviours exhibited towards him were appropriate and the causes of mental illness. They responded by saying;

“No, because they see him as a mad person and also want to avoid him. Drug abuse like Marijuana, also cocaine all these substances cause mental illness” (FGRESP 1).

“I also think it is not appropriate because something like that can even worsen the situation, but rather such a person needs love, and also try to help him emotionally and not to neglect him, try to seek medical care for him. I think family history and excessive depression” (FGRESP 2)

“Evil eyes, because there are wicked people around us all the time (those who wish bad for people) It isnot appropriate, because with such a person you don’t know what may happen, because any one who is not correct can even do something bad to you at any time so staying away from him is good” (FGRESP 3)

“It wasn’t appropriate, because someone suffering from mental illness needs his family around and other people to help him overcome the condition. Drug abuse and brain disorders” (FGRESP 4)

“Mmmm, I don’t think it is appropriate because, they need to be supported, so that they know that the people around them are supportive. The wife should have stayed to take care of her husband but could have taken the children away for their safety precaution. The friends too should have shown support to the man because it is likely his condition was not that extreme. I think stress can cause you to have mental illness and also drug abuse and pressure, basically are things that can cause mental illness” (FGRESP 5)

4.5 Community/household perception on mental illness

Individuals suffering from psychological disorders live in communities as such, it was imperative to how they are accepted and/or rejected by friends and people in the Tema community two. Due to misconceptions about mental illness, persons with mental illness are robbed of the opportunities that define quality life, which include affiliation with friends and community members. Contrasting responses were recorded. Below are some responses from participants who agreed to live with mentally ill persons:

“Oh I have one in my house so I have taken him as a friend he is even my elderly child,” Erh” all the siblings are not around me now, so it is this person who is mentally ill who is helping me out in the house. What I do is that on days that I think he is mentally sound I benefit from him, so we should not neglect them totally or render them useless but we should rather take them to the hospital

so they can be given medications to control them, because they are also human beings and we shouldn't regard them as persons with no benefit.

Ooh why not, I can live with the person in the same neighborhood” (F, 79).

“Yes I would, oh he is also a human being it is just the brain that has being affected in a way, and when you talk to him you can realize is not as bad as it seems. I can live with him because my brother is not a troublesome person” (F, 56).

“Yes, because in the society we are all one and you need to assist the person, so I can manage and live in the same community with the person, but not as a friend” (M, 30).

Yes I can because I have a relative with a similar problem (F, 69)

“Yes I actually live in the same house with one, though at times it is not easy but when people begin to know then it becomes a problem there are some who are also dangerous, I remember we use to live in the same us with one initially we didn't know he had the condition until one time when he almost killed someone before the mother told us about it” (F, 34).

Though most agreed to live with mentally ill persons in the community, they were skeptical. Participants disclosed the following;

“It will depend on how low or high the person's condition is, sometimes you know people who are mentally challenged and you can pass by them without any issues

and also know the way they react. There is one in my area the way he even throws sticks you will be even scared to go close to him” (F, 34).

Yes, but it will depend on the state of the person (F, 20).

“She breath in” ok you can live in the same community, but you have to be careful, for my grandmother we don’t allow her to go out often even if she does we monitor her movement (F, 21).

“Well, I will live, but I will still be very very careful. For the neighborhood yeah, because see them all the time” (M, 28).

“No, because they can easily hurt you due to the fact that their brains are not functioning properly. As such, I wouldn’t feel comfortable” (F, 24)

From the focus group discussion, some participants’ views/perception on mental illness after presenting them with a case scenario. The case scenario asked whether they can live in the same community/household with mentally ill persons. Only a handful of participants agreed to live with mental patients. They responded by saying;

“Yes, because he is a human being like us, you can get closer to him and offer him some assistances rather than avoiding him” (FGRESP 1)

“If his situation or condition is not severe then I can live with the person, but if it is severe I can’t” (FGRESP 4)

Some participants who vehemently declined to live with mentally ill persons said the following;

“For a fact No, Mmmm, I will fear for my life, but if the situation is not so severe then I can manage (FGRESP 2)”

“I don’t think I can live with him. No me I can’t live with him because I would be afraid that he can take something and hurt me.” Aaah a mad personNo” Laughing. (FGRESP 3)”

“Honestly, I don’t think I can live with him, but if the person is close to me then I think I would have to support him and try as much as possible to make him feel better about himself by sending him to the psychiatric hospital for some treatment” (FGRESP 5).

4.6 Mental illness integration

Public attitudes towards mental illness are of great significance mainly because they help inform the healthseeking behaviour of the mentally ill and their relations. In some societies, the manner to which people exhibit negative attitude towards the mentally depends on the nature of the illness. In effect, the more severe the mental illness, the greater the negative attitude exhibited towards the mentally ill (Roberts, Mogan, & Asare, 2014). Generally, mental illness evokes a sense of shame from friends and families of those affected. On whether participants were willing to „mingle“ with mentally persons, below are some responses from participants;

“Because they know him in the area, some of the community members are not afraid of him but others are also not comfortable living with him in the community” (F, 79)

“I would say they do not accept them in the community. From someone’s story a girl who had a relative who was mentally ill was not able to get married because the community members knew the brother was sick, and no man wanted to marry her because of that. So they don’t accept them and at times you can’t even go for social gathering because of the stigma they associate with you” (F, 34).

“I think we should encourage the person and also advise him or her and we shouldn’t let them feel unwanted or neglected, but always try to get them close because not all of them are harmful” (F, 21).

“Ok my understanding is that when you say integration it means a mental person living in the society with people who are normal, so I think we all form part of the society so they should be accepted in the society and shouldn’t be rejected because they are not mentally sound” (M, 30).

“Aaah, if mingling with them in the society is not going to cause any problem, then I have no option, but if they are going to be problematic to the society then I think they should be confined in the psychiatric homes. “Laughing”, for example if you bring someone from the psychiatric home and later you see that they have gone naked on the street then these people must be kept in the hospital” (M, 28).

“Well, there are different forms of mental illness so those that are not harmful can be assisted in the community so that they can recover faster” (F, 20).

“I think they shouldn’t be allowed to mingle with normal people in the community because they can harm us” (F, 24).

4.6 Coping strategies

Mental illnesses expose victims to stigma-induced identity threats. People cope with this threat in a number of ways. While some of the efforts in coping with this stress are primarily problem focused, others focus on their emotions. Coping strategies are in most cases expressed as „engaging“ and „disengaging“. The engaging strategy involves fighting the stigma-induced identity threat whereas the disengaging strategy involves avoiding the source of stigma-induced identity threat. Commenting on the strategies families and the community has instituted for mentally ill persons to cope favorably in the community, the following were disclosed;

“There are no services available for them in my community, except the hospital (Tema Polyclinic) where he goes to take his drugs. I think educating the public can reduce the perception people have about mental illness” (F, 79)

“There is nothing like that here to help him recover. Mmmn, if the government can look for a job for them to do, that will help because at the moment all he does is to eat and sleep. So I told the nurses and I was advice to look for something for him to do. So now I have given my provision shop to him to run which he manages it very well” (F, 69).

“There are no services available, beside I have not seen one yet in the community. My brother is not troublesome, but I believe with public education people will accept them in the community” (F, 59).

“There is nothing available for us to access. A rehabilitation center can help and also public education about mental illness” (F, 34).

“No services. Well, education through the schools, For example an NGO came to my church and educated us on mental illness and we were taught on how to associate ourselves with them and that we shouldn’t stigmatized them, since then I got to know that everyone is at risk of developing mental illness” (M, 28).

“No services available. Educating the general public about the causes, how mental illness comes about and how to live with these people then we will be good to go” (F, 25).

From the focus group discussion, some participants’ views/perception on ways for mental health persons to cope after presenting them with a case scenario was gathered. They disclosed the following;

“I think the government should provide more facilities and more education on mental health issues” FGRESP 1.

“I think they need to be taken care of very properly, and they have to send them to the hospitals and the government should provide more drugs for their treatment” I think people suffering from mental illness should be taken to the psychiatric hospitals for them to get treatment” FGRESP 3

“Mental awareness should be taken seriously, because the more people know about it the less they discriminate anybody who is suffering from any kind of mental illness” (FGRESP 4).

Also rehabilitation centres should be built across the country” (FGRESP 5)

CHAPTER FIVE

DISCUSSION

5.0 Introduction

The purpose of this study was to assess household and community perceptions on the integration of persons with mental illness in the Tema Metropolis. Specifically, the researcher examined how people perceive mental illness and explored community perceptions towards integration of persons with mental illness and support mechanism on integration of persons with mental illness.

5.1 Individual perception on mental illness

The responses from participants clearly indicate that due to the irrational behavior of mentally ill persons, some persons with mental illness are scoffed and others discriminated against. In addition, the results showed that families and friends are financiallyburdened with providing quality care for mentally persons. Again, the responses indicated that the condition is not curable and had spiritual connotations. However, it was unearthed that mentally ill persons are „cool“ to associate with especially when they are in their „normalized“ state of mind. Though, they (mentally ill persons) can be nuisance, the responses indicated they are humans just like any other person and should be provided the required resources to facilitate their living and wellbeing. By implication, individuals have „mixed“ perception about mental illness in Tema community two.

The results corroborate the WHO (2004) reports that individuals stand the risk of being discriminated against if they are identified to be suffering from a mental illness.

Undoubtedly, the social context of illness has direct effect on whether the condition will be stigmatized or otherwise (Griffiths et al., 2006). The general misconception about mental illness, for instance that they cannot be cured or the inefficiency of drug treatment is what remains in the minds of many people in populations (Todor, 2013).

Additionally, Al-Naggar (2013) argues that the multiple consequences that result from negative perceptions of mental illnesses could prevent persons with mental illness from fully living and could serve as a barrier to proper care. In this study, it was found that some family members perceived mental ill persons as dangerous and incapable of engaging in daily activities. The finding further corroborates other research findings which suggest that people's attitudes towards persons with mental illness often include beliefs that they are dangerous and less capable when compared with the general population (Al-Naggar, 2013; Coker, 2005; Gureje, *et al.* 2005). However, it is important to mention that there could be people in the general population who are dangerous and incapable though may not have been diagnosed with mental illness.

5.2 Community/household perception on mental health

As indicated by the participants, establishing a harmonious relationship with mentally ill persons in the community is difficult, because of the irrational behavior of these persons. However, the result indicated that a cordial relationship could be established. It was further discovered that mentally ill persons were shunned by community members so as to assert to being stigmatized and discriminated against. Households "had to accept them because of their close relation with them. By implication, community has a negative perception with mental health.

The results resonates similar studies undertaken on community attitudes in West Africa which showed widespread negative views towards mental illness and the belief that persons with mental illness are not suitable for normal social contact (Gureje et al., 2005). Similar perceptions were held by community members included in this study. These negative perceptions are likely to account for the social distancing and isolation that people with mental disorders experience and could also make people unfamiliar with the realities of sufferer's experiences and illness (Crisp, *et al.* 2000).

In many African countries, including Ghana, people's attitudes towards mental illness are influenced strongly by social and traditional norms that are in turn informed by historical, cultural and symbolic practices such as beliefs in supernatural causes (Read et al., 2009). Many Ghanaians view persons with mental illness as dangerous, violent and unpredictable. This is usually due to inadequate mental health resources, lack of money and stigma associated with mental illness and psychiatric treatment (Barke et al., 2011; Rosenberg, 2002).

5.3 Mentally ill integration

For reasons of not knowing how a mentally ill person will react to a „joke“ or sarcastic comments, it is near impossible to wholly accept them as bonafide part of the community. As indicated by some participants, allowing mentally ill persons to mingle with cognizant persons because they could be harmful. Public attitudes towards mental illness are of great significance mainly because they inform the help seeking behaviour of the mentally ill and his relations (Mariam & A, 2016).

In some societies, the manner to which people exhibit negative attitude towards the mentally depends on the nature of the illness. In effect, the severe the mental illness, the greater the negative attitude exhibited towards the mentally ill (Roberts, Mogan, & Asare, 2014).

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 extreme cases, not only are the mentally ill shunned, they are tagged as dangerous (Salve et al., 2013). Indirectly, the larger society extends this attitude of shunning and ridicule to friends and family of the mentally ill person.

5.4 Coping strategies

Coping strategies are in most cases expressed as „engaging“ and „disengaging“. The engaging strategy involves fighting the stigma-induced identity threat whereas the disengaging strategy involves avoiding the source of stigma-induced identity threat (Verelst et al., 2014). There was no laid process, practices and procedure by community leaders to help mentally ill persons blend with „normal“ persons in the community. How these persons survive and/or cope are the sole responsibilities of their families. This situation as per the results emanates from the poor knowledge people have about mental illness.

The results corroborate that groups of people who suffer stigmatization, one way or the other may cope with the threat to their self-esteem by blaming the outcome. Another way in which the stigmatized cope with identity threat is by withdrawing their efforts and or disengaging their self-esteem from domains in which they are negatively stereotyped or

fear being a target of discrimination (Kazantzis, Wakefield, Deane, Ronan, & Johnson, 2009). They sometimes cope with identity threat by approaching, or identifying more closely with their group (Egbe et al., 2014). Groups can provide emotional, informational, and instrumental support, social validation for one's perceptions, social consensus for one's attributions, and a sense of belonging. Group identification is positively correlated with self-esteem among stigmatized groups (Ofori-Atta et al., 2010)

5.5 Limitations of the study

A qualitative method was used primarily to solicit the views and experiences from a small number of participants in a large community. This presents the challenge of selection bias as participants were purposively selected to represent the thoughts and mouth piece of the entire community.

Only one community in the Tema community two was used as a unit for data collection and this community could not reflect the thoughts and opinions of the entire community. Though, the perceptions and beliefs of participants were delved into via IDI and FGD, it was restricted to only thirty-eight participants. This cannot be extended to represent the entire population in the community.

Another limitation encountered was the selection of participants. Using nurses that work in the facility Tema Polyclinic (Psychiatric Unit) where mental patients and care givers received care led to participants consenting to participate in the study and this posed bridge of trust.

Only parents were selected as representation to the perception, integration and coping strategies about mental illness at the household level. Preferably, every individual in the household should have been interviewed. This was hampered by the lack of time and

funds. Therefore, the results may not accurately represent the community's perspectives as a whole.

CHAPTER SIX

CONCLUSION AND RECOMMENDATION

6.1 Conclusion

The results indicate a mixed reaction of attitude towards mental illness among participant. Though there is knowledge on mental illness, people always have drawbacks to integrating or mingling with persons with mental illness into society. Notwithstanding, some are also willing to accept them into society

6.2 Recommendations

As part of measures that needs to be taken, educating the public about mental health promotion and increasing awareness campaign through the media and schools regarding the nature of mental illness and also promote acceptance by the community.

There should be provision of more psycho-social rehabilitation centres, including some form of homes at mental health facilitates at the community level. This is needed to protect the community from the potential threat posed by the mental ill patients.

In addition, more personnel from the community must be trained to manage these centres. This will help break the gap between the community members and mental ill patients and it will also help people to recover from mental health problems and give the skills and confidence to live successfully in the community.

This will also help to facilitate launching of the rehabilitation centres in the communities to decrease social restrictive view of the community as well as serve better treatment and reduce stigmatization.

REFERENCES

- Atilola, O. (2016). Mental health service utilization in sub-Saharan Africa: is public mental health literacy the problem? Setting the perspectives right. *Global Health Promotion, 23*(2), 30–37. <http://doi.org/10.1177/1757975914567179>
- Al-Naggar, R. A. (2013). Attitudes towards persons with mental illness among university students. *ASEAN Journal of Psychiatry, 14*(1).
- Barke, A., Nyarko, S., & Klecha, D. (2011). The stigma of mental illness in Southern Ghana: Attitudes of the urban population and patients' views. *Social Psychiatry and Psychiatric Epidemiology 46*, 1191–1202.
- Benedicto, M., Mndeme, E., Mwakagile, D. S. M., & Mwansisya, T. E. (2016). Community Knowledge, Attitudes and Perception towards Mental Illness in Dodoma Municipality, Tanzania. *ARC Journal of Public Health and Community Medicine, 1*(3), 2456–596. <http://doi.org/10.20431/2456-0596.0103002>
- Benti, M., Ebrahim, J., Awoke, T., Yohannis, Z., & Bedaso, A. (2016). Community Perception towards Mental Illness among Residents of Gimbi Town, Western Ethiopia. *Psychiatry Journal, 2016*, 1–8. <http://doi.org/10.1155/2016/6740346>
- Coker, E. (2005). Selfhood and social distance: Toward a cultural understanding of psychiatric stigma in Egypt. *Social Science & Medicine. 61*, 920-930.
- Crisp, A. H., Gelder, M. G., Rix, S., Howard, I., Meltzer, H. I., & Rowlands, O. J. (2000). Stigmatization of people with mental illnesses. *The British Journal of Psychiatry, 177*, 4-7.
- Egbe, C. O., Brooke-Sumner, C., Kathree, T., Selohilwe, O., Thornicroft, G., & Petersen, I. (2014). Psychiatric stigma and discrimination in South Africa: perspectives from key stakeholders. *BMC Psychiatry, 14*(1), 191. <http://doi.org/10.1186/1471-244X->

14-191

- Florence, A. (2015). University of Ghana perceptions and attitudes towards mental illness : the case of pantang community this thesis is submitted to the university of Ghana , legon in partial fulfilment of the requirement for the award of mphil social work degree.
- Griffiths, K. M., Nakane, Y., Christensen, H., Yoshioka, K., Jorm, A. F., & Nakane, H. (2006). Stigma in response to mental disorders: a comparison of Australia and Japan. *BMC Psychiatry*, *6*(1), 21. <http://doi.org/10.1186/1471-244X-6-21>
- Gureje, O., Lasebikan, V. O., Ephraim-Oluwanuga, O., Olley, B. O., & Kola, L. (2005). Community study of knowledge of and attitude to mental illness in Nigeria. *British Journal of Psychiatry*, *186*, 436-441.
- Jupe, T., Elezi, F., Zenelaj, B., & Myslimi, E. (2017). Stigmatization of mental health problems in Albania, ways of diminishing it. *European Psychiatry*, *41*, S573–S574. <http://doi.org/10.1016/j.eurpsy.2017.01.850>
- K, G. (2011). Knowledge and Attitude of Mental Illness Among General Public of Southern India. *National Journal of Community Medicine*, *2*(1), 175–178.
- Kazantzis, N., Wakefield, A., Deane, F. P., Ronan, K. R., & Johnson, M. (2009). Public Attitudes Toward People With Mental Illness in New Zealand, 1995–1996. *Australian Journal of Rehabilitation Counselling*, *15*(2), 74–91. <http://doi.org/10.1375/jrc.15.2.74>
- Mariam, M. G., & A, B. (2016). Knowledge, Attitude and Factors Associated with Mental Illness among Nurses Working in Public Hospitals, Addis Ababa, Ethiopia. *Journal of Mental Disorders and Treatment*, *2*(1), 1–5. <http://doi.org/10.4172/2471->

271X.1000108

- Ofori-Atta, a, Read, U. M., & Lund, C. (2010). A situation analysis of mental health services and legislation in Ghana: challenges for transformation. *African Journal of Psychiatry*, 13(2), 99–108. <http://doi.org/10.4314/ajpsy.v13i2.54353>
- Page, D. (2014). Changing Conceptualisations of Mental Illness and Exclusion : Revisiting the concept of Stigma? *Centre for Employment Studies Research, University of West of England, Bristol*, 1–13.
- Pahwa, R., Daly, K. A., Brekke, J. S., & Ph, D. (2013). NIH Public Access, 64(7), 1–14. <http://doi.org/10.1176/appi.ps.201200235>. Experiencing
- Read, U. M., Adiibokah, E., & Nyame, S. (2009). Local suffering and the global discourse of mental health and human rights: An ethnographic study of responses to mental illness in rural Ghana. *Globalization and Health*, 5(13), 1-16.
- Roberts, M., Mogan, C., & Asare, J. B. (2014). An overview of Ghana ‘‘s mental health system: results from an assessment using the World Health Organization ‘‘ s Assessment Instrument for Mental Health Systems (WHO-AIMS), 8(1), 1–13. <http://doi.org/10.1186/1752-4458-8-16>
- Rosenberg, D. (2002). It also takes a village. Developing community mental health. *International Social Work*, 45, 305-314
- Sadik, S., Bradley, M., Al-Hasoon, S., & Jenkins, R. (2010). Public perception of mental health in Iraq. *International Journal of Mental Health Systems*, 4(1), 26. <http://doi.org/10.1186/1752-4458-4-26>
- Salve, H., Goswami, K., Sagar, R., Nongkynrih, B., & Sreenivas, V. (2013). Perception and attitude towards mental illness in an urban community in South Delhi - A

- community based study. *Indian Journal of Psychological Medicine*, 35(2), 154.
<http://doi.org/10.4103/0253-7176.116244>
- Sebastian, J., & Richards, D. (2017). Changing stigmatizing attitudes to mental health via education and contact with embodied conversational agents. *Computers in Human Behavior*, 73, 479–488. <http://doi.org/10.1016/j.chb.2017.03.071>
- Shrivastava, A., Bureau, Y., & Johnston, M. (2012). Stigma of Mental Illness-1: Clinical reflections. *Mens Sana Monographs*, 10(1), 70. <http://doi.org/10.4103/0973-1229.90181>
- Tawiah, P. E., Adongo, P. B., & Aikins, M. (2015). Mental Health-Related Stigma and Discrimination in Ghana: Experience of Patients and Their Caregivers. *Ghana Medical Journal*, 49(1), 30–6. <http://doi.org/10.4314/gmj.v49i1.6>
- Tibebe, A., & Tesfay, K. (2015). Public Knowledge and Beliefs about Mental Disorders in Developing Countries: A Review. *Journal of Depression and Anxiety*, s3. <http://doi.org/10.4172/2167-1044.S3-004>
- Todor, I. (2013). Opinions about Mental Illness. *Procedia - Social and Behavioral Sciences*, 82, 209–214. <http://doi.org/10.1016/j.sbspro.2013.06.247>
- Trikkas, G., & Zafirakopoulou, K. (1996). The opinion about mental illness, with respect to general psychopathology and personality characteristics, in a sample of subjects of a small greek island. *European Neuropsychopharmacology*, 6, S4-165. [http://doi.org/10.1016/0924-977X\(96\)83097-5](http://doi.org/10.1016/0924-977X(96)83097-5)
- Verelst, A., De Schryver, M., De Haene, L., Broekaert, E., & Derluyn, I. (2014). The mediating role of stigmatization in the mental health of adolescent victims of sexual violence in Eastern Congo. *Child Abuse and Neglect*, 38(7), 1139–1146.

<http://doi.org/10.1016/j.chiabu.2014.04.003>

Vos, M. de, Graafmans, W., Kooistra, M., Meijboom, B., Voort, P. van der, & Westert, G. (2009). Using quality indicators to improve hospital care: a review of the literature. *International Journal for Quality in Health Care: Journal of the International Society for Quality in Health Care / ISQua*, 21(2), 119–29.
<http://doi.org/10.1093/intqhc/mzn059>

APPENDIX 1: INFORMED CONSENT

Topic: HOUSEHOLD AND COMMUNITY PERCEPTIONS ON THE INTEGRATION OF PERSONS WITH MENTAL ILLNESS IN THE TEMA METROPLIS

Introduction

My name is Bertha Smith, a student of University of Ghana, School of Public Health. I am conducting a study on “Household and Community Perceptions on the integration of persons with mental illness in the Tema Metropolis”.

Procedures

The study seeks to explore the beliefs, perception and attitude of households and community on mental illness and to also assess the available mechanisms for the reintegration of persons with mental illness.

Benefits

The study will help in policy making in the area of mental health and stigma prevention. It will also help in coming out

Risks/ Discomforts

The study might pose some inconveniences to you in terms of the time spent answering questions and invasion of your privacy. You are however not obliged to answer any question you are not comfortable with.

Voluntariness

You can decline or withdraw from participating if you desire. However, your participation would be very much appreciated. Participation in the study is voluntary

Confidentiality

Whatever information you provide will be kept strictly confidential and will not be shown to other persons. All forms filled will be highly secured and only members of the research team will have access to them.

Do you want to ask anything before consenting to the study? If yes,

.....
.....
.....
.....

You can contact the researcher on 0246810815 or bedina7@yahoo.com or the Ghana Health Service Ethics Review Committee Administrator (Hannah Frimpong) on 050-7041223 to seek further clarification when needed.

Consent Form

I, declare that the purpose, procedures as well as risks and benefits of the study have been thoroughly explained to me and I have understood them. I hereby agree to take part in this study.

Signature of participant/ thumbprint:

Date: / /

Interviewer's Statement

I, the undersigned, have explained this consent form to the subject in simple language that he/she understands, clarified the purpose of the study, procedures to be followed as well as the risks and benefits involved. The subject has freely agreed to participate in the study.

Signature of interviewer:

Date: / /

Address: Bertha Smith

University of Ghana (School of Public Health)

bedina7@yahoo.com

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 or a relative?

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 neighborhood with a mentally ill person? Why/Why not?

Section C

14. What do you understand by integration of mentally ill persons in the community?
15. What services are available to the mentally ill in this community?
16. What do you think can be done to facilitate integration of mentally ill persons in your community?

APPENDIX 3: Vignette for Focus Group

Discussions

Mr. Owusu 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. Owusu 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. Owusu- Why/why not?
- What services are available to him in this community /What resources are available in the community that can help Mr. Owusu?
- What suggestions or comments do we have about mental health issue?

APPENDIX 4

Table 1: .General characteristics of in-depth interviews

IDI	Sex	Religion	Age	Education	Employment
Person 1	Female	Christian	79	Tertiary	Retired
Person 2	Female	Christian	69	Illiterate	Trader
Person 3	Female	Christian	56	Primary	Trader
Person 4	Female	Christian	34	Tertiary	Health worker
Person 5	Female	Christian	21	Tertiary	Student
Person 6	Male	Christian	30	Tertiary	Contractor
Person 7	Male	Christian	28	Tertiary	Sales personnel
Person 8	Female	Christian	25	Tertiary	Nurse
Person 9	Female	Christian	31	Tertiary	Teacher
Person 10	Female	Christian	20	Secondary	Student

Table. 2 General Characteristics of Focus group discussion Characteristics of participants
FGD 1

FGD	Female Sex	Male	Religion	Age Range	Education	Employment
GROUP 1	5 females	2 male s	All Christian s	24 - 33	Tertiary	Pharmacy Technician, Martketer, Sales Personnel, Teacher
GROUP 2	4 Females	3 male s	Christian s	27-45	Secondary, Tertiary	Traders, Student, Clearing Agent, Exporters
GROUP 3	6 females	1 male	Christian s	24-37	Junior high, Secondary and Tertiary	Student, Business woman, Janitor, Shop operator,
GROUP 4	7 females	0	Christian s	30-44	Secondary, Tertiary	Hairdresser, Banker, Clearing Agent, Shop attendant