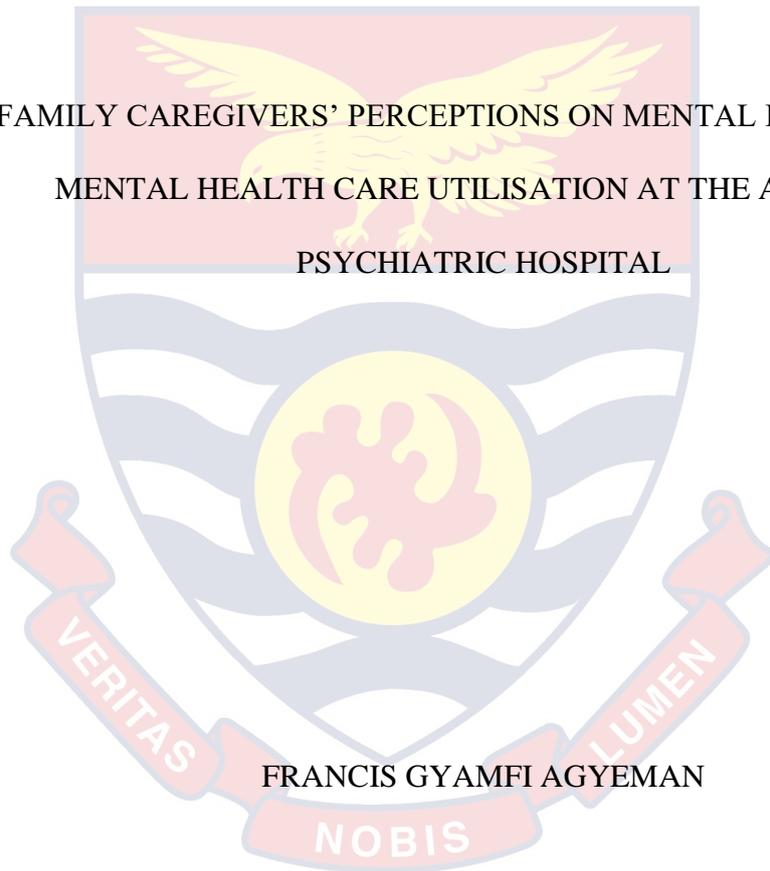


UNIVERSITY OF CAPE COAST

FAMILY CAREGIVERS' PERCEPTIONS ON MENTAL ILLNESS AND  
MENTAL HEALTH CARE UTILISATION AT THE ANKAFUL  
PSYCHIATRIC HOSPITAL



FRANCIS GYAMFI AGYEMAN

2021

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BY

FRANCIS GYAMFI AGYEMAN

Thesis submitted to the Department of Sociology and Anthropology of the  
Faculty of Social Sciences, College of Humanities and Legal Studies,  
University of Cape Coast, in partial fulfillment of the requirements for the  
award of Master of Philosophy degree in Sociology

JULY 2021

## DECLARATION

### Candidate's Declaration

I hereby declare that this thesis is the result of my own original research and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's Signature..... Date.....

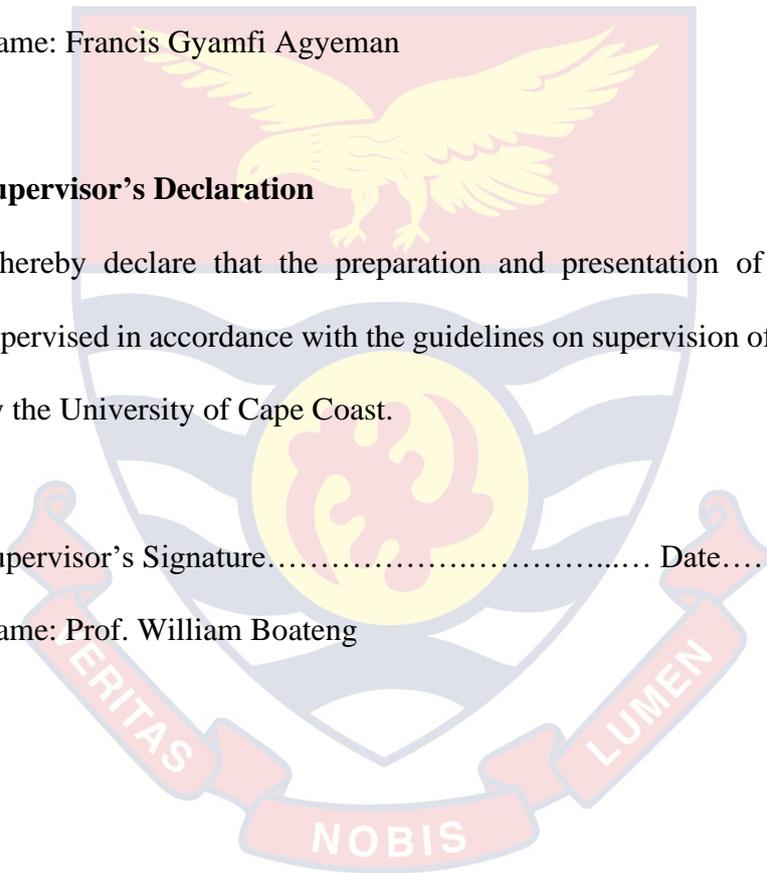
Name: Francis Gyamfi Agyeman

### Supervisor's Declaration

I hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.

Supervisor's Signature..... Date.....

Name: Prof. William Boateng



## ABSTRACT

Family caregivers' perceptions on mental illness play an important role in the recovery process of relatives with mental illness. The study examined how family caregivers' perceptions on mental illness influenced their decisions and treatment-seeking behaviours towards the utilisation of mental health care (MHC) at the Ankaful Psychiatric Hospital in the Central Region of Ghana. Using the social construction theory and the health care utilisation model, the study explored the family caregivers' perceptions on the causes and treatment of mental illness; their experiences with their relatives' condition; and how those perceptions influenced the utilisation of MHC for their mentally ill relatives. Guided by the exploratory design, the study purposively selected and interviewed 14 family caregivers who had their mentally ill relatives at the facility. Family caregivers largely attributed mental illness to supernatural factors such as witchcraft and evil spirits. As a result of their relatives' condition, family caregivers were often stigmatized and socially excluded. Although they believed the condition could be treated through spiritual consultations and healings, family caregivers utilised a combination of treatment options (herbal/traditional and orthodox treatment options) to seek wellness for their mentally ill relatives. The study recommended that the management of Ankaful Psychiatric Hospitals should form in-group support services to educate family caregivers on the possible causes and the treatment process of mental illness, and also to serve as a platform for them to share their experiences.

**KEY WORDS**

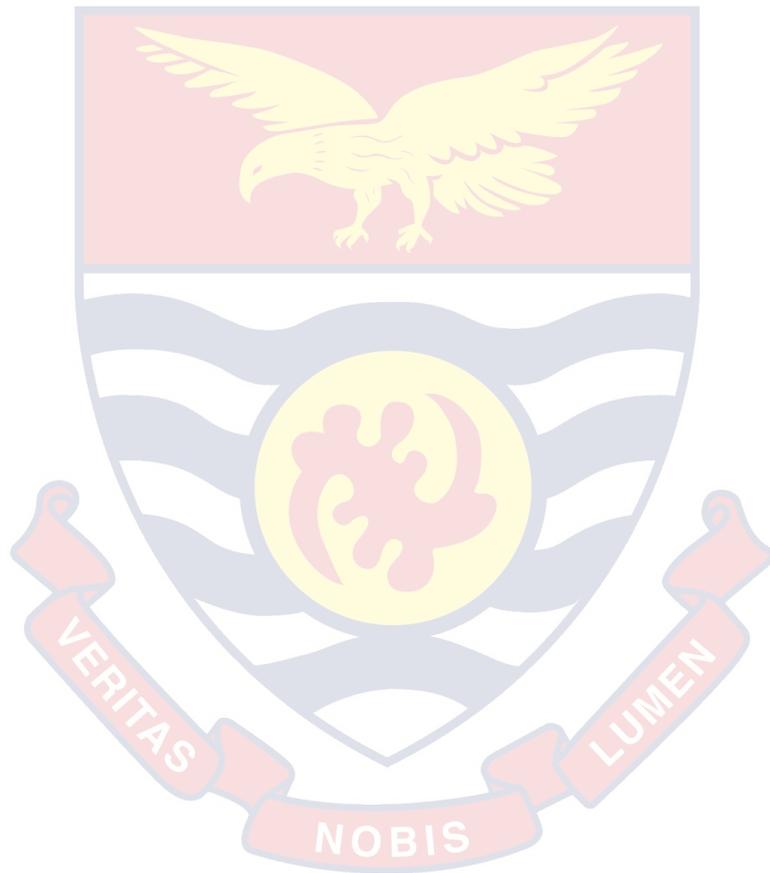
Family caregivers

Mental illness

Mental health care

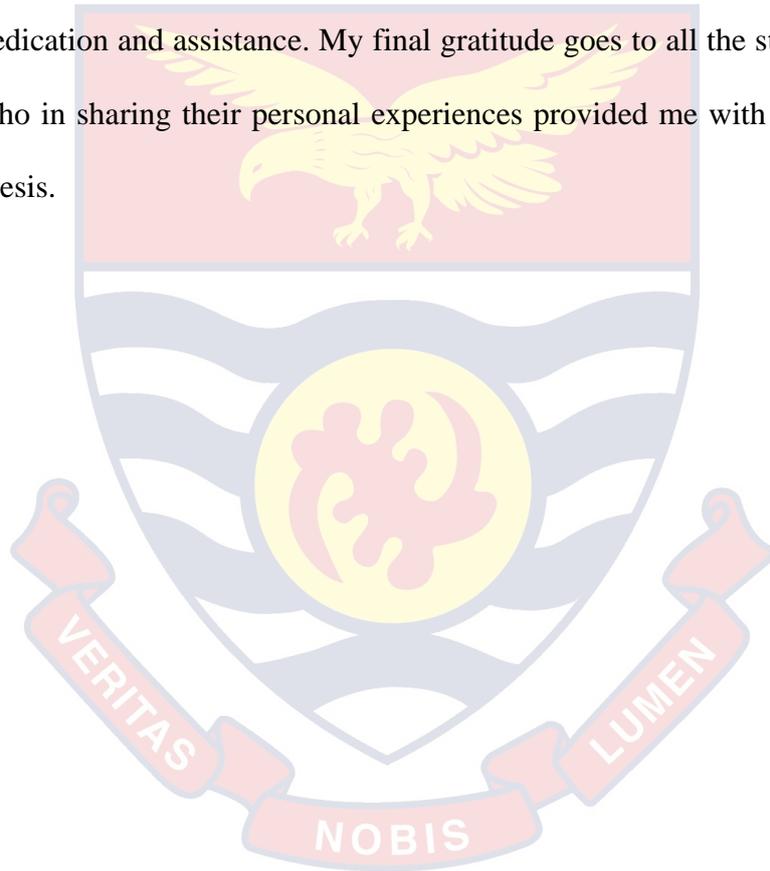
Perceptions

Treatment-seeking behaviours



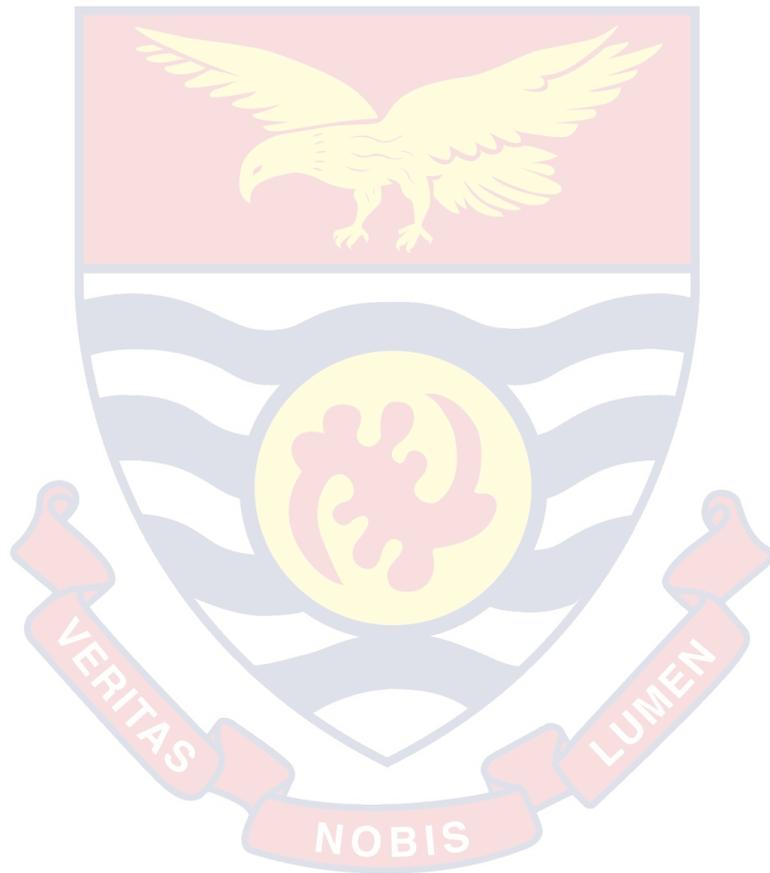
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## DEDICATION

To my parents, Rev. (Rtd.) Mathias Kwame and Mrs. Agnes Abena Agyeman



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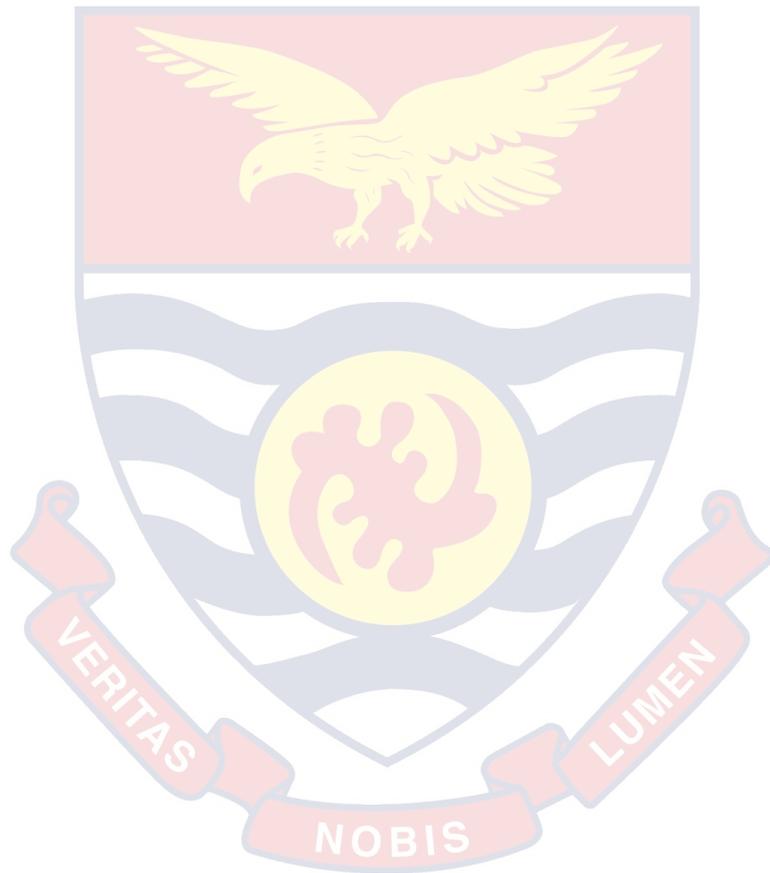
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## LIST OF ACRONYMS

CRHD	Central Regional Health Directorate
CHPS	Community-based Health Planning and Service
ERB-APH	Ethical Review Board, Ankaful Psychiatric Hospital
GHS	Ghana Health Service
IDI	In-Depth Interview
UCCIRB	University of Cape Coast Institutional Review Board
KEEA	Komenda-Edina-Eguafo-Abirim
MHA	Mental Health Authority
MHC	Mental Health Care
MHWs	Mental health workers
MoH	Ministry of Health
NGO	Non-governmental Organizations
NHIA	National Health Insurance Authority
NHIS	National Health Insurance Scheme
OPD	Out-patient Department
UK	United Kingdom
USA	United States of America
WHO	World Health Organization

## CHAPTER ONE

### INTRODUCTION

#### Background to the Study

Mental health is an essential part of human well-being. It includes our emotional, psychological, and social well-being which affects how we think, feel, and act at a point in time (Davidson & Begley, 2013). Poor mental health predisposes individuals to a variety of illnesses such as heart diseases, body aches, headaches, stomach aches, cancer, and diabetes (Kolstad & Gjesvik, 2014) which reduces the quality of life, individual productivity, and narrows opportunities for income (Osei, 2008). Individuals with poor mental health sometimes engage in social vices such as violence, drug trafficking, child abuse, paedophilia, and suicide (Silver & Teasdale, 2005). Based on the preceding consequences, it has become a global concern to promote good mental health (Saxena, Funk, & Chisholm, 2013).

Over the last two decades, the concern to promote good mental health has compelled individuals and organisations in developed regions like Europe and America to provide steps to increase access and use of mental health care (MHC) services (Goldney, Fisher, & Wilson, 2001). One of the many ways to achieve this was through improved public knowledge on the nature, dynamics, and treatment of mental disorders (Angermeyer, Matschinger, & Schomerus, 2013). The reason is that, the knowledge, perceptions, and beliefs that individuals, especially, primary caregivers (who are usually family members) have on the causes and treatment of mental illness influence their decisions to utilise MHC for relatives suffering from it (Gureje & Lasebikan, 2006).

Family caregivers play an important role in the care and healing process of relatives with mental illness (Albert & Simpson, 2015). Their role includes, among other things, the provision of emotional, physical, and financial support (Sreeja, Sandhya, Rakesh, & Singh, 2009). Based on their contributions to the care and healing processes, family caregiving to the mentally ill became a globally accepted practice after the Deinstitutionalization Policy in the United States of America (USA) in the early 1960s. The policy ensured that mentally ill patients in the various mental health institutions were discharged and integrated into their respective communities to aid responsible family care (Parker, 1993). Consequently, the policy had an enormous impact on improving the mental health status of the patients; hence this practice was generally accepted in other regions. For instance, in India, it was reported that about two-thirds (69%) of family members (caregivers) became responsible for providing care for their mentally ill relatives (Sterling, Silke, Tucker, Fricks, & Druss, 2010).

It is important to stress that persons with mental illness and their families face several challenges such as discrimination, social isolation and exclusion, human rights violations, and stigma, just to mention a few (Glozman, 2004; Prince et al., 2007). In some instances, family caregivers experience physical, emotional, and financial challenges in the process of caring for their mentally ill relatives. In other instances, they feel worried and guilty about their relatives' condition, and above all, they are distressed due to lack of support from other relatives, friends, and the society at large (Schulz & Sherwood, 2008).

The caregiver's experiences vary across gender (Pinquart & Sorensen, 2006). Women are generally socialized to nurture, provide help, and care for

others, as compared to men. Yet, there is an anticipation that family caregivers, irrespective of their gender, occupation, educational level, and other socio-demographic characteristics, do experience strain in the course of providing care for their mentally ill relatives. These experiences, together with existing belief system, personal knowledge about the illness, interaction with individuals living with the illness, and stereotypes associated with it, influence their perceptions on the cause of the mental disorder (Corrigan, Markowitz, & Watson, 2004; Read, Adiibokah, & Nyame, 2009).

Perceptions that family caregivers have on the causes and treatment of their relatives' condition are socially constructed (Wahl, 2003), and its understanding and interpretation vary from one society to another (Choudhry, Mani, Ming, & Khan, 2016). In Canada and among the Hispanic immigrants in USA, the causes of mental illnesses were attributed to social factors like drugs and alcohol misuse, and other traumatic experiences (Angermeyer & Dietrich, 2006; Cook & Wang, 2011). In Germany, however, mental illnesses like schizophrenia were attributed to biological factors (Angermeyer & Matschinger, 2005). That is, it was believed that persons suffering from conditions like schizophrenia had it through birth.

Invariably, the perceptions of family caregivers on the causes of their relatives' condition influence their treatment-seeking behaviours (Muga & Jenkins, 2008). In Pakistan, stress-related mental health problems were believed to be treated with orthodox medicines (Naeem, Ayub, Kingdon, & Gobbi, 2012). Kolstad and Gjesvik (2014) in China and Van der Ham, Wright, Van, Doan and Broerse (2011) in Vietnam also revealed that hospitalization

following medical treatment was the best treatment option for persons with mental health disorders.

In most developing countries in Africa, knowledge and perceptions regarding the causes of mental illness are largely associated with supernatural beliefs. In Uganda and Malawi, for instance, mental illnesses were attributed to supernatural causes (Abbo, Okello, Ekblad, Waako, & Musisi, 2008; Crabb, Stewart, Kokota, Masson, Chabunya, & Krishnadas, 2012). These include curses resulting from hatred or wrong done to someone, or punishment from God or the gods. Also, some community dwellers in Ethiopia perceived and attributed mental illnesses mostly to extra-human factors like possession of evil spirits (such as witchcraft) (Teferra & Shibre, 2012). More so, mental illnesses were attributed to spiritual issues like witchcraft and other evil spirits among some Nigerians (Adewuya & Makanjuola, 2008; Kabir, Iliyasu, Abubakar, & Aliyu, 2004).

In Ghana, knowledge of mental illness and its causal attributions is not so different from other African countries. Its explanation and interpretation have some underlying roots from existing cultural beliefs, norms, and practices; hence, its attribution to supernatural forces (Roberts, 2001; Rosenberg, 2002). As such, mental illness has mainly been associated with witchcraft (Ofori Atta, Read, & Lund, 2010; Quinn, 2007; Read, Adiibokah, & Nyame, 2009).

Explaining mental illness in the African context is largely based on cultural beliefs that determine the type of treatment pattern to be adopted; whether formal (medical) or informal (non-medical) (Muga & Jenkins, 2008). In Ghana, most family caregivers rely on prevailing cultural practices to respond to mental illness (Read, Adiibokah, & Nyame, 2009). Areas/places where

mental illnesses were attributed to supernatural factors utilised informal treatment options. Through that, faith and spiritual healers were consulted for cure (Choudhry & Bokharey, 2013; Fellmeth et al., 2015). Practices like prayers, recitation of sacred texts, and the use of holy water were the best options utilised in the process of healing (Hailemariam, 2015).

The utilisation of health care and services involves three main factors: predisposing, enabling, and need factors (Andersen, 1995). According to Andersen, not only enabling factors (resources available) and need factors (why an individual uses available health service) influence an individual to seek health care, but also what an individual is predisposed to (such as the social structure, socio-demographic characteristics, and health beliefs) before and during the illness play a role. Therefore, predisposing factors such as family, education, religion, society/community, sex, age, ethnic affiliations, beliefs, and values of individuals shape their thoughts on mental illness, and that play an intrinsic role in their treatment-seeking decisions. Therefore, if the goal is to improve access and use of MHC, there is the need to first understand first how individuals, especially family caregivers perceive their relatives' mental illness.

### **Statement of the Problem**

Mental health disorders constitute a major public health concern worldwide (Wang et al., 2007). This has drawn the attention of various countries' governments to take initiatives to provide adequate MHC to reduce it. However, these provisions are met with some challenges which have negatively affected the utilisation of available MHC (Dilworth-Anderson, Williams, & Gibson, 2002; Jack-Ide & Uys, 2013). This has created a huge treatment gap among most countries, with Ghana's gap recorded to be above 98

percent (Eaton & Ohene, 2016; Dako-Gyeke & Asumang, 2013). This means that 98 out of every 100 persons that develop mental disorders do not get treated.

Usually, relatives (who are caregivers) of persons with mental illness take charge of decision-making since persons with mental illness cannot make outright decisions for themselves (Livingston et al., 2010). Therefore, the perceptions family caregivers have on their relative's mental illness determine their treatment-seeking decisions and behaviours (Dow, 2011; Ofori-Atta, Reed, & Lund, 2010). Hence, some family caregivers seek treatment from informal centers (such as faith-based and herbal practitioners), while others also seek treatment from formal centers (like the hospital) for their mentally ill relatives (Ofori-Atta, Reed, & Lund, 2010). In some cases, family caregivers fallout from treatment even after their relative has been diagnosed with the condition and resort to other forms of care as a result of some existing perceptions (Edlund et al., 2002).

Therefore, over the years, several studies have examined how perceptions on mental illness influence the utilisation of available MHC (Angermeyer, Matschinger, & Schomerus, 2013; Crabb et al., 2012; Teferra & Shibre, 2012; Muga & Jenkins, 2008). In the case of Ghana, however, much attention has not been paid to examining the role that perceptions on mental illness play in utilising available MHC and that has left a gap in the literature. Although studies like Kyei, Dueck, Indart and Nyarko (2014), Ofori-Atta et al. (2010), Opare-Henaku and Utsey (2017), and Quinn (2007) have examined the perceptions and beliefs of Ghanaians on mental illness, these studies did not specifically look at how these perceptions influence treatment-seeking decisions and behaviours of family caregivers. To fill this gap, this study investigates

family caregivers' perceptions on mental illness and how it influences health-seeking decisions and behaviours for their mentally ill relatives.

### **Research Objectives**

Generally, the study investigated how family caregivers' perceptions on mental illness influence the utilisation of mental health care (MHC) at the Ankaful Psychiatric Hospital.

Specifically, the study sought to:

1. Explore the perceptions of family caregivers on mental illness.
2. Explore the experiences of family caregivers with their caregiving role.
3. Examine how family caregivers' perceptions on mental illness influence their utilisation of MHC.

### **Research Questions**

The study is guided by the following questions:

1. How do family caregivers perceive mental illness?
2. What are the experiences of family caregivers with their caregiving role?
3. How do family caregivers' perceptions on mental illness influence their utilisation of MHC?

### **Significance of the Study**

The study helps in understanding the lay perceptions associated with mental illness. This is important as it influences help-seeking decisions and behaviours of family caregivers for relatives with mental illness (Olafsdottir & Pescosolido, 2011). Also, with the responsibility of Psychiatric Hospitals: treatment, welfare, training, and rehabilitation of mentally ill patients, the study contributes to the understanding of the essence of utilising MHC and services. The study could also help these facilities to redefine their practices of improving

and strengthening their support systems for family caregivers as that could reduce treatment drop-outs. More so, the study adds to existing studies of literature in the fields of Medical Sociology and Sociology of Mental Illness.

Finally, the study could contribute to the achievement of Sustainable Development Goal (SDG) 3.4. This goal seeks to reduce premature mortality from non-communicable diseases by one-third through prevention and treatment and also promote mental health and well-being by the year 2030. This is done through the recommendations and suggestions generated from the study which could be adopted by the various stakeholders like the MHC providers, government, and Non-Governmental Organisations (NGOs) to guide in the planning and implementation of mental health programs and policies.

#### **Delimitation of the Study**

The study focused on the Ankaful Psychiatric Hospital in the Central Region, though there are two other psychiatric hospitals in Ghana - Accra and Pantang Psychiatric Hospitals, both located in the Greater Accra Region. Choosing this facility was based on convenience as its location was closer to me than the other two facilities. Also, as the Ankaful Psychiatric Hospital serves similar functions as the two psychiatric hospitals (that is, serves as a major referral facility responsible for the treatment, welfare, training, and rehabilitation of mentally ill patients), choosing it to represent the three was not farfetched from the reality.

#### **Limitations of the Study**

Although, the focus of the study was to examine how family caregivers' perceptions on their relatives' mental illness influence their decisions and behaviours on seeking treatment for them, some limitations to this work this

work have been identified. First, as the research only focused on family caregivers who were seeking treatment for their mentally ill relatives at the Ankaful Psychiatric Hospital, family caregivers who were not present at the study premises during the data collection period and also, those who sought for treatment for their mentally ill relatives from different facilities/centres, as well as those at home not seeking for any treatment at all were missed out. This could have revealed different perspectives on the phenomenon, especially considering the accounts of those who were not seeking for treatment at all for their mentally ill relatives.

Also, the study employed in-depth interviews (one-on-one) which facilitated open and candid experiential accounts for the study; but it is important to acknowledge the weakness associated with it in a qualitative study. One such limitation is the sampling technique adopted (purposive sampling technique). The adoption of this technique to specifically employ family caregivers for the study presented a level of subjectivity in the selection process. However, some inclusion and exclusion criteria were developed to guide the participants' selection which made the process scientific to reduce personal biases that could be present in the process. Finally, given the relatively small sample size, generalizing the findings to the general population of Ghana might pose a challenge.

### **Operational Definitions of Terms**

This section is concerned with identifying key concepts and defining it as how it is used in the study. Some of these concepts include:

**Family Caregiver:** A relative who actively provides physical and/or emotional care and support for a mentally ill patient.

**Perception:** Conceptualized as how formed impression about any event or situation is interpreted by people.

**Mental Illness:** It is used interchangeably with mental disorders, mental health disorders, or conditions in the study. It is a mental health condition that is characterized by alteration in mood, thought, and behaviour among individuals.

**Mental Health Care (MHC):** Services devoted to the treatment of mental illnesses as well as the improvement of mental health among mentally challenged individuals.

**Mental Health Care Utilisation:** The act of accessing and using MHC for the treatment of mental illness.

#### **Organisation of the Study**

The study is organized into five chapters. Chapter One comprises the background to the study, statement of the problem, research objectives and questions, significance of the study, delimitation of the study, limitations of the study, operational definition of terms, and organisation of the study. Chapter Two contains a review of related literature comprising conceptual, empirical, and theoretical reviews. Chapter Three focuses on a brief description of the Ankaful Psychiatric Hospital and the research methods employed for the study. Also, Chapter Four covers data results and discussion. Chapter Five focuses on the summary, conclusions, and recommendations of the study.

## CHAPTER TWO

### LITERATURE REVIEW

#### Introduction

This chapter contains a review of related studies and the theoretical underpinnings of the study on family caregivers' perceptions on mental illness and MHC utilisation in Ghana. It is divided into three sections. The first section expounds on conceptual issues on mental illness, MHC in Ghana. The second section presents the empirical review of the central tenets of the study; that is, perceptions associated with mental illness (causes and treatment), experiences of family caregivers, and perceptions on mental illness and MHC utilisation. Another important issue discussed in this section is caregiving and the caregiver; the role of family caregivers. The third section discusses the review of the theoretical underpinnings of the study. The social construction theory and the health care utilisation model were discussed as theories underpinning the study.

#### The Issue of Mental Illness

Mental illness is a disabling chronic condition that exposes its victims to the risk of other health problems (Prince et al., 2007). It is often used interchangeably with mental disorders or conditions. According to Johnstone (2001), "it is a mental health condition that affects the mood, thinking, and behaviour of its victims". Jenkins (2018), on the other hand, defined mental illness as a situation in human life that is interpreted from subjective perspectives. Consequently, the issue of mental illness has been a subject of discussion because of how it is understood and interpreted.

Before the 17<sup>th</sup> century, persons with mental illnesses were pronounced as “mad” as a result of some behaviours that they exhibited (Zechmeister, 2005). They were either cared for by their families or set loose to move freely. Later in the 18<sup>th</sup> century, a strategy was developed to remove all mentally ill persons from the street. As a result, “mad” persons, criminals, and the poor in the society were ascribed similar status and were kept in custodial care, like an asylum (Zechmeister, 2005).

Later, separate places were established to address the respective needs of these categories of persons. For instance, mental asylums were established for the mad/insane; prisons were also established as punishing houses for criminals; and 'working-houses' for the poor (Zechmeister, 2005). According to Zechmeister, the onus for admission and discharge regulations lied with the judiciary rather than medical professionals. Also, the reasons for confinement were on morality rather than medical. Therefore, it was conceived during the period that exhibiting some form of insanity and at the same time belonging to the opposition group constituted madness. For this reason, inmates were kept in chains and straitjackets (Majerus, 2017).

The growth of public health education in the 19<sup>th</sup> century led the majority of people to understand mental illness as an ill-health condition that is treatable (Van Eeuwijk, 2006). As such, forms of mental illnesses like depression, schizophrenia, stress or trauma-related disorders, and addictive behaviours were identified among inmates. They were then freed from their chains and straitjackets for treatment (Albee & Joffe, 2004). In the past few years, studies have reported a global increase in mental health problems among people (Prince, 2015). This health challenge comes with devastating effects

transcending from the individual level to the family, society, and then to the national level. To a more severe extent, mental disorders cause a high burden of mortality and morbidity at the individual and state levels (Walker, McGee, & Druss, 2015).

The issue of mental illness is not new in Ghana. The 2007 World Health Organisation (WHO) report indicated that 2,816,000 out of the 21.6 million population suffered different levels of mental disorders (Dako-Gyeke & Asumang, 2013). However, the diverse understanding and interpretation of the condition have led to differing use of terminologies which has reinforced existing socially and culturally constructed myths (Walker, 2006). This has led to a draw back with the use of available MHC and services leading to a considerable treatment gap of 98 percent. That is, 98 percent of persons with mental illnesses go untreated.

### **Mental Health Care and the Mental Health Act of Ghana**

Mental health care (MHC) is provided in Ghana by both orthodox (formal) and traditional (informal) MHC providers. The orthodox MHC is provided by both the public and private sectors under the Mental Health Authority (MHA). The Ministry of Health (MoH) exercises control over the whole system in terms of policy formulation, monitoring, and evaluation of activities (Savedoff, 2011). Currently, there are three (3) psychiatric hospitals in Ghana which are located in two administrative regions (Greater Accra and Central regions). The general hospitals in all the regions also provide 10-20 beds for MHC. More so, all hospitals in the country provide outpatient services. To make MHC more accessible to the people, the Mental Health Act 846, 2012 provided its inclusion into the Community-based Health Planning and Service

([CHPS], Walker & Osei, 2017). But the provision and use of these services are entangled with some challenges making the treatment gap of mental disorders in the country to remain pronounced (that is, 98 percent) (WHO, 2007).

Cultural beliefs and traditions about mental illness, as well as limited facilities for its care and cure in the country, have made many family caregivers seek help from informal mental health centers for their mentally ill relatives (Azman, Jamir Singh, & Sulaiman, 2017). Some of these informal centers include the traditional and faith-based centers (such as traditional/herbal practitioners, spiritual, and faith healers). This is common in most communities (in Ghana and most developing countries) as a result of the lay perceptions associated with mental illness which are rooted in the supernatural belief systems (Kpobi & Swartz, 2018). Yet, the informal center fills the treatment gap left by the orthodox MHC providers. These practitioners in the informal center offer varying treatment services which are believed to be of higher healing efficacy (Ofori-Atta, Reed, & Lund, 2010).

### **Perceptions on the Causes and Treatment of Mental Illness**

Mental illness has occurred throughout history, and community knowledge and perceptions about it differ from one society to another. Earlier, mental illness (in terms of causes and treatment) was associated with religion; thus, it was explained from the religious point of view (Johnson, 2018; Loue, 2017). For instance, excessive sexual activities were condemned; hence, individuals who engaged in such acts felt a strong sense of guilt. Also, individuals who defied some religious doctrines experienced some form of stress which affected their mental health. Therefore, mental illnesses were

believed to be a punishment for individuals who violated religious doctrines and was further believed to be treated through some religious/spiritual exercises.

In recent times, knowledge on the causes and treatment of mental illness has evolved. The reason being that new perspectives on its interpretations has emerged since the 19<sup>th</sup> century. Consequently, numerous studies have explored the diverse explanations associated with mental illnesses (Crabb et al., 2012; Naeem et al., 2012; Teferra & Shibre, 2012). Broadly, two perspectives exist in explaining the causes of mental illnesses; the medical and non-medical/traditional perspectives (van der Watt et al., 2017). The medical perspective emphasizes the clinical diagnosis of symptoms or behaviour to explain the cause of a mental health disorder. This includes biological or genetic conditions, and social and environmental conditions that negatively affect the mental health of individuals. The non-medical/traditional also attributes mental illness to supernatural conditions like witchcraft, curses, or possession of evil spirits.

Accordingly, different perspectives also exist on the treatment of mental illnesses (Choudhry, Mani, Ming, & Khang, 2016). These views could also be traced as far back to the 17<sup>th</sup> century, where persons with mental disorders were kept in chains, straitjackets, and other physical restraints as ways of treatment (Zechmeister, 2005). In recent times, there has been a shift in knowledge where mental illnesses are treated as medical conditions (Zechmeister, 2005). As such, therapeutic options to its treatment have emerged where mentally ill patients now have access to some several available options. Generally, two perspectives exist concerning treatment of mental illness: medical (orthodox) and non-medical (traditional/spiritual) perspectives (van der Watt et al., 2017). Thus, the

kind of perceptions associated with the cause of the condition determine the kind of option(s) to be utilised in its treatment.

***Medical Situations (Biological/Genetic and Social and Environmental Conditions)***

The attribution of mental illness to medical conditions like genetic or biological as well as social and environmental conditions has been evident in most empirical studies. Hence, it is believed that genetically/biologically as well as socially and environmentally induced conditions could be treated through medical/orthodox processes. This process of treatment involves clinical diagnosis of mental disorders for activities and services such as medications, counselling, and rehabilitation to be employed for its treatment.

In a study by Angermeyer and Matschinger (2005) on the causal beliefs and attitudes towards people with schizophrenia in Germany, biological factors were mentioned as one of the possible causes of mental illness. In other words, the participants believed that schizophrenia which is a mental health disorder is genetic, that is, a condition that an individual is born with. Therefore, the participants mentioned that seeking professional help for some therapeutic services was most appropriate for the treatment of such conditions. In other studies by Barke, Nyarko and Klecha (2011) on the stigma of mental illness in Ghana and Shibre et al. (2008) on community attitudes towards epilepsy in rural Ethiopia, similar findings were recorded. The participants in both studies attributed mental illnesses to genetic or biological conditions and further indicated that utilising the services of the hospital for some medications was appropriate to remedy the conditions.

In similar vein, researchers have revealed how daily social activities and environmental conditions affect the mental health of individuals. According to Cabassa, Lester and Zayas (2007), intrapersonal and interpersonal relationships form part of every individual, and these pose some stress which affects the mental health. The authors reported that as a result of this relationship stress, some individuals have developed mental disorders such as depression. But, according to Cabassa and his colleagues, individuals suffering from such conditions need other people around them, experts to talk to, and some medications for their relief. The study therefore mentioned counseling sessions and medications as means of treatment for persons with such conditions.

In a study by Cook and Wang (2011), it was revealed that social issues such as family, relationships, and work come with stress which caused depression among many individuals. In other words, relationships among individuals in the family, society, and at the workplace pose some form of stress which could trigger mental disorders. More so, Barrera, Gonzalez and Jordan (2013) revealed in their study that Mexican-Americans in the Rio Grande Valley believed bad experiences that individuals faced in life caused mental illnesses. According to Barrera, Gonzalez and Jordan, experiences such as domestic violence, divorce, vehicle accidents, financial distress, unemployment, trauma as a result of death/loss of a loved one could cause mental disorders. These experiences, include (among others) physical or sexual abuse, and the loss/death of a loved one. The study therefore mentioned orthodox medications and treatment as effective means of managing such conditions. This is because, the participants/victims of such situations employed medical services for treatments and they indicated how helpful it has been.

Kabir, Iliyasu, Abubakar and Aliyu (2004) also mentioned abuse/misuse of alcohol and drugs (like weed, cannabis, etc.) as the major cause of mental illness among most adults in Karfi village in northern Nigeria. The study further indicated that such conditions are addiction issues and could be treated through orthodox medications and counselling services.

### *Non-medical Situations (Supernatural Conditions)*

Usually, perceptions associated with the causes and treatment of mental illness have its root from supernatural beliefs and traditions. Therefore, its understanding, explanation, and interpretation are influenced by existing traditional or cultural beliefs, norms, and practices (Roberts, 2001). In studies by Adewuya and Makanjuola (2008) in Nigeria and Crabb et al. (2012) in Germany, the respondents perceived mental illness to be caused by supernatural factors. Witchcraft and evil spirits were mentioned as agents causing these conditions. In parallel, participants of these studies as well as several others (such as, Kabir et al., 2004 in Nigeria; Choudhry et al., 2016 in Pakistan) indicated that herbal and spiritual consultations were the appropriate treatment options.

In Ghana, the interpretation and explanation of mental illness are based on some existing cultural beliefs, norms, and practices, hence, its attribution to supernatural forces (Roberts, 2001; Rosenberg, 2002). Therefore, the condition has mainly been associated with witchcraft in the country (Ofori-Atta et al., 2010; Quinn, 2007; Read, Adiibokah & Nyame, 2009). In other studies, in Uganda (Abbo et al., 2008) and Malawi (Crabb et al., 2012), the studies' respondents perceived mental illness to be caused by supernatural reasons. The authors revealed that mental illnesses among individuals were caused by curses

as a result of hatred or wrong done to someone. So, if person A hates person B, the former (person A) can curse the latter (person B) to go mad. In the same vein, if the latter (person B) does wrong to the former (person A), the latter (person B) can cause the former (person A) to go mad through a curse. In cases like these, some individuals and relatives of persons with such conditions undertake special/ritual prayers for deliverance and exorcism in the healing/treatment process.

There are also instances where individuals are bewitched to go mad (Teferra & Shibre, 2012). Teferra and Shibre, in their study in Ethiopia, revealed that the community dwellers perceived and attributed mental illness to extra-human factors like possession of evil spirits and witchcraft. Pfeifer (1994) and Adebowale and Ogunlesi (1999), on the other hand, emphasized that evil spirits caused mental illnesses as punishments in occult associations. Further, the authors revealed that mental illnesses were perceived to be God's will or divine wrath on the victim due to such actions. As such, having faith in God has been indicated as an essential help-seeking strategy for the treatment of mental health conditions as the participants believed that God will cause a change during the time (Cook & Wang, 2011).

In conclusion, the evidence presented shows that the understanding, explanations, and interpretations of the causes and treatment of mental illnesses are based on individuals' perceptions and are also contextual; that is, it differs from place to place. However, it should also be noted that the perceptions associated with the causes (medical [genetic/biological and social and environmental conditions] and non-medical [supernatural factors]) of mental illness go hand-in-hand with how the condition is managed/treated; whether

medical and non-medical means (Muga & Jenkins, 2008). Therefore, based on the perceived cause of the condition, its appropriate treatment option(s) is/are sought for.

### **Caregiving and the Caregiver: The Role of Family Caregivers**

Caregiving refers to the help and support provided daily to individuals who are either temporarily or permanently unable to function independently (Costa-Font, Jiménez-Martín, & Vilaplana, 2017). This involves activities such as assisting with personal hygiene, helping with medication, hospital visits, as well as providing emotional and financial support. A caregiver performs tasks for someone, given that the person is aged or has a health condition that prevents his/her independence. Usually, such care is provided either voluntarily or for a fee (Goodhead & McDonald, 2007). However, family caregivers are usually not paid for the service they render because of their relationship with the patients.

Caregiving for persons with mental illnesses in Africa is mostly done by family members (Albert & Simpson, 2015). The role of family caregivers in traditional communities towards the healing of mentally ill relatives includes spiritual consultations to remedy the situation (Chakrabarti & Gill, 2002) as well as emotional and physical support (Von Kardorff, Soltaninejad, Kamali, & Shahrabaki, 2016; Sreeja et al., 2009). According to Anokye (2018), the role that family caregivers play in Ghana is critical, especially, in bridging the treatment gap. However, family members who play the caregiving role are usually not appreciated and supported, hence, faced with some challenges (Glozman, 2004). This has a tone on their lives and affects their decisions and response to help-seeking for their relatives suffering from such conditions.

## Characteristics of Family Caregivers

Over the years, studies conducted on family caregivers of persons with mental illness have unveiled some of their characteristics. Intuitively, this has helped for us to know the kind/category of individuals who take up the caregiving role. Some of these characteristics include sex, age, religion, ethnicity, occupation, and relationship with patients (Breland et al., 2014; Burnett-Zeigler & Lyons, 2010; Costello, He, Sampson, Kessler, & Merikangas, 2014).

### *Sex of Family Caregivers*

Usually, caregiving role is taken up by females. This is as a result of how socialization is done in the society. Generally, females are socialized to nurture and provide help and care as compared to males (Pinquart & Sörensen, 2006). Therefore, it is not surprising that females have dominated in every sampled/selected participants/respondents in a study. Evidently, numerous studies on family caregivers of persons with mental illnesses have shown a clear proportional difference between the two sexes - male and female - with the female always dominating. These studies did not focus of purposively on selecting one sex more than the other, but ended up having most of the participants/respondents been females. For instance, in the study by Shamsaei, Cheraghi and Bashirian (2015) study on the burden on family caregivers caring for patients with schizophrenia” in Iran, the majority (73.7%) of the caregivers that were captured were female. Similarly, Gabra, Ebrahim, Osman and Al-Attar’s (2020) study on the knowledge, attitude, and health-seeking behavior among family caregivers of mentally ill patients at Assiut University Hospitals, in Egypt, 60.7 percent of the study participants were also females. Lastly, in

Ghana, Anokye's (2018) study on the needs of family caregivers of people living with mental illness, eight out of the thirteen participants were females. Based on these, an inference could be drawn that female dominate the sphere of caregiving for mentally ill persons.

### ***Age of Family Caregivers***

Ages of family caregivers of persons with mental illness have been captured in different categories across different studies with no specific age bracket dominating in the caregiving role. This means that, caregiving does not is not done by specific individuals within a certain age bracket. In the study by Shamsaei, Cheraghi and Bashirian (2015), the majority (28.4%) of the study participants belonged to the 51-60 years age category with the rest spread below age 50. In other studies by Addo, Nonvignon and Aikins (2013) and Ae-Ngibise, Doku, Asante and Owusu-Agyei (2015) from rural Ghana, 46.6 percent and 60 percent (which constituted the majority) were within the 20-39 years and 35-64years age brackets. Finally, in Gabra's et al. (2020) study, 64 percent of the study's participants were equal or above 40 years of age. These figures show some inconsistencies in the ages of family caregivers of persons with mental illnesses as different studies have reported different age brackets taking charge in the caregiving role with none been very pronounced in related literature yet.

### ***Level of Education of Family Caregivers***

The level of education of family caregivers has been found to play an important role in the utilisation of MHC and services for relatives with mental illness. However, it has not been evident in literature on how that influence their responsibility of taking charge in the caregiving role yet. Barksdale, Azur and Leaf (2010) reported that family caregivers who had acquired higher formal

education (up to the college) were more likely to seek MHC for their mentally ill relatives than those who had their education less than high school diploma. This means that, those with higher formal education take charge in the caregiving more as compared to those with less or no formal education. On the contrary, other studies have also reported some family caregivers of persons with mental illnesses having low levels of education. For instance, Gabra's et al. (2020) study mentioned that 63.1 percent of the study participants were illiterates. This finding confirmed Ae-Ngibise's et al. (2015) study in Ghana which also reported that more than 65 percent (49/75) of the study participants had no formal education. There is again no empirical emphasis on the category of family caregivers that dominate in the caregiving for persons with mental disorders; whether the educated or non-educated.

#### ***Marital Status of Family Caregivers***

Family caregivers' marital status and caregiving of persons with mental illness is not well pronounced in literature. Yet, some studies have reported that a majority of family caregivers of persons with mental illness were married. In Gabra's et al (2020) study, for instance, 70 percent of the total participants were married. This confirms earlier studies by Ae-Ngibise's et al (2015) which reported that 60 percent were married. However, in Anokye's (2018) study 68.6 percent of the total participants were not married. These findings indicate that the caregiving role for persons with mental illness necessarily is not dependent on a person's marital status.

#### ***Religious Affiliation of Family Caregivers***

Family caregivers' religious affiliations have been identified to be important in seeking treatment for relatives with mental illness (Breland et al.,

2014). According to Breland et al., family caregivers who are affiliated to a particular religious body are more likely to utilise MHC for their relatives suffering from mental disorders than those who are affiliated to none. However, with the specific religious body that has its members dominate in the utilisation of MHC for their victims (persons with mental conditions) is contextual. This is because, depending on the study setting, the dominant religion will prevail in the study. In Ghana, for instance, the 2010 Population and Housing Census reported that a high percentage (94.7%) of the population were affiliated to the three dominant religious bodies (that is, Christianity, Islam, and Traditional), with a few (5.3%) non-affiliates (Ghana Statistical Service [GSS], 2014). Individuals who belong to any of these religious bodies have some kind of perceptions on mental illness. This is because, each religion comes with its own set of doctrines, beliefs, ways of explanation and interpretation, and handling social events (like mental illness), hence, influence individuals' perceptions on the condition as well as on its management/treatment (Breland et al., 2014).

#### ***Ethnicity or Culture of Family Caregivers***

The ethnic background or culture of family caregivers has also been identified to be an important variable in the treatment-seeking for persons with mental illness (Costello et al., 2014). The reason is that ethnic groups are defined by a set of beliefs that influence the way social events like mental illness are understood, explained, and managed/treated. Therefore, ethnicity, through its defined beliefs and norms (way of life - culture), influences how its members should perceive mental illness; the causes, and most important, its treatment (Costello et al., 2014). In a study by Cummings and Druss (2011), ethnicity was not significantly associated with mental health service use and caregiving. But,

whether or not, depending on the study setting, the dominant ethnic group or culture dominates in the study. Therefore, if a study is conducted in southern Ghana, there is a higher probability that Akans will dominate in the study and vice versa if it is conducted in the northern part of Ghana. This implies that, taking up the role of caregiving is a matter of cultural norms, so depending on the existing cultural beliefs and norms is what prevails.

### *Occupation of Family Caregivers*

Eapen and Ghubash (2004) indicated that socio-economic status, like the kind of occupation engaged in and income of family caregivers, is an essential factor influencing the utilisation and adherence to the treatment of mental illnesses. This is as a result of the financial burden associated with its care. This implies that individuals who take up the caregiving role are usually gainfully employed with some stable incomes. In another study by Breland et al. (2014), family caregivers with good occupation and high income took care and utilised MHC and its related services for their mentally ill relatives. However, other studies also found no significant association between income through one's occupation and caregiving, as well as MHC and service use by family caregivers (Alonzo, Conway, & Modrek, 2016). Family caregivers in these studies were reported to be engaged in activities that fetched them with a reasonable income. Thus, some were engaged in non-casual activities like farming, driving, business/trading, among others, while others were also engaged in casual activities like teaching, nursing, and banking. Nonetheless, family caregivers who were gainfully engaged in some activities have always dominated in related studies. The studies by Shamsaei, Cheraghi and Bashirian (2015) in Iran, and Anokye (2018) in Ghana reported that 65.8 percent and 70.1

percent of the study participants were engaged in some gainful activities (occupation) respectively.

### ***Family Caregivers' Relationship with Patients***

Relations are very important in the primary care of persons with mental illness. As such, studies have identified the category of persons (family caregivers) that play this role. Usually, it is done by family members. In a study by Wolff and Kasper (2006), spouses and adult children of affected persons (with mental illness) formed nearly 80 percent of the caregivers. Also, in Gabra's et al. (2020) study, parents represented about half (48.9%) as principal primary caregivers of persons with mental illness with siblings, spouses, and other relatives occupying the 51.1 percent. These findings are consistent with the work of Albert and Simpson (2015) which also reported that family members are mostly the caregivers for persons with mental illness.

### **Experiences of Family Caregivers**

Mental health conditions are associated with the presence of an illness that interferes with the person's ability to take care of themselves (Jiménez, Rivera, Benítez, Tarrats, & Ramos, 2013). In such situations, the presence of a caretaker/caregiver is very crucial. Caring for relatives with mental illness comes with severe consequences for the physical and emotional health of the caregivers (Breitborde, López, & Kopelowicz, 2010; Brodaty & Donkin, 2009). The experiences they go through depend on the personal, financial, and emotional resources available; but there is often little or no support from the family, society, or the state (Anokye, 2018). Because of this, family caregivers go through numerous challenges in the process of caregiving.

Family caregivers, like any other individual, have to make time for social activities like weddings, funerals, religious meetings, and at the same time, attend to family responsibilities. However, they are sometimes faced with public ridicule as a result of their responsibilities of taking care of their mentally ill relatives (Ae-Ngibise et al., 2015). There are times where they are stigmatized, discriminated against or rejected, mocked, and called with names (Tawiah, Adongo, & Aikins, 2015). According to Tawiah and his colleagues, the social stigma associated with caregiving transcends through the entire family which sets them apart/away from others in the society. Corrigan and Watson (2002) also mentioned that stigma experienced by family caregivers of the mentally ill leads to suffering, disability, and to a larger extent, poverty.

Above all, family caregivers are socially isolated whiles their social interactions and contacts consequently reduce, with inadequate social support (Robinson-Whelen, Tada, MacCallum, McGuire, & Kiecolt-Glaser, 2001). This is because of the perceived cause (evil spirit) associated with mental illness. Anyone who gets closer to such persons (patients) were believed to be either possessed or had a strong soul that cannot be defeated by the “spirit of madness”. Therefore, the spirits get into the family to seek for those with weak souls to replace the one helping the possessed relative (patient). Family caregivers in this situation are given names (labels) and are also seen as evil in the community/society (Tawiah, Adongo, & Aikins, 2015).

In a study by Ae-Ngibise et al. (2015) on the experiences of caregivers of people living with serious mental disorders from rural Ghana, the authors reported a huge burden experienced by family caregivers. These burdens included; financial burden, lack of support networks, social exclusion, negative

health impact, and absence of decentralized mental health services. In the study, the participants mentioned that the cost of treating mental illness is very high, thereby stressing them on their caregiving responsibilities.

Anokye's (2018) study on the needs of family caregivers of people living with mental illness in Kumasi, Ghana indicated that family caregivers go through a lot of stress. According to Anokye, some family caregivers who participated in the study were faced with accommodation challenges for themselves and their mentally ill relatives. Some were also faced with financial problems and challenges with access to information on the treatment of their relatives' condition. Consequently, these affect the psychological health of family caregivers (Anokye, 2018; Schulz & Sherwood, 2008). Also, stress as a result of lack of sleep, guilt and anxiety feelings, shock, and sadness experienced by family caregivers through the caregiving process affect their mental health; thus, having an increased risk of developing symptoms of depression (Schulz & Sherwood, 2008).

### **Perceptions on Mental Illness and Utilisation of MHC and Services**

Perceptions on mental illness have some historical antecedents, and people's thoughts and beliefs on it are seen in the various attempts made in its treatment (Link & Stuart, 2017). Consequently, some regional studies, though limited, have examined how perceptions of family caregivers influence the utilisation of MHC and services for their relatives with such conditions. Nevertheless, options of MHC and services utilised by family caregivers for relatives with mental illness have been seen in two broad categories: traditional (religious/spiritual and herbal/traditional means) and medical/hospital options. There is also a third option which brings to light the utilisation of more than one

treatment option at a time by family caregivers for the treatment of their mentally ill relatives.

In a study by Wood and Parham (1990) on coping with perceived burden: ethnic and cultural issues in Alzheimer's family caregiving, the authors examined the differences in the use of various cognitive and behavioural coping strategies and differences in social support patterns. The study revealed that Black family caregivers sought information about the MHC and services less frequently than White family caregivers. This was as a result of the ethnic and cultural differences that existed between these groups. As such, the Black family caregivers used a broad range of informal supports. The study concluded that the utilisation of available treatment for persons with mental disorders was dependent on the kind of perceptions associated with the condition by their respective caregivers.

According to Ruiz (1995), psychiatry has always been influenced by culture. The author conducted a study on the assessment, diagnoses, and treatment of culturally diverse individuals from a Hispanic perspective. It was revealed that the cultural identity of both providers and consumers, their cultural perceptions on mental illness and its treatment, their psychosocial and socioeconomic environment influenced the kind of psychiatric diagnosis created and the kind of treatment utilised. Participants who had a formal education, employed in the formal sector, and earned reasonable income had a different perception from their counterparts on the other side. In this case, 'formal' participants attributed mental illness to social stressors; hence, they utilised the services of the hospital for its treatment. Informal participants also

attributed mental illness to spiritual factors, hence, they also utilised the services of herbal and spiritual/prayer centers.

In another study by Toseland, McCallion, Gerber and Banks (2002), the authors examined the predictors of health and human services used by persons with dementia and their family caregivers in the United States of America. The authors reported that the utilisation of MHC was influenced by Andersen's (1968) predisposing, enabling, and need variables. Though the emphasis was placed on the enabling factors (such as the income of family members, and conducive policies on MHC), the study further revealed that family caregivers' perceptions on the cost (high) associated with the medical MHC and services for the treatment of their mentally ill relatives also influenced their decisions on the use of MHC. Hence, the participants in the study mentioned that the traditional treatment options were appropriate and less expensive to treat their relatives' condition.

Kim, Loi, Chiriboga, Jang, Parmelee and Allen (2011) further reported that language used in the assessment, diagnosis, and treatment of mental disorders has created a barrier to mental health service use among Latino immigrants. In this case, family caregivers who were not abreast with the terms used by mental health professionals were not motivated to access MHC for their mentally ill relatives and vice versa. According to the authors, family caregivers' perceptions on mental illness depended on their social status (such as level of education, level of knowledge on mental illness, among others). However, the study was silent on drawing a link between social status and perceptions on mental illness hence, leaves a gap that needs to be filled on how one's social status influences the perception developed on mental illness.

Quinn (2007) examined the beliefs and community response to mental illness in Ghana. The author examined how culture influenced the way families in urban and rural areas understood and responded to mental ill-health. The study revealed that urban dwellers attribute mental illnesses to social pressures (like pressures from the family and work) thereby mentioned western/orthodox medicines for the treatment of such conditions. Rural dwellers on the other hand also attributed the causes of mental illnesses to factors such as charms, curse, or bad spirits, thereby, its treatment through traditional/spiritual healings. However, the study further revealed that, though this disparity exists, some urban and rural dwellers utilised the services of traditional and orthodox treatment options respectively. This was as a result of their socialization (being cultural or religious).

Finally, a study by Assion, Zarouchas, Multamäki, Zolotova and Schröder (2007) on “patients’ use of alternative methods parallel to psychiatric therapy” in Germany revealed something different. In the study, the participants mentioned that they had utilised more than one treatment option in their attempts of seeking treatment. The participants used traditional or complementary medicine which they believed were effective as compared to the psychiatric (medical) treatment. The usage of traditional medicine and orthodox medication for the treatment of psychiatric patients is common, not just in Africa, but also, in some countries like Malaysia and Norway in Asia and Germany in Europe (Assion et al., 2007; Razali & Yassin, 2008; Sexton & Sørliie, 2008). However, the studies did not report on whether the participants utilised more than one treatment option at the same time; which this current study provides information on.

In conclusion, this current study dwells on issues and events that surround individuals, who are family caregivers and investigates how that has shaped their thoughts on their relatives' condition and also, how these thoughts have influenced their decisions on utilising MHC for their mentally ill relatives. This could be theoretically explained with the social construction theory and health care utilisation model which were employed as theoretical basis for the study.

### **Theoretical Underpinnings**

The study is underpinned by the social construction theory and health care utilisation model. These theories were chosen because they offer useful insights for the study. The social construction theory explains how individuals develop knowledge or reality about their social world while the health care utilisation model discusses the factors that influence people to utilise available health care.

### **Social Construction Theory**

Social constructionism originated as an attempt to come to terms with the nature of reality. It first appeared in the book titled "Social Construction of Reality" which was written by Peter Berger and Thomas Luckmann in 1966. Berger and Luckmann were concerned with the nature, construction, and institutionalization of knowledge. They viewed knowledge as a creation based on the interactions among individuals within the society. When people interact, they do so with the understanding that their respective perceptions of reality are related. Acting upon this understanding, their common knowledge (perceived thought) of reality becomes reinforced. Knowledge on what exists in the society

is maintained through what is seen and/or heard through interactions. Therefore, individuals participate in the construction of this perceived social reality.

Social constructionism could be defined as a perspective which believes that human life exists due to social and interpersonal influences. According to the theory, the reality about any social phenomena is constructed by individuals. That is, any idea, knowledge, belief, and/or view about the world are constructed by the society with the use of agreed and shared meanings which are communicated through language. “The Social Construction of What?” by Ian Hacking in 1999 argues that social construction should not only be applied to physical objects or things that exist, but also to intangible objects like beliefs that people have.

Therefore, beliefs about whatever exists in the world are social and cultural inventions and are shaped through interactions and experiences among members in the society. This makes “constructed reality” differ from one person to another since interactions and experiences among members in the society differ. On this note, how person ‘A’ sees a situation could differ from that of a person ‘B’ given the differences that exist with their interactions and experiences with that situation.

### **Relevance and Application of the Social Construction Theory**

Social construction theory is concerned with the meaning placed on a situation and how it is adopted by members of the society concerning how they view or deal with the situation. It espouses that social reality is socially constructed by individuals. Therefore, how individuals understand a situation emanates from the perception and knowledge developed about it. In that vein, what is true is a social construct and it is an idea that is accepted by the society.

With mental illness, the theory is concerned with how people interpret and give account to its cause through socially and culturally constructed beliefs. Therefore, the theory is relevant to this study because it gives the chance to explore the diverse interpretations attached to mental illness by people (family caregivers) within their social contexts. It is important to note that the knowledge and perceptions of family caregivers on the condition of mental illness influence their choices of treatments for their mentally ill relatives (Muga & Jenkins, 2008).

The theory explains that people's perceptions, knowledge, beliefs, and experiences of mental illness are socially motivated. Therefore, issues on the causes and treatment often emanate from the knowledge that already exists in the society through interactions with and experiences of people living with the disease in the society. These, influence health-seeking decisions and behaviours. And so, for instance, if the perceived cause of a mental illness is attributed to spiritual forces, the family caregiver is likely to seek treatment from a faith-based/spiritual healing center. In this case, depending on the perceived cause, the appropriate treatment option is utilised.

Using the social construction theory, the study explores how family caregivers perceive mental illness within the Ghanaian context. The study, with the use of this theory, is not concerned with what mental illness means; nor intends to dismiss myths or correct any understandings or perceptions regarding mental illness. Instead, it explores how family caregivers produce meanings attached to mental illness in the society, and how that translates into treatment-seeking for persons with mental illness in the society.

## Health Care Utilisation Model

Andersen developed the health care utilisation model in 1968. It is a conceptual model aimed at demonstrating the factors that lead to the use of health care services. Though the model has gone through several phases after its development, the purpose has remained the same; that is, determining the factors that either facilitate or obstruct the utilisation of health care services. According to Andersen (1968), the utilisation of health care service involves a complicated process. Thus, for an individual to access health care, it is determined by three factors: predisposing, enabling, and need factors.

Predisposing factors consist of socio-cultural characteristics of individuals that existed before their health situation(s) and influence their decisions on utilising health care services. These include the social structure, demographic characteristics of the people, and health beliefs held by the people. Variables such as age, sex, religion, occupation, level of education, marital status, family size, ethnicity, culture, social networks and interactions, attitude, knowledge, perceptions, beliefs, and values are issues that characterize every individual; hence, influence thoughts.

Enabling factors also denote variables that engender the use of health care services. In other words, it is the logistical aspects or means of obtaining health care. These include personal/family income, availability of health insurance, the proximity of health care facilities, language proficiency, availability in terms of time, costs involved, and third-party (family/friend) influence.

The need factor represents both perceived and the actual need for health care services. Here, individuals weigh the perceived need to the evaluated need

before a decision on utilising health care is made. In other words, people suffering from mental illness or caring for a person with mental illness usually consider why they should access the health care services and the process of treatment before a decision is made.

### **Relevance and Application of the Health Care Utilisation Model**

In the field of health and illness, the health care utilisation model remains a useful tool for predicting and explaining the treatment/health-seeking behaviour of individuals (Barreto & Segal, 2005). This model helps to understand that decisions made and actions taken towards treatment-seeking involve a complex process that often presents a state of dilemma for affected individuals and families, of which in this case are family caregivers.

For this study, the emphasis was placed on the predisposing factors to serve as the basis to explain what influences family caregivers to seek treatment for their mentally ill relatives. Predisposing factors reflect the various variables that characterize an individual. In simple terms, what individuals (family caregivers) were exposed to before the ill-health condition of their relative. Age, sex, religion, occupation, level of education, marital status, ethnicity, perceptions, and knowledge about the condition have been suggested as variables under the predisposing factors. And it is obvious that all these existed with respective family caregivers even before their relatives' condition and somehow influenced their health-seeking decisions and behaviours.

According to Mojtabai, Olfson and Mechanic (2002) and Zuvekas and Fleishman (2008), perceptions on mental health influence health service utilisation. Therefore, by extension, perceptions that family caregivers have on mental illness also predict their use of available MHC and services for their

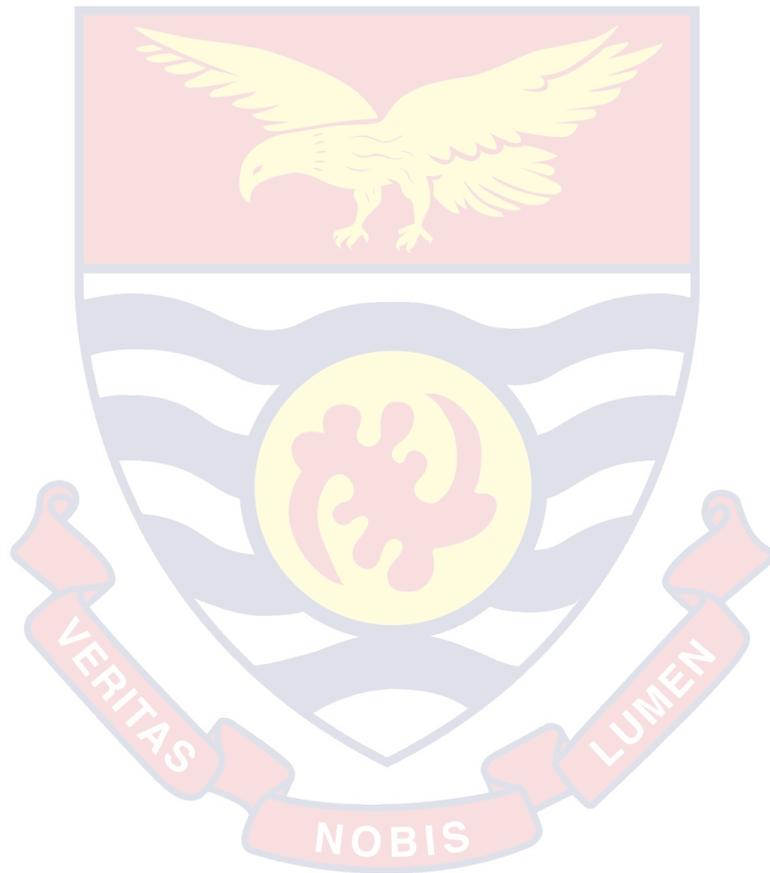
mentally ill relatives. Usually, perceptions are developed based on how people are socialized. These perceptions stem from the social structure like the family, community/society, culture, and education system. These social structures have their own set beliefs, norms, and interpretations of social events like mental illness. Therefore, information about mental illness is gotten from these arenas, and knowledge developed in this regard is based on that. In other words, depending on the attribution on the cause and treatment of mental illness, individuals create their perceptions and also develop knowledge based on it (Owens et al., 2002). For instance, if mental illness is attributed to witchcraft and it is believed to be managed/treated through chaining and spiritual healings in the society, it becomes a norm and accepted by individuals in the society. In that way, seeking medical attention for individuals with these conditions is absent. The opposite also holds.

The predisposing factors made the health care utilisation model appropriate to explain the treatment/health-seeking behaviour of family caregivers. The reason being that family caregivers in this context were predisposed to certain variables such as age, sex, education, religion, and culture which shaped their beliefs, perceptions, and knowledge on the cause as well as the treatment of mental illnesses which further influenced their decisions and behaviours towards seeking help for their mentally ill relatives.

### **Chapter Summary**

The above review shows that different perceptions existed on the cause and treatment of mental illnesses. The empirical literature reviewed was about the perceptions on the cause and treatment of mental illness since these influence decisions made on the utilisation of MHC. It is essential to state that

literature in this area is limited with a few studies done in recent times. The empirical studies demonstrated that family caregivers are caught in the dilemma of utilising MHC for their mentally ill relatives as a result of existing perceptions and beliefs on the condition. However, though the review shows that some family caregivers utilised a certain kind of treatment based on the perceptions associated with its cause, this study sought to find out if some of these claims are valid in the Ghanaian context.



## CHAPTER THREE

### RESEARCH METHODS

#### Introduction

This chapter provides information on the research philosophy, research design, study area and population, sample size and sampling procedure, data collection instrument, data collection procedure, source of data, and data processing and analysis. Other issues like ethics and validity and reliability are further discussed.

#### Research Philosophy

Research philosophy deals with the source, nature, and development of knowledge (Bajpai, 2011). It is the belief about how data on a social phenomenon should be collected, analyzed, and used. In the tradition of science, two major research philosophies have been identified: positivism and interpretivism. Positivists, like Auguste Comte and Emile Durkheim, believe that reality is stable and can be observed and described from an objective point of view. Interpretivists, like Max Weber and George Herbert Mead, on the other side, also argue that reality could only be fully understood through the subjective interpretation of that reality.

For this study, the interpretivism philosophy was adopted. Interpretivists look for meanings in the subjective experiences of individuals that are engaged in social interactions (Potrac, Jones, & Nelson, 2014). Notwithstanding, as this study explored the perceptions and experiences of family caregivers which are subjective in nature, and also, as perceptions that individuals have on mental illness are constructed/created/developed through social interactions in society, then employing this philosophy is appropriate and justified.

## Research Design

Research design is vital in every research work. I employed an exploratory research design for this study. An exploratory research design is a form of qualitative research approach which allows studies to be conducted into new social events (on which little or no previous research has been conducted), or to gain further insights (Brown, 2006). According to Berg and Lune (2012), it is “concerned with finding answers to ‘why’ and ‘how’ about a human behaviour”. Notwithstanding, the study investigates first, the perceptions that family caregivers have on mental illness, second, their experiences with their caregiving role, and lastly, how these perceptions influence their treatment-seeking decisions and behaviours for their mentally-ill relatives. Therefore, the design becomes appropriate to gain further insights as little research has been conducted in these areas in Ghana.

## Study Area

The study was conducted at the Ankaful Psychiatric Hospital, one of the three state-owned psychiatric hospitals in Ghana. Currently, only these three psychiatric hospitals, namely, Accra and Pantang and Ankaful Psychiatric Hospitals serve the over 31 million population of the country (Worldometer [United Nations data], 2020). The Ankaful Psychiatric Hospital is located in the Komenda-Edina-Eguafo-Abirim (KEEA) Municipality, Central Region. The hospital was established in 1965 with a bed capacity of 500, several years after the establishment of the Accra Psychiatric Hospital in 1906, to ease congestion; but currently, the hospital has a bed capacity of 311 (Agyemang & Ninnoni, 2018). It has four male wards, two female wards, a VIP facility for drug and alcohol rehabilitation center, and a general and psychological Out-Patients

Department (OPD). The other two psychiatric hospitals (Accra and Pantang) are located in the Greater Accra Region of Ghana.

The Ankaful Psychiatric Hospital is a specialized health facility that serves the same function as the other two facilities. Besides its general responsibility of treatment, welfare, training, and rehabilitation of mentally ill patients, it renders major psychiatric referral services from the various general hospitals in the country (Agyemang & Ninnoni, 2018). Attached to the hospital is a nurses' training school that trains psychiatric nurses and also, the hospital gives affiliation training to the nursing and medical students across the country on psychiatry. The hospital is staffed with a team of psychiatrists, medical doctors, psychiatric nurses, general nurses as well as other administrative staffs. It receives patients from the country and beyond each day of the week for both treatment and reviews.

The Ankaful Psychiatric Hospital was selected as the study institution based on convenience. This is because the facility was closer to me as compared to the other two facilities in Accra - Pantang and Accra Psychiatric Hospitals. Therefore, there was a conviction that the facility will present clients from diverse backgrounds as it serves similar functions (that is, serves as a major referral facility responsible for the treatment, welfare, training, and rehabilitation of mentally ill patients) as the two psychiatric hospitals.

### **Study Population**

All family caregivers who were at the Ankaful Psychiatric Hospital with their mentally ill relatives (detention/admission) during the data collection period (from Tuesday, 23<sup>rd</sup> June 2020 to Thursday, 7<sup>th</sup> July 2020) constituted

the study population. According to the facility's records, they totalled 197. Therefore, they all formed the targeted population for the study.

### **Sample and Sampling Procedure**

Fourteen (14) family caregivers with different backgrounds in terms of sex, age, religious and ethnic affiliations, marital status, level of education, and occupation participated in the study. The diverse nature of the participants brought out different perspectives on the issue under study. It should be noted that qualitative research does not strictly lend itself to numbers therefore, though the number seems small, it allowed me to learn and retrieve in-depth data from the participants. Also, considering the issue of saturation of data as espoused by Guest, Bunce and Johnson (2006), having 14 participants for my study was appropriate as no new information was discovered after the 14<sup>th</sup> interview.

Purposive sampling technique was used to select family caregivers as participants for the study. As such, some inclusion criteria were developed to guide the selection of the participants as it was based on their knowledge and experience with the issue under study.

### **Inclusion Criteria**

In attempt to select suitable family caregivers as participants for the study, some inclusion criteria were applied. The criteria were that,

- 1) Their mentally ill relative should be on admission at the Ankaful Psychiatric Hospital either at the ward (for those with severe cases) or at the psycho/detention unit (for those under review) during the time of the study.
- 2) Their mentally ill relative should have had the condition for at least six months from the time of the study.

3) The family caregiver should be the main (primary) caregivers of the mentally ill relative at the facility.

After strictly applying the inclusion criteria, the number of family caregivers who qualified to participate in the study came to 59. Nonetheless, only those who were available during the time of the study and were willing to participate in the study were recruited. As such, the number further dropped based on the following reasons:

- 1) Twenty-two of the 59 qualified family caregivers were having their relatives discharged from admission (from both the wards and detention facilities) on the day of introduction.
- 2) Ten were not willing to participate in the study due to their personal reasons.
- 3) Four could also not be traced during the data collection period.

This brought the number down to a total of 23 being recruited from the various units for the study: one from the Medical Unit; four from the Data and Records Unit; and 18 from the Psycho/Detention Unit/ward. A large number (18) of family caregivers were recruited from the Detention Unit because all cases of mental health disorders were first managed at the Psycho/Detention Unit. Also, the hospital protocol required that new patients were temporarily admitted at the Psycho/Detention Unit for a two-week assessment and treatment before either their discharge or transfer to the ward. In this case, family members were expected to stay around throughout the detention period to play the caregiving role (like feeding, bathing, etc.). Therefore, unlike meeting a large number of family caregivers at the Data and Records Unit every morning during

the recognizance survey, the numbers had piled up at the Psycho/Detention Unit this time.

It should however be noted that though 23 family caregivers were recruited, 14 of them got the opportunity to participate in the study. This was as a result of data saturation in the course of the interview. The breakdown of the participants per the various units are as follows:

- 1) Eleven family caregivers from the Psycho/Detention Unit
- 2) Two family caregivers from the Data and Records Unit
- 3) One from the Medical Unit

#### **Data Collection Instrument**

I used an in-depth interview (IDI) guide for the data collection. The guide was structured in four sections (A, B, C, and D). Section A looked at the socio-demographic characteristics of the family caregivers, and Section B considered the perceptions of family caregivers on mental illness. Section C concerned itself with the experiences of family caregivers with their relatives' condition, and Section D also looked at how the perceptions of family caregivers on their relatives' condition influence their treatment-seeking decisions and behaviours. The instrument was constructed based on the study objectives.

The data were collected through one-on-one interviews, therefore, the participants freely expressed themselves and shared their beliefs and opinions on the subject under study; that is, perceptions on mental illness. Also, the instrument helped me to explore and gather experiential narratives from the family caregivers as argued by Oppong (2013). Finally, the instrument allowed for further probes to some of the responses and gestures for clarification.

## Data Collection Procedure

The fieldwork took place within a period of six months; February, March, April, May, June, and July 2020. All necessary and relevant protocols related to the study were duly followed. The procedure was in four phases: starting from the home institution; the Central Regional Health Directorate (CRHD); the study area (that is, Ankaful Psychiatric Hospital); and the actual interview sessions. Consequently, some relevant ethics were satisfied at each stage.

Before commencing the data collection, some home works/exercises were undertaken. Here, introductory letters from my supervisor and the Department of Sociology and Anthropology were sent to the University of Cape Coast Institutional Review Board, (UCCIRB) to seek ethical clearance. Attached to the letters were copies of the research proposal and instrument, participants' consent and volunteer agreement forms, as well as other requirements that were completed and sent to the UCCIRB for vetting and clearance. This application was done on Friday, 14<sup>th</sup> of February, 2020, and it took ten 10 working days before my proposal and research instrument was accepted for vetting. On Thursday, 21<sup>st</sup> of May, 2020, I received my ethical clearance from the UCCIRB with identification (ID) UCCIRB/CHLS/2020/06. I then headed to the Central Regional Health Directorate (CRHD) for the next stage of permission and clearance.

I went through similar phase of the ethical clearance procedure where my research proposal and instrument, as well as consent form were vetted by the CRHD Research Unit. These documents/requirements were sent to the CRHD on Thursday, 27<sup>th</sup> of February, 2020. On Thursday, 12<sup>th</sup> of March, 2020,

I received the permission and clearance letter to access the Ankaful Psychiatric facility for the research.

Upon receiving permission from the CCRHD, an introductory letter from the Department of Sociology and Anthropology, research proposal and instrument, as well as consent form and the ethical clearance from the CCRHD were sent to the Ethical Review Board of the Ankaful Psychiatric Hospital ((ERB-APH) on Friday, 13<sup>th</sup> March 2020 for ethical clearance and more importantly, to seek permission. On the Friday, 22<sup>nd</sup> of May, 2020, I went to add the ethical clearance from the UCCIRB as it was a requirement of the process. On Tuesday, 16<sup>th</sup> of June, 2020, ethical clearance was issued by the Ankaful Psychiatric Hospital permitting me to officially access and use the facility to recruit their clients as my participants for the study. It is important to mention that this permission was given based on some strict conditions of which some were written/documented (attached in Appendix C) and some, unwritten/undocumented. I was then introduced to the OPD manager and the various unit heads at the OPD on Friday, 19<sup>th</sup> of June, 2020 by hospital administrator.

### **The Interview Procedure**

An in-depth interview guide was used for the data collection. This was done through face-to-face interaction in both Akan and English languages with the selected participants. Three well-ventilated cubicles - at the Data and Records, Medical and Psycho/Detention Units - were allocated by the respective heads for the interviews.

Each selected family caregiver was taken through the objectives of the study and the data collection procedure for them to voluntarily decide whether

to participate in the study or not. Their consents were obtained through both oral and with the use of consent forms. In order not to miss any relevant data, the interviews were audio-recorded with the permission of the participants. However, the majority (10) of them did not agree to be recorded irrespective of the explanations that were given. Therefore, note-taking was used to collect the data of these participants and that took much time for an interview to be completed as compared to those in which the voice recorder was used. Interviews with family caregivers who allowed voice recording lasted between 20 minutes and 35 minutes while interviews in which note-taking was used lasted between 1 hour: 20 minutes and 3 hours. But it is imperative to state that all the selected family caregivers were taken through the same themes as developed in the IDI guide for the study.

Through the interviews, the participants had the opportunity to freely express themselves to explain and interpret their socially and culturally constructed perceptions on mental illness, their experiences concerning their roles as caregivers, and how these have influenced their treatment-seeking decisions and behaviours. These helped to satisfy the intent of the study and also served as a good source of data for the study.

### **Data Source**

The data for the study were derived solely from the primary source. This was obtained directly from the field through in-depth interviews. Though I referred to the OPD records to get the total number of clients that visited the facility during the fieldwork period, the records (dataset) were not used for any analytical purpose.

## Validity and Reliability

Validity and reliability are two concepts that when adequately ensured, increase transparency and decrease opportunities of introducing biases in research (Mohajan, 2017). To Bryman (2012), the establishment of validity and reliability in qualitative research is all about the trustworthiness of the data. Therefore, in ensuring trustworthiness of the data, some measures were adopted.

First, to ensure instrument (IDI guide) validity, a pilot study was done with four families of persons with mental illness at the Amamoma community. This was imperative as it ensured the appropriateness of some of the questions. It should also be stated that the development and final approval of the instrument for use was done by my supervisor and some experts in the field of Medical Sociology and Mental Health.

Secondly, all the participants were taken through the same themes in the IDI guide in the course of the interviews. This exercise was necessary to ensure that consistency was built and appropriate responses were retrieved during the interview process. Secondly, expressions and gestures made by the participants in the course of the interview were observed and probed for confirmation and clarification. There were instances where some gestures portrayed by the participants seemed divergent from the response given. Therefore, to understand them well, they were probed accordingly based on the unclear expressions and observable gestures that they made for confirmation and clarification.

More so, each participant was interviewed on each theme to the point of saturation in knowledge. Also, the participants were interviewed to the point of data saturation where no differing information was raised. That is why the interviews ended after the 14<sup>th</sup> participant.

The tape-recorded interviews were played to the respective participants (who were interested) to ascertain the information given. The first two participants added new insights to what they were already given and that motivated me to do it with all the participants that allowed for the interviews to be tape recorded. Lastly, the transcripts were made available for interested participants to review their responses (that is, number checking). This was adopted to verify interpretive accuracy as espoused by Bashir, Afzal and Azeem (2008).

### **Data Processing and Analysis**

The data collection was done largely using the Akan language (specifically, Twi and Fante) as most of the participants were more conversant and comfortable with it. The data was then transcribed and translated from the Akan language into the English language for the analysis. This was carefully done in order not to twist the meaning. Also, to avoid dangers of procrastination and inaccurate representation of experiences from each interview, transcriptions were done at the end of each day's interview.

The data processing and analysis was done per Braun and Clarke (2006) thematic analysis plan. Braun and Clarke provided six phases for qualitative data analysis using thematic analysis. These are; familiarization with the data set, generation of codes, searching for themes, reviewing themes, defining and naming themes, and report writing. At the first stage, I thoroughly read through all the transcripts to acquaint myself with the issues that the participants shared with me. Through that, codes were given to the various issues that emerged. Themes were searched for from the transcripts, grouped, and were again reviewed to ensure appropriateness in the third and fourth stages. In the fifth

and sixth stages, the grouped themes were assigned/given overarching names/headings for the report (as given in Chapter 4) to be written in an orderly manner.

Through that, the data were organized into three main themes reflecting the research objectives and questions. These were: perceptions of family caregivers on mental illness; experiences of family caregivers with their relatives' condition; and family caregivers' perceptions on mental illness and mental health care utilisation. An additional 13 and two sub-themes emerged within and outside the main themes, respectively. The data were represented qualitatively in the form of descriptions and narrations with the use of quotations from the participants. These were then discussed in the light of the reviewed empirical studies and the underlying theories.

### **Ethical Considerations**

For research to be conducted responsibly and professionally, ethical issues are very important (Fouka & Mantzourou, 2011). Ethical principles are a set of moral rules which guide a research study to prevent harming others in the course of the research. As such, the following principles were employed and acknowledged.

First, informed consent for each participant was ensured. Each participant was taken through the objectives and methods of the study. This was done to ensure that all the participants understood the entire research process for them to voluntarily participate in the study. The participants gave oral consents and were documented with the use of consent forms per the requirement of UCCIRB. More so, participants' freedom to withdraw at any

time during the research process as espoused by Blanche, Blanche, Durrheim, and Painter (2006), was acknowledged.

Secondly, to ensure that the privacy of each participant was respected, they were asked to ignore questions that they felt emotional with. This was important as the participants were required to share their experiences as far as their caregiving role is concerned for the purpose of the study. Yet, to be on safer side, all the selected participants were taken through some form of counselling by the in-charges of the various units to manage any (potential) emotional feelings and situations.

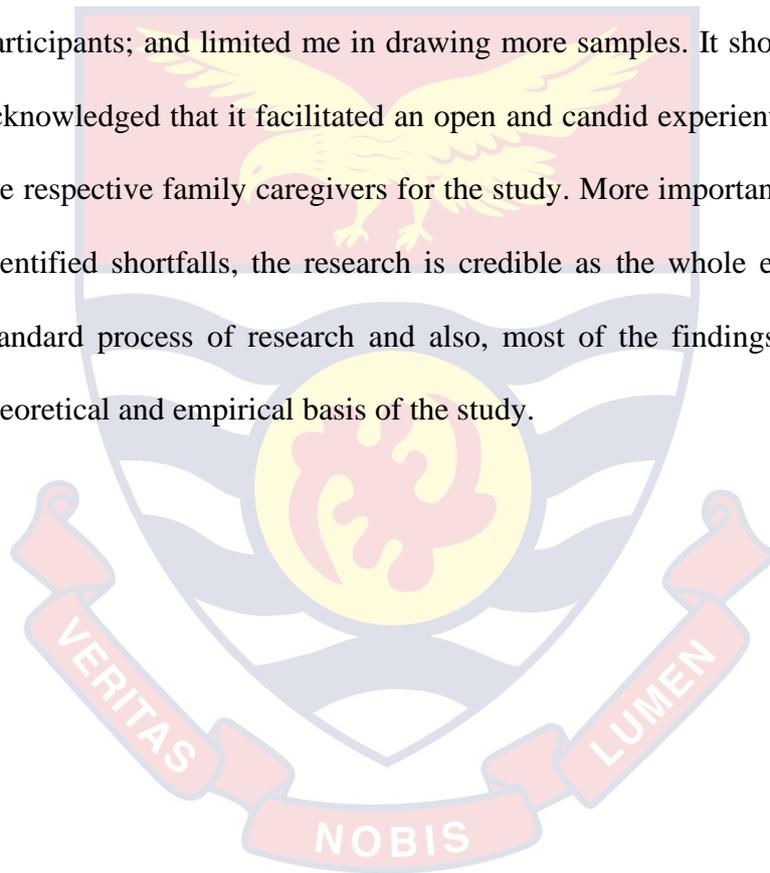
Also, it was imperative to protect the information gathered from the participants. Therefore, I ensured that responses given by participants could not be traced back to them in any way in the analysis. Participants' names were not included in any part of the study report, but pseudonyms were used to ensure anonymity. Finally, the information given by participants were managed as private and sensitive, thus, treated as such to ensure confidentiality. In this case, adequate security was provided to prevent third party access to my field notes, tape recorder, and laptop throughout the whole exercise.

### **Chapter Summary**

This chapter expounds on the methodological approach of the study. It provides information on the study institution, research philosophy and design, population, sampled participants and sampling procedure, data collection instrument and procedure, data sources as well as data processing and analysis. Other issues like ethics and validity and reliability were also discussed.

It is important to note that the study focused mainly on family caregivers - as it sought to examine how their perceptions on mental illness influenced their

treatment-seeking decisions and behaviours for their mentally ill relatives - thereby, my inability to include those suffering from the condition to participate in the study. Though their inclusion in the study could have added a new perspective to the phenomenon, they were excluded because of their unstable mental condition which could affect their responses. Also, the adoption of the qualitative approach cornered me to choose in-depth interviews as a data collection technique; used a purposive sampling technique to select the participants; and limited me in drawing more samples. It should, however, be acknowledged that it facilitated an open and candid experiential account from the respective family caregivers for the study. More importantly, despite these identified shortfalls, the research is credible as the whole exercise followed standard process of research and also, most of the findings corroborate the theoretical and empirical basis of the study.



## CHAPTER FOUR

### RESULTS AND DISCUSSION

#### Introduction

This chapter presents the results and discussion of the data collected from the field. The chapter is in four sections. The first section describes the socio-demographic characteristics of family caregivers, while the other three sections focus on the perceptions of family caregivers on mental illness, experiences of family caregivers with their caregiving role, and the influence of their perceptions on mental illness on MHC utilisation. A total of twelve (12) sub-themes emerged from the main themes. Additionally, two other issues emerged outside the main themes and have also been reported.

#### Socio-Demographic Characteristics of Family Caregivers

The socio-demographic characteristics provide an idea of the kind of family caregivers that participated in the study. In the discourse of mental health and illness, it is vital to consider the socio-demographic characteristics of family caregivers to understand their treatment-seeking decisions and behaviours. The socio-demographic characteristics of family caregivers presented were sex, age, religious affiliation, ethnicity, marital status, level of education, occupation, and family caregivers' relationship with the patient. This profile has been captured in Table 1.

Out of 14 participants, 11 were females and three were males. This disparity is not surprising as the caregiving role is ascribed more to the females than the males. The ages of the study participants as captured in Table 1 have been grouped into three cohorts with an interval of 10 for easy count. The minimum and maximum ages recorded were 29 and 57 years respectively. The

age cohorts are 29-38 years; 39-48 years; and 49-58 years. The ages were spread across the three cohorts: one participant was between 29-38 years; six participants were also between 39-48 years; while seven were between 49-58 years. Also, out of the 14 family caregivers, 9 were Christians, and 10 were Akans.

It is often assumed that the education of family caregivers could influence their decision to utilise mental health facility. In this regard, it was imperative to obtain their level of education. An observation from the data in Table 1 shows that two out of the 14 family caregivers had no formal education, with the rest having some form of formal education ranging through the various cycles from primary to the Ph.D. degree.

The kind of occupation that family caregivers were engaged in is essential in the discourse of mental illness. This is because caregiving comes with a cost; hence, an income is needed in that regard to take care of the mentally ill relatives. The occupation of family caregivers as shown in Table 1 indicates that all the family caregivers were engaged in various activities that accrued them with some incomes. While some worked in the informal sector, others also worked in the formal sector of the economy. Notwithstanding, majority (9) of them were engaged in the informal sector of the economy and this has been captured in Table 1.

**Table 1: Background Information of Family Caregivers**

S/N	Pseudonyms	Sex	Age	Religion	Ethnicity	Marital Status	Educational Level	Occupation	Relationship with Patient
1	Participant 1	Male	31	Christian	Akan	Single	SHS	Building contractor	Twin brother
2	Participant 2	Female	56	Christian	Akan	Married	Form 4	Trader	Daughter
3	Participant 3	Female	55	Christian	Akan	Married	Middle School Cert	Retired Hospital Staff/Farmer	Daughter
4	Participant 4	Female	49	Christian	Akan	Married	SHS	Trader	Daughter
5	Participant 5	Female	39	Christian	Ewe	Married	Diploma	Teacher	Mother
6	Participant 6	Male	39	Christian	Akan	Married	PhD	Lecturer	Sister
7	Participant 7	Female	49	Christian	Akan	Divorced	First degree	Cocoa buyer	Brother
8	Participant 8	Female	40	Christian	Akan	Married	First degree	Immigration officer	Sister
9	Participant 9	Female	57	Christian	Akan	Widowed	None	Farmer	Daughter
10	Participant 10	Female	43	Christian	Akan	Married	Diploma	Care worker	Sister
11	Participant 11	Female	41	Christian	Akan	Married	First degree	Psychiatric nurse	Sister
12	Participant 12	Female	43	Muslim	Akan	Married	Second degree	Business woman	Daughter
13	Participant 13	Female	54	Christian	Akan	Complicated	Primary	Queen mother/ Business woman	Sister
14	Participant 14	Male	51	Traditionalist	Northerner	Married	None	Herbalist	Brother

Source: Fieldwork (April, 2020)

### **Research Question 1: How do Family Caregivers Perceive Mental Illness?**

One of the main tenets of this study was to explore the perceptions associated with mental illness by the family caregivers at Ankaful Psychiatric Hospital. This was imperative because, as far as the healing or treatment of persons with mental disorders is concerned, family caregivers' perceptions about their condition is very critical. According to Muga and Jenkins (2008), perceptions that family caregivers associate with their relatives' condition is imperative as it ties with their treatment-seeking decisions, behaviours, and options to be utilised. This section has three sub-themes: perceptions on the causes of mental illness; perceptions on the treatment of mental illness; and source(s) of knowledge of the family caregivers on mental illness. Inquiring from the participants on these sub-themes, the participants expressed varying views, though some of the views cut across. These varied views were as a result of the differences in the socio-demographic backgrounds of the participants.

#### **Perceptions of Family Caregivers on the Causes of Mental Illness**

Three main ideas emerged with the perceptions on the cause of mental illness. While some believed that mental illness was a result of supernatural factors, others attributed it to social factors and genetic factors. Specifically, six of the participants said that their relatives' condition was due to supernatural causes whereas four said that their relatives' condition is due to social factors. The remaining participants either attributed it to supernatural, social, and genetic factors concurrently.

#### **Supernatural Factors Underlying Mental Illness**

Some of the family caregivers were of the view that supernatural factors caused their relatives' mental illness. They did not understand why their

relatives could suffer from such a condition if it were not a spiritual attack. Some of the participants uttered:

*“For us from the rural communities, witchcraft is a common thing and don’t forget we don’t use these powers for good things in Ghana. They (witches) always find ways to disgrace people who are excelling in the family...they won’t kill you ooo...but they will just let you spend all that you’ve acquired treating it and at the same time, cause a big shame to you for you to lose everyone”* (Participant 8, a 49-year-old cocoa buyer).

Participant 1, a 31-year-old building contractor also indicated that:

*“I think there are some spiritual forces behind this. With my brother’s case, I think someone cast an evil spell on him. He’s a teacher in an international school and in the same school, one teacher developed similar condition, when he got well, my brother’s own came...you get what I am trying to say? Someone is doing something evil with the teachers in that school...I tell you!”*

*“Condition like these is either a spiritual attack or a punishment from God. As Christians, we are supposed to pray during such times. Who knows, maybe something is wrong somewhere...maybe she’s done something I don’t know.”* (Participant 11, a 57-year-old farmer).

The views expressed by the participants who believed supernatural factors caused their relatives' conditions range from bewitchment, spell cast,

will of God, to punishment from God as a result of wrong done. In the case of Participant 1, he believed that his brother's condition was repercussions of some evil rituals that were going on in the school. From his narration, just like in the case of Participant 8, they are not the only victims, but someone had suffered a similar fate, hence, their attribution of the condition to spiritual forces. These sentiments by the participants were in line with the findings of other studies in Ghana like Ofori Atta et al. (2010) and Read, Adiibokah and Nyame (2009) which revealed that supernatural factors cause mental illness. The scholars also reported from their studies that mental illness among individuals was caused by witchcraft and evil spirits in the family.

Also, the narration by Participant 11, who was not so sure about the cause of her daughter's condition corroborates the findings by Adebowale and Ogunlesi (1999) in Nigeria. However, she was in a state of dilemma as to whether the condition was a spiritual attack or caused by the will of God. The findings from the earlier studies by Adebowale and Ogunlesi revealed that mental illness was caused by spiritual factors such as the will of God, divine wrath, or as a form of punishment to individuals.

### **Social Factors Underlying Mental Illness**

Other family caregivers were of the view that social factors caused mental illness. Those who indicated this believed that day-to-day happenings and interactions among individuals in the society pose some form of stress which could cause mental disorders. For instance, Participant 6, a 39-year-old lecturer summarized it by saying;

*“Mental illness is caused by negative or unfortunate circumstances. It could be as a result of the death of a loved*

*one, harsh treatment, abuse of alcohol and drugs, among others. Yeah, also relationship issues could trigger it...just like my girl here (his junior sister). Sometimes, trauma from horrible situations like rape, car accidents, kidnapping, like it was happening in Takoradi, yeah, those girls...errrr... robbery... this is simple, but I don't know why people attach spirituality to this."*

The narration by this participant as well as other participants supports the findings of Cook and Wang (2011). According to the authors, issues that individuals experience from their social relationships, like their families and work cause negative stress which affects their mental health. Through these experiences, some develop mental disorders like depression and anxiety disorders. Further studies by Barrera, Gonzalez and Jordan (2013) and Naeem et al. (2012), also corroborate the finding of the current study. The authors in these studies re-emphasized that bad experiences from childhood violence, domestic violence experienced by adults in relationships, divorce, trauma from accidents, and the death of a loved one could cause mental health disorders.

One participant had a mixed-view on the causes of mental illness. The participant started first by indicating that individuals develop mental disorders through social factors like abuse of drugs. Again, the participant believed that mental disorders could be biological, though attributed the relative's condition to social-related issues. While interacting with Participant 10, a 43-year-old care worker, she narrated that:

*"Since childhood, all I knew from our hometown was that only individuals who abuse drugs develop mental problems."*

*While I was growing up in school, I learnt it's genetic...just like that AA, AS, SS things that the doctors have been talking about...sickle cell (she muttered).*

*But with my sister's condition, I asked one doctor and he said it's called 'anxiety disorder or depression or so.' I think he's right because she was about to travel to the US to visit our mum when corona came and her boyfriend too left her.*

*Hmmm...so I will say it's a combination of several factors like overthinking, anticipation, stress, self-blaming, and disappointment."*

From the above narration, the participant had enough ideas about the causes of mental illness from her community and school. Though her view cut across different findings from different studies, it showed two broad points: genetic/biological, and happenings in the society (social factors). The first perceived cause of mental disorder confirms the findings of Kabir et al. (2004) in Nigeria. The authors reported in their study that abuse or misuse of drugs was the major cause of mental disorders in their study area.

Also, the part that she attributed the mental illness to genetic/biological factors supported the findings of a study by Angermeyer and Matschinger (2005) on the causal beliefs and attitudes to people with schizophrenia in Germany. Some of the participants in this study believed that mental illness among individuals has some biological or genetic connections. Rachael in my study also believed that mental disorders could be transferred from parents to their children during birth.

Finally, it was revealed from Participant 10's narration that issues such as overthinking, anticipation, stress, self-blaming as a result of accidents /misfortune, and disappointments among individuals could cause mental illness. These were what Cabassa et al. (2007), termed as interpersonal and social factors that caused mental illness in their study. Cabassa and his colleagues termed the issues as interpersonal and social factors because these factors affect individual relationships in the society, thereby, affecting mental health. Also, the finding from my study confirms the assertion of Barrera et al. (2013). In that study, it was reported that experiences that individuals go through in the society usually affect their mental health thereby causing mental disorders.

Interpretations given by the family caregivers in the study institution on their perceived thoughts on the cause of mental illness were largely from their experiences with their relatives' condition and interactions with others within their respective communities (Corrigan, Markowitz, & Watson, 2004; Read, Adiibokah, & Nyame, 2009). These experiences and interactions shaped the thoughts of these individuals, making them accept it as reality.

Theoretically, the social construction theory gives a basis for this explanation and posits that the reality of any event is socially constructed. The construction could be seen as an ongoing process as a result of the change of environment of individuals at a point in time. In this case, someone who was born and raised in a rural community already has his/her created perception about the mental illness, but when the person moves out, say to an urban community or school (like in the case of Participant 10 and other participants in the study), their perception changes about the same condition. Therefore, it

could be realized that beliefs, experiences, and interactions within the society played a role in shaping the perceptions of family caregivers.

### **Perceptions of Family Caregivers on the Treatment of Mental Illness**

Based on the perceived cause associated with mental illness by family caregivers, they were asked of their views on whether their relatives' condition was treatable or not. At this point, all the family caregivers, irrespective of their socio-demographic background, and perceptions expressed on the cause of the condition, believed that mental illness is treatable. Though their views differed from one another, it confirmed the work of van der Watt et al. (2017) in Ghana. The study of van der Watt and his colleagues on the collaboration between medical and complementary and alternative care providers revealed the two ways in the treatment of mental illness: medical means which involves the utilising of the hospital/medical services, and non-medical means which involves the utilising of the services of religious, herbal and spiritual centers.

The views expressed by the family caregivers in the study institution were within the two main treatment options. But, some of the views were interwoven under both treatments. For instance, Participant 3, a 55-year-old retired hospital staff/farmer said that;

*“Why will I be here (the hospital) if it can't be treated?...this is not the first place I have visited...I have been here for just three days and have seen improvement in her condition...the most important thing is continuous medication. Even the first places (prayer camps) I visited to fix the problem, it was effective, just that this one has persisted for long that's why I brought her here.”*

*“What condition can’t be treated, tell me, apart from death? Allah is the greatest...for we the Muslims, we consult in everything. So, after consultation and knowing the cause, then we find out the appropriate way of treating it...  
...if its caused through charm or something or maybe it’s a punishment as a result of a wrong she has done, some rituals will be done to cleanse her and that wouldn’t be any long process.”* (Participant 12, a 43-year-old business woman).

Participant 6 further said that mental illness was treatable and could be treated through the medical means. He said;

*“...oh yeah, this isn’t anything serious...I have been telling her. It’s just like malaria or headache...all I need to do is to make sure she sticks to the treatment/medication and she will be fine soon.”*

The perceived treatment of mental illness by family caregivers depends on its perceived cause (Muga & Jenkins, 2008). Therefore, family caregivers who believed that some spiritual forces underline their relatives’ condition had utilised the services of prayer camps for spiritual consultations, healing, and treatment. Like in the case of Participant 3, and others, they took their relatives to prayer centers around their place/area for spiritual healing and sanctification. This was because they believed their relatives’ condition was a result of bewitchment, charm and punishment from God. These findings corroborated the works of Adewuya and Makanjuola (2008) and Choudhry et al. (2016) whose studies revealed that mental health disorders that were perceived to be

caused by spiritual factors were also perceived to be treated through herbal and spiritual means.

Also, some family caregivers mentioned the utilisation of the services of the hospital for the treatment of mental disorders. They believed that mental illness was caused by personal, interpersonal and other social factors. Interactions among individuals in the society posed some stress which negatively affects the mental health of individuals. Therefore, these findings confirmed that of Cabassa et al. (2007) study which cited counseling sessions and medication for the treatment of persons suffering from mental illness.

The health care utilisation model explains this phenomenon with a justification that what individuals are predisposed to influence their health-seeking decisions and behaviours. Therefore, as family caregivers already had their perceptions created about mental illness through the interactions they have had with others in the society as well as their experiences with the condition, it influenced their decisions and behaviours whether to seek for treatment or not as well as the kind of treatment to seek; whether medical or non-medical - for their mentally ill relatives.

### **Sources of Knowledge on Mental Illness**

The third theme that emerged in the course of the interview was on how and where the participants got to know about the condition under study. This was imperative since family caregivers were exposed to numerous agents and agencies (such as family and friends, school, and the media) and could serve as source(s) of their knowledge. Hence, they were asked on their knowledge - both on the causes and treatment - on mental illness. Participant 4, a 49-year-old trader indicated that:

*“For the knowledge on the causes, I listen to “Ewiase mu nsem” on Nhyira FM, so I got it from there. I knew someone can bewitch you so that you don’t progress or give you stroke or AIDS or something evil, but I never knew mental illness is part till I heard it on that program.*

*For the treatment, because of that program, all I knew was the spiritual consultations through some prophets and divine healers which they did on the radio, but my husband never allowed me to send his daughter there. He wanted us to bring her here first and if they fail to treat her, then we think about those places as plan B. He believed it was stress, you know she was about to write the WASSCE before it happened.”*

Participant 1 also revealed that:

*“To be sincere, as we are walking in this world, there are spiritual forces at work...you don’t need anyone to tell you this. And since my brother’s condition started, I have been researching and asking questions about it from different places and people. That’s where I got to know that his colleague teacher in that same school developed a similar condition. He’s the one who explained everything to me.”*

*“This is what I have been trained to do...I am a counselor...so that’s the source. But...errrrrm...I will also give credit to my family and church...you know, they scared us with alcohol and drugs when we were kids so...(she laughed)” (Participant 11, a 41-year-old psychiatric nurse).*

The source of knowledge of family caregivers on mental illness came from different arena. However, majority of the sources came from their family and friends, with a few mentioning school (education) as their source of knowledge. Some also had theirs from the media and the society/community in which they live. The social construction theory explains how individuals create their knowledge about an event/situation from the environment that they find themselves. In this case, the society/community, education/school, media, as well as family and friends served as platforms for which individual participant got to know about mental illness.

**Research Question 2: What are the Experiences of Family Caregivers with their Caregiving Role?**

Family caregivers of persons with mental illness have over the years gone through series of challenges (Glozman, 2004). This, in a way, affect their daily lives and also affects their decisions and response to help-seeking for their mentally ill relatives. As such, the participants were asked about their personal experiences, in relation to their social and economic lives as far as their caregiving roles were concerned. Varied responses were given, but also, they were asked about how these experiences had influenced their decisions to seek treatment for their mentally ill relatives.

**Personal and Social Life**

All the family caregivers have had some experiences with their relatives' condition and gave an account on how that had affected their personal and social lives. Some of them indicated that:

*“hmmm...it has not been easy at all. I can't do anything...I can't go anywhere...I can't go to church, I am just shy, they*

*just stare at you when you step out...the stigma alone...hmmm...I always cry at night. I've locked my store, all those who used to come to me even for help have stopped because someone spread in the community that we've used my own daughter for rituals.*

*You see, my husband works with this UK people, so coincidentally, our daughter's situation started when they allowed him to bring the company car home after work. The people think the car is for us ooo. That means we used our daughter for a car...just a car...could you believe that?...but I know God is alive!...she sighed” (Participant 4, a 49-year-old trader).*

*“...I told you they are old now right?...so instead of them to be enjoying peacefully in their old ages, they are thinking about his (my twin brother's) condition. They now look like 150 years old people now (he smiled sadly). I know they are very hurt and sad from within and have done all that they could.*

*Also, because we are twins and I am hard and at the same time he's the one suffering from this condition, those “village” people say I've bewitched him. How can I bewitch him and leave my work to take care of him?...who does that? It's because of him that's why I've not even married. (Participant 1)*

Experiences faced by the participants cut across one another. Some mentioned stigma which confirmed the earlier work of Tawiah, Adongo and Aikins (2015). Tawiah and his colleagues reported that family caregivers, as well as the entire family of persons with mental disorders, experience social stigma which is usually associated with the condition.

Also, most of the family caregivers mentioned that they feel shy and cannot go out because of the relatives' condition. This was a result of how people in their communities had interpreted the cause of mental illness. To a farther extent, close friends of the family caregivers had ceased coming to them like they used to because of their relatives' condition. This finding was in line with the studies of Robinson-Whelen et al. (2001) and Ae-Ngibise et al. (2015). The scholars, in their findings, mentioned that family caregivers of persons with mental illness were socially isolated/excluded, thus, reducing their social contacts and interactions. As such, they could not attend social activities like weddings, funerals and religious meetings as a result of public ridicule that was associated with their role as caregivers; which is exactly like in the case of Participant 4.

Lastly, instances where family caregivers were starred at and mocked again confirmed the work of Tawiah et al. (2015). These works reported that family caregivers of persons with mental illness were stigmatized, mocked, and were labelled with names; which is similar to Participant 4's experience.

### **Economic Life**

On how the role of caregiving had affected the economic lives of the participants, many worrying views were expressed. Some of the responses are:

*“I told you I am into business...so I had money...I really had money. I was the one taking care of all my sisters and their children...so money wasn't a problem. At the initial stage, I was recording all the expenses, but I lost track. You see, I decided to halt with my business and treat her first...(she sighed). If I tell you the amount of money I've paid to the so-called prophets in their so-called attempts to heal her, you will be shocked.*

*Aside the pastors, I took her to other herbal clinics and hospitals before she was finally referred to this facility. And the medical bills are no joke (she sighed). If you don't have money, pray that your relative doesn't get this kind of condition.” (Participant 12).*

*“We have lost everything...my work, my house...everything. It's expensive to treat these conditions ooo. And I've borrowed money all around to the extent that I've exhausted all my options...not even a loan from the bank. I took a loan of Ghc 5,000 and it flew...whim...just like that.” (Participant 7, a 49-year-old cocoa buyer).*

The participants highlighted that they were faced with financial stress as a result of their caregiving role. Some had borrowed money from other family members, as well as from people outside the family since they had already spent all that they had. Some had stopped working, which had rendered them poor. As a result, some had developed some ill-health conditions. The findings from the current study concurred with the previous work of Anokye (2018) on the

needs of family caregivers of people living with mental illness in Kumasi, Ghana. According to Anokye, family caregivers were faced with huge financial problems in the quest of treating their relatives' condition. Some were also faced with challenges with their accommodation and that of their mentally ill relatives.

### **Experiences of Family Caregivers and Treatment-seeking Decisions**

This subject emerged during the interactions with the participants. I realized majority of them decided to use the facility because of the stress, stigma, shame, and loss that they had gone through as a result of their relatives' condition. For instance, Participant 12 narrated that:

*"I'm tired...these prophets can't help. They were just interested in my money. I had my money before I got pregnant with this girl and even when she came, I had always had my money through my hard work, and it's not now that I will want to use her for (money) rituals. Coming here is two things: one, I want my sweet girl to get better so that I can also have a rest, peace of mind and start my business; and two, see if my wicked sisters and neighbours who think I am the cause of this condition can call or come back to me for help"* (she sighed with disappointment)

Besides, Participant 8, a 40-year-old immigration officer also indicated that what she, together with her entire family had gone through influenced her decision to seek medical attention for her mentally-ill relative. She said:

*"Right from the beginning, I told them that we should take her to the hospital since I knew it wasn't spiritual. I am not*

*a doctor, nor health worker, but I knew it wasn't spiritual...this started when our mother died...she was very close to her.*

*The community elders even accused my father of her condition. The whole family has gone through a lot, aside the money that we've thrown away...the stigma and social exclusion are too much...That's why we are here, for quick and professional treatment. Why should I be paying for services that was not producing positive results...tell me (confusedly, she asked)?*

Experiences faced by the participants were identified to have influenced their treatment-seeking decisions and response to the condition. Empirically, this finding seems to be missing in literature thereby serving as an identified gap. However, it could be true since almost all the family caregivers that discussed this stressed on it as a facilitating factor on their decisions to access MHC for their mentally ill relatives.

### **Research Question 3: How do Family Caregivers' Perceptions on Mental Illness Influence the Utilisation of Mental Health Care?**

The third central theme which is also the main drive of the study examined how the perceptions associated with mental illness by family caregivers influenced their treatment-seeking decisions and utilisation of MHC of available options for their mentally-ill relatives. At this stage, the participants gave accounts on the kinds of treatment options they had utilised and why they did so. Three sub-themes (religious/spiritual, herbal, and medical [hospital] treatment options utilisation) emerged which gave a clear picture of how

socially constructed reality about the condition by family caregivers influenced their treatment-seeking decisions and behaviours. These could also be explained in the light of both the social construction theory and the predisposing factors in the health care utilisation model, which underpin the study.

The predisposing factors assumed that individuals had their own socially and culturally constructed perceptions about mental illness even before their relatives' condition. These perceptions as denoted by the social construction theory were created through the interactions among individuals and with other agencies (like the family, school, religion and health institutions) as well as the experiences with their relatives' condition. This, according to Andersen (1968), influences their decisions whether to utilise health care services or otherwise. Therefore, depending on the perceived cause associated with the mental disorder, appropriate treatment option(s) is/are utilised for the treatment of their mentally-ill relatives (Owens et al., 2002).

The three sub-themes that emerged are religious/spiritual, herbal and medical (hospital) treatment options. However, 9 out of the 14 study participants indicated that they had utilised a combination of at least two of the treatment options. Additional sub-themes emerged in the course of the interview as some participants narrated what influenced their decisions towards the use of those treatment options their mentally ill relatives.

### **Religious/Spiritual Treatment Option**

Utilising the services of religious or spiritual centers was believed to be one of the means of treating mental illness. Just a few of the participants made mention of this treatment option with only one placing much emphasis on its efficacy. Participant 14, a 51-year-old farmer stated that;

*“I knew it wasn’t physical so had to make some spiritual consultations. It helped, just that we didn’t finish the whole process...I didn’t know too...so it got severe again about a year ago. Though we are here to try this treatment, I am still undergoing through the rituals in our hometown. The man said I will have to complete the whole ritual process before he will be okay.”*

The participant, like many other family caregivers of persons with mental illness, had much believe in the spiritual means of treating mental illness. This was as a result of the perceived cause of the condition and also the background of the family caregivers. At this moment, mental illness was perceived to be caused by evil spirits and witchcraft. Therefore, its treatment involved driving out the evil spirits by individuals who were believed to possess some form of spiritual powers and were spiritual healers. Ruiz (1995), reported similar results in his study on the assessment, diagnoses and treatment of culturally diverse individuals from a Hispanic perspective. According to Ruiz, family caregivers who had no formal education, working in the informal sector and were earning low income usually attributed mental illness to spiritual factors, hence, utilised the services of spiritual/prayer centers to heal/treat their mentally ill relatives.

Also, the studies by Adewuya and Makanjuola (2008) and Choudhry et al. (2016), further confirmed the findings in my study. According to these authors, family caregivers in their studies attributed mental illnesses to spiritual factors, hence, cited spiritual consultations as its perceived treatment option.

It is also worth noting that all the participants in my study expressed hope in God, and took consolation from God as a coping strategy. For instance, Participant 5, a 39-year-old teacher said that;

*“God knows best, therefore, I just have to pray and hope. He knows I can’t carry this cross. It’s not easy (she sighed).”*

Participant 2, a 56-year-old trader also indicated that:

*“What can I say or do, Yes, condition like this is treatable but unless God Himself intervenes. Because, to be sincere, we’ve done all the best that we can. That’s why whatever you ask, I say only God knows”*

Having hope and faith in God was one coping strategy that I realized was used by most of the family caregivers. They mentioned that God knows all what was happening; therefore, they knew God would help/intervene at the appropriate time. This was parallel with the works of Cabassa et al. (2007) and Cook and Wang (2011). Their works revealed that one crucial help-seeking strategy employed by participants in their study for the treatment of depressions, a mental health condition, was having faith in God.

### **Herbal/Traditional Treatment Option**

The herbal treatment was seen as another option utilised by some family caregivers. Only one participant mentioned that he utilised the service of a herbal treatment center throughout his brother’s ailment. Participant 14, a 51-year-old traditionalist indicated that:

*“I am a traditional man, I believe in herbs...when herbs talk, I hear. So, I was combining some herbs at home for my brother. But you know two good heads are better than one,*

*so I consulted another friend who's also good in herbal medicine to help, but... (he sighed)."*

In a developing country like Ghana, herbal medication is common. Usually, the first point of contact for the treatment for all kinds of conditions is herbs. Herbal medicines were believed to possess some healing powers. As such, Participant 14, just like several other people in rural Ghana patronize herbal medicines in the treatment of symptoms of mental disorders. This confirms the study of Wood and Parham (1990) on the coping with perceived burden: ethnic and cultural issues in Alzheimer's family caregiving. The authors of the study reported that Black family caregivers used a broad range of informal supports. These informal supports included the use of herbs and concoctions for the treatment of mental illnesses. This option was chosen as a result of their ethnic and cultural background as well as the lay-explanations given to the cause and treatment of the condition.

Also, Ruiz's (1995) study, reported that family caregivers who had no formal education, working in the informal sector and were earning low income usually attributed the cause of mental illness to spiritual factors. Therefore, they utilised the services of herbal medicines means to treat their mentally ill relatives. By inference, participants in this study who had utilised the services of herbal treatment did so as a result of their background (occupation and where they lived), as well as the perceived efficacy of the herbal medicine. Nonetheless, the findings contradict Ruiz report since the majority (12/14) of the participants in my study had some form of education but patronized herbal treatment options.

### Treatment Using Hospital/Medical Means

On the treatment of mental illness using the services of the hospital or medical means, only three among the 14 participants mentioned that they had solely utilised this option since the beginning of their relatives' condition. They believed that the cause of mental illness had nothing to do with spiritual forces, hence, should be treated through medical process of diagnosis and appropriate prescriptions by psychiatric experts. Participant 6 narrated that:

*“Hey, you see the problem I have...why should you take a mentally ill person to these money-conscious men and women of God, mallams, and herbalists who call themselves doctors? Some even call themselves doctor-doctor and even professors.*

*As I've been saying right from the beginning, the application of common sense is very important, especially when it comes to a situation like this. For this my girl (pointing to his junior sister at the Detention Unit), no powers can bewitch her to cause this problem that's why I brought her here. When the specialists ask me to go and see a fetish priest, then I know it's a scientific direction.”*

Nevertheless, God's intervention, as reported in the studies of Cabassa et al. (2007) and Cook and Wang (2011) was still mentioned by some participant even while they were at Ankaful Psychiatric Hospital seeking for treatment for their mentally ill relatives. For instance, Participant 1 indicated that:

*“Errrrm, actually, we've only been utilising the services of the hospital all this while. You know we are Christians, and*

*my father doesn't like these prayer center things. So, though they have been praying for him at home for the past 7years, we've also been moving from hospital to hospital. If I could recall, we went to Dompase, Benito Hospital, that's where they gave him some medication which was effective but he wasn't taking it so the doctor referred us to Komfo Anokye Hospital and finally here.*

*Not that I doubt the effectiveness of prayer centers or shrine ooo, but you know if the condition is not spiritual, you can't solely rely on one means for treatment. That's why my parents pray at home and we use the hospital in addition. God works at the right time."*

Some of the participants revealed that orthodox treatment was appropriate for treating mental illness. This is because, revealed that as far as we live in the society, we cannot do away with families, relationships, and work/job, among other things. These come with stress and other consequences that affect the mental health of individuals. As such, some individuals live with traumatic experiences which were believed to cause mental disorders. During such times, the appropriate treatment option that was mentioned was seeing experts of mental health who would help in the medical diagnosis and therapy.

Empirically, the finding was akin to earlier works of Barrera, Gonzalez and Jordan (2013) and Kim et al. (2011). Barrera et al. revealed that victims of mental disorders employed medical services to manage the situation. This was because of their perceived knowledge on the cause of the condition which translated into the choice of medications as the effective means of managing the

condition. Kim and his colleagues on the other hand, also reported in their study that family caregivers who were abreast of the terms used by mental health professionals were motivated to access MHC for their mentally ill relatives and vice versa. They further reported that for family caregivers to be abreast with the terms used depended on their social status (like their exposure to the various relevant agencies and agents in the society, such as education/school, religious bodies, health experts, family, and friends).

Again, this has its theoretical basis in the two theories that underpin the study. This is because, as these agencies and agents help in shaping the perceptions and knowledge of the family caregivers (as argued in the social construction theory), it by extension, influence the kind of treatment to be utilised by family caregivers for their mentally ill relatives (as also argued in the light of the health care utilisation model) (Zuvekas & Fleishman, 2008).

### **Combination of Treatment Options**

Most of the participants in the study believed that fighting mental illness should not be done one-sidedly. In that case, resorting to different means was identified to be appropriate since one does not know where “miracle” could come from. Some of the responses given by the participants include:

*“Please ooo, can you see through the hole of a bottle with your two eyes? Never...(she muttered). So for me, as far as the recovery of my sister is concerned, I don't know where I have not entered...from mallams, fetish priests, pastors, prophets, herbal centers, hospitals. We even went to Pantang (Psychiatric Hospital) last year but we left there after some*

*time...they were too slow to my liking” (Participant 13, a 54-year-old queen mother).*

*“Though it started about 15 years ago, the sickness has been on and off. Usually, I take her to the prayer camp and she will be fine, but this one has been long...1 year now. So, I brought her here. So far, only two places - the prayer camp and here and I know this is the last stop per the little observation I have made.” (Participant 3).*

Participant 2, a 56-year-old trader also indicated that;

*“It started about 2 years ago, but she started preaching so we thought it was the holy spirit that had descended on her. We took her to one pastor who prayed for her. She became okay so we didn’t take her to any hospital because of how the condition presented itself. But on the 8<sup>th</sup> of April (2020) it became severe and she threw all the things in the store away. That’s where we took her to the hospital at Dunkwa for medication. Though I’m a Christian, I realised relying only on prayers might not help so I added hospital to it.”*

Most times, family caregivers are in the dilemma of which treatment to seek for their mentally ill relatives. Therefore, they are tempted to try any available treatment option. There were some instances where some of the participants mentioned that they had accessed interventions from faith/spiritual healers. In this case, they had to abide by the directions prescribed by these healers. In some cases too, some of the participants combined the directions from the spiritual healer with prescriptions from the herbal 'doctor' and/or

psychiatrists or medical doctors. Just as in the case of Participant 14 who was though at the facility with his mentally ill relative undertaking treatment, he was at the same time undergoing some ritual processes in his hometown.

Assion et al. (2007), in their study on patients' use of alternative methods parallel to psychiatric therapy, reported that family caregivers utilised more than one treatment options in their attempts to seek treatment for their mentally ill relatives. It could therefore be inferred that the utilisation of available treatment by family caregivers for relatives with mental illness is dependent on the family caregivers' and the entire family's perceptions associated with the cause and treatment of the condition, as well as the experiences that they had gone through. Therefore, if the family caregiver associates mental illness to social factors, and the family also attributes it to supernatural factors, conflict may arise in the kind of treatment option to seek. In this case, several options with the combination of medical treatment, herbal treatment as well as spiritual treatment options will be utilised either sequentially or concurrently.

In furtherance, according to Razali and Yassin (2008), and Sexton and Sorlie (2008), the use of traditional medicine together with orthodox medicines for the treatment of mental illness was common in Norway, and Germany. However, studies from Ghana and West Africa at large have been silent on reporting on this. Nonetheless, this study provides information on that.

### **Factors that Influenced the Decisions and Actions of Family Caregivers**

This subsection (as part of the research instrument) was developed to check consistency with the information given by the participants. Hence, it consists of bits of all the research questions. As such, the participants were asked

of what informed their decisions and actions towards the use of any treatment options for the wellbeing of their mentally ill relative. Some of the responses are as follow:

*“...I told you I was a staff at the Leprosarium before I was transferred and then to pension (retirement). So, I know all these places...the Leprosarium, Mental and the Prison. Since her condition has persisted for the past one year, I realized this is not spiritual, so stopped taking her to the prayer camp.” (Participant 3).*

*“oh my friend, if you know the cause of your problem, what should prevent you from tackling it from the root? You see, as I said, he acts like he’s possessed. Fortunately, one of his colleagues in the school suffered the same fate and was taken to the hospital which he became okay. He insisted, together with some of my relatives to take him to the hospital. We know the hospital medication is effective just that we couldn’t force him to take the medication regularly, and that caused some lapses. But, I know this place is professional so he will be fine.” (Participant 1).*

*“I have really suffered...I got tired and had no option than to bring her here. I know this condition came purposely to disgrace me but that won’t happen...(she started singing a hymnal). You see, it’s good to surround yourself with positive people. Some friends motivated and encouraged me on the hospital medication that’s why we ended up here. But it’s*

*very expensive to use the hospital...I now understand why people take their mentally ill relatives to prayer camps for them to be chained.” (Participant 9).*

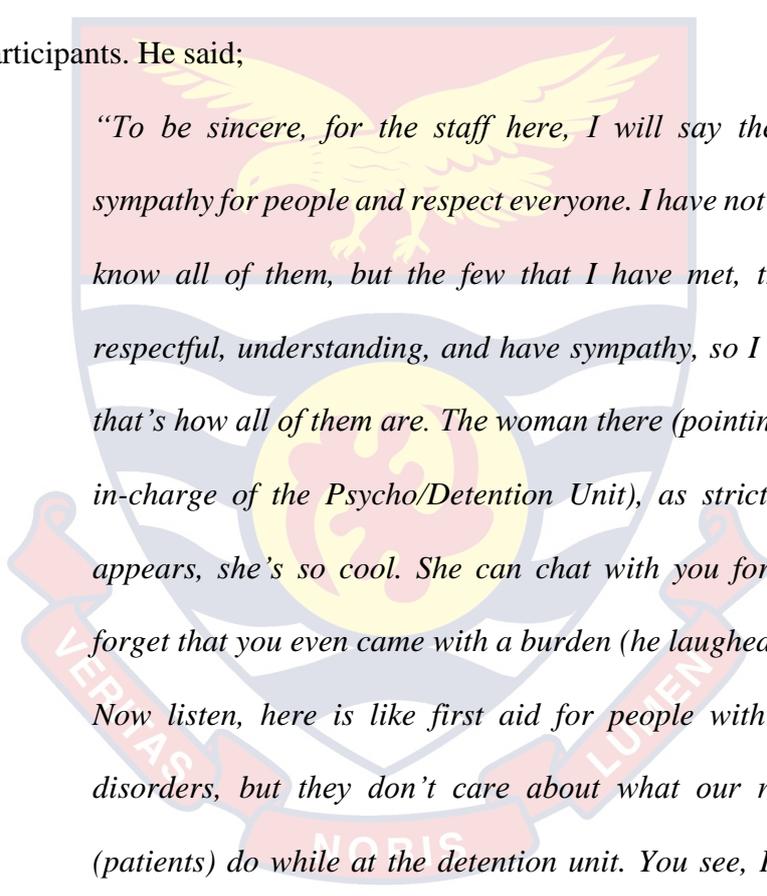
The participants’ decisions to seek treatment for their mentally ill relatives were informed primarily by their perceived view on the causes as well as their experiences with their relatives’ condition. Also, family, friends, as well as their perceived effectiveness of a particular treatment option played a role.

Theoretically, the two theories - social construction theory and health care utilisation model - that underpin the study help in the understanding and explanation of these behaviours. The social construction theory posits that individuals’ perceptual thoughts are shaped by the society; that is, the things that surround them like family, friends, education, and their work/occupation (Berger & Luckmann, 1991). Therefore, considering where some lived, worked, and the people that surrounded them, their perceptions on effective treatment strategy were established. The health care utilisation model also reinforces the notion that issues that surround family caregivers influence their decisions and behaviours of seeking treatment for their mentally ill relatives (Andersen, 1968).

Two additional issues emerged while interacting with the participants which were not part of the main intent of the study. However, the issues were important, so I decided to report as part of the findings. These are their (family caregivers) experiences with the use of the Ankaful Psychiatric Hospital and their concerns with my study. These have been reported in the subsequent subsections.

## Family Caregivers' Experience at Ankaful Psychiatric Hospital

One of the issues that emerged outside the main intent of the study is the experiences that the participants had with the use of the Ankaful Psychiatric Hospital. The experiences, as they shared with me, were both challenging and encouraging. Some were happy with the services available at the facility while some were not. Some too expressed a mixed-feeling on the services delivery at the facility. The view of Participant 3 summarised the views of all the other participants. He said;



*“To be sincere, for the staff here, I will say they have sympathy for people and respect everyone. I have not met nor know all of them, but the few that I have met, they are respectful, understanding, and have sympathy, so I can say that’s how all of them are. The woman there (pointing at the in-charge of the Psycho/Detention Unit), as strict as she appears, she’s so cool. She can chat with you for you to forget that you even came with a burden (he laughed).*

*Now listen, here is like first aid for people with mental disorders, but they don’t care about what our relatives (patients) do while at the detention unit. You see, I cannot handle my daughter that’s why I brought her here, but if I come and we still have to be running after our relatives (patients), then why are the staff here taking huge monies? (he asked softly).*

The major dissatisfaction that the participants expressed was the attitude of the health workers during the detention period. I observed an incident where

one young man (patient) ran on top speed through the hallway out of the OPD facility. I was expecting the health workers to act on that, but what I heard confirmed what Participant 3 said. Someone (a female voice) from one cubicle said a relative who was standing close that, “*let him go, don’t worry yourself.*” I was not expecting to hear that, then again, I thought maybe there was someone at the OPD entrance to stop the patient from going out. Unfortunately, that was not the case; it is “no man’s business” when that happens, but lies on the family caregiver to bring the patient back by any means. Some of the participants recommended how that could be solved. In brief, this is what Participant 2 said;

*“...there’s this drug they give to aggressive patients, so I suggest they give it to us (family caregivers) to keep it so that we administer intermittently for them (patients) to be calm always. If that is not possible, then I suggest they bring macho security men here. Let me ask, have you seen any security here? Not even one at the main gate. They should place security men at all points in the facility, especially here (the OPD). They (the security) could help by stopping patients who ran outside the facility during treatment.”*

### **General View of Family Caregivers on the Study**

Some of the participants raised some issues about the study and mental health care in general. Their concerns centered on two main issues; public knowledge on mental health/illness, and financial coverage on MHC under the National Health Insurance Scheme (NHIS). As some were concerned about the low level of education of mental health in the country, some were also

concerned about the high cost involved in the care and treatment of mental illness. Some of the responses are:

*“...until you get a condition like this, you wouldn’t hear anything about it. I didn’t take it seriously until my sister developed it. Look, when I came here, I have had a series of interactions with other relatives (family caregivers), and I can say the knowledge on it is low. I therefore recommend through your studies that the Government of Ghana, Ministry of Health, Ghana Health Service and its allied agencies should enhance the promotion and campaigns of mental health...it will be for our own good.”* (Participant 6).

*“When you put on your radio, all you could hear is Dr. Amuzu Dr. Amuzu. Everything on the radio nowadays is about sex and alcohol. Meanwhile, the Mental Health Authority as the mother body could do small education across the country like how the Ghana Health Service do with malaria, cholera...”* (Participant 10, a 43-year-old care worker).

On the issue of the NHIS, this is what Participant 5 had to say;

*“...they said NHIS covers mental health care, but that’s not the case...(she said with a disappointing voice). Look, I paid Ghc 400.00 before she was taken to the detention unit...the small small amounts I’ve paid is not part ooo. Before admission to the ward too, I’ll have to pay another Ghc 300.00, but you know I will spend about Ghc 500.00 in*

*reality there. Does it mean those who are poor shouldn't seek medical (mental) health care for their mentally ill relatives? That's not fair?...please, I don't know how, but something must be done about it!"*

Though the study did not aim at soliciting for views of the participants on anything outside the scope of the study. Nevertheless, these issues erupted. It is worth stating that the issues raised by the study participants were genuine concerns of most family caregivers of persons with mental illness.

### **Chapter Summary**

The chapter presented and discussed the findings of the study; family caregivers' perceptions on mental illness and MHC utilisation at the Ankaful Psychiatric Hospital. The study had 14 family caregivers participating in the study. Out of these, majority (11/14) of them were females, and 40 years and above respectively. Also, majority (12/14) were Christians, Akans, and had some form of formal education respectively, and most (10/14) of them were married.

The study was guided by three research objectives. Objective one explored the perceptions of family caregivers on mental illness. This objective had three sub-themes: perception on the cause of mental illness, perception on the treatment of mental illness; and source of knowledge on mental illness. Most family caregivers believed supernatural forces such as witchcraft and evil spirits caused mental illness. On the treatment of mental illness, though the study was conducted at a mental health hospital, majority of the participants were pointing to the spiritual means of treatment due to the perceived cause associated with it. Finally, family and friends, education (school), and the media were the main

source of information to the family caregivers. The second objective also explored the experiences of family caregivers with their caregiving role. Social exclusion, stigma, and financial issues were the main challenges that were mentioned to have experienced by the family caregivers. It was revealed that these experiences in a way, influence their treatment-seeking decisions. The last objective examined how the perceptions of family caregivers on their relatives' condition influenced their treatment-seeking decisions and behaviours. Treatment using the religious/spiritual, herbal/traditional, and hospital/medical means were revealed to be utilised by family caregivers of persons with mental illness. However, it was revealed in the study that most of them had utilised a combination of these treatment options in their quest to seek good mental health for their mentally ill relatives.

Finally, two additional issues emerged where the participants indicated their displeasure with the attitude of the mental health workers and the high cost associated with the care and treatment of mental illness. Nonetheless, in the light of the social construction theory and the health care utilisation model, the society (including the various agents and agencies/institutions) shape the perceptions of individuals on mental illness which influence their treatment-seeking decisions and behaviours which was evident in the study. The summary, conclusions, and recommendations of the study have been presented in the next chapter.

## CHAPTER FIVE

### SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

#### Introduction

This chapter is the final phase of the study on family caregivers' perceptions on mental illness and MHC utilisation at the Ankaful Psychiatric Hospital. It provides a summary of the research process and the key findings, conclusions, and some recommendations based on the conclusions of the study.

#### Summary

The study examined how the perceptions of family caregivers on mental illness influence the utilisation of MHC for persons with mental illness at the Ankaful Psychiatric Hospital. Specifically, the study explored the perceptions of family caregivers on mental illness (on the causes and treatment); explored their experiences of family caregivers with their caregiving role; and finally examined how their perceptions on mental illness influenced their utilisation of MHC. The study filled a gap in literature on issues related to MHC utilisation and bring into the awareness of the major stakeholders in mental health and its care in Ghana.

I employed the exploratory research design for the study. As such, the data was gathered through a purely qualitative approach with an in-depth interview (IDI) guide. Fourteen (14) family caregivers at the Ankaful Psychiatric Hospital were purposively selected as study participants. Their selection was based on their knowledge and experience as far as caregiving for the mentally ill is concerned, as well as their willingness to participate in the study. Each participant was taken through some form of counselling with the

various heads of the units (Data and Records, Medical and Psycho/Detention Units) before the interview sessions were conducted.

The demographic characteristics of the participants revealed that majority (11/14) of them were females, and were 40 years and above respectively. Also, majority (12/14) were Christians, Akans, and had some form of formal education respectively, and most (10/14) of them were married. Each participant was taken through the same themes of the study as captured in the IDI guide (as derived from the research objectives) and was collected largely through notes taking. The data was analyzed manually based on the themes that emerged. Key findings that emerged from the study have been presented in the subsequent sections.

### **Summary of the Key Findings**

This section gives a synopsis of the findings from the study.

The first objective explored the perceptions (on the causes and treatment) of family caregivers on mental illness. It was revealed that most family caregivers believed supernatural forces such as witchcraft and evil spirits were the cause of mental illness; and though the study was conducted at the Ankaful Psychiatric Hospital, majority of the participants mentioned the spiritual means of treatment due to their perceived cause associated with the condition. Sources of knowledge to most of the family caregivers were mainly from family and friends, their education (school), and the media.

The second objective which explored the experiences of family caregivers with their caregiving role discovered that they were faced with social exclusion, stigma, and financial challenges. The challenges faced by these family caregivers had an influence on their treatment-seeking decisions.

The last objective examined how the perceptions of family caregivers on their relatives' condition influenced their treatment-seeking decisions and behaviours. This also discovered that family caregivers utilised a combination of treatment options (that is, herbal/traditional and orthodox treatment options) in their attempt to seek good mental health for their mentally ill relatives. This was so considering the pluralistic nature of health care in Ghana.

It should also be noted that perceptions that family caregivers have on mental illness are imperative as it influences their decisions and response to the utilisation of MHC. However, family caregivers at the Ankaful Psychiatric Hospital reported their dissatisfaction with the attitude of the mental health workers (MHWs) as the MHWs do not take full custody of their (family caregivers) relatives (patients) during the detention period.

Finally, the study revealed that most family caregivers had subscribed to the National Health Insurance Scheme (NHIS) for their mentally challenged relatives to cushion their medical expenses. Unfortunately, they reported a high cost associated with the care and treatment of mental illnesses at the facility and believed it was not covered under the scheme.

### **Conclusions**

Based on the findings of the study, it could be concluded that the utilisation of MHC for persons with mental illness by family caregivers is based on the socially and culturally constructed perceptions associated with the condition. Also, the perceived cause of mental illness by family caregivers in the study is supernatural forces such as witchcraft and evil spirits. Hence, they believed that it could be treated through spiritual consultations and healings.

The study further concludes that, family caregivers of persons with mental illness were stigmatized, socially excluded with name callings, and were financially challenged which influenced their treatment-seeking decisions. Finally, a combination of treatment options like the herbal/traditional and orthodox treatment options was utilised by family caregivers in their attempt to seek wellness for their mentally ill relatives.

### **Recommendations**

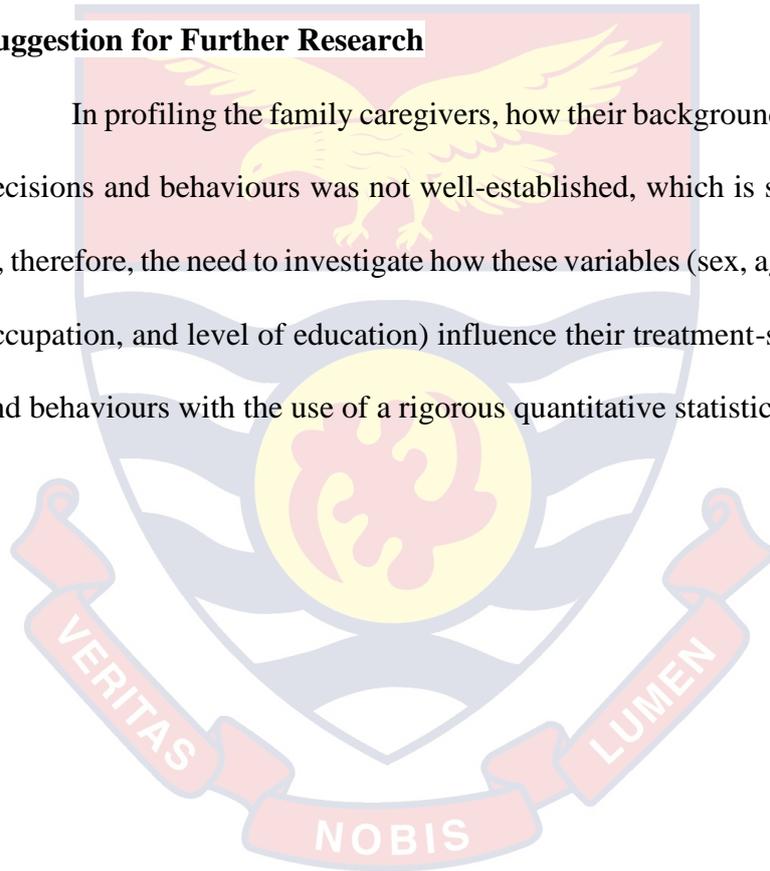
Based on the conclusions drawn on family caregivers' perceptions on mental illness and MHC utilisation at the Ankaful Psychiatric Hospital, the following recommendations are made.

1. The management of the Ankaful Psychiatric Hospital should intensify counselling of family caregivers to educate family caregivers on their relatives' condition and the processes involved in the treatment. This will minimize situations where some family caregivers terminate treatment due to perceptions surrounding the condition and their expectations of the treatment.
2. Also, family caregivers should engage the management of the Ankaful Psychiatric Hospital to establish informal groups for family caregivers during their stay through the detention period with a counsellor as a moderator. This will help them to share their experiences with other family caregivers and with the help of the expert, create new perceptions on the illness and its treatment.
3. It is also recommended that the National Health Insurance Authority (NHIA) should restructure the inclusion plan for the NHIS to absorb medication cost to reduce some of financial burden on family caregivers.

4. Stakeholder institutions like the Ministry of Health, Mental Health Authority, as well as relevant related NGOs should campaign and educate the general population on mental health. This strategy could be done through engagements with the media and also with other institutions like schools, religious organizations, and community information platforms. This will be good to enhance public knowledge on mental health.

#### **Suggestion for Further Research**

In profiling the family caregivers, how their background influenced their decisions and behaviours was not well-established, which is significant. There is, therefore, the need to investigate how these variables (sex, age, marital status, occupation, and level of education) influence their treatment-seeking decisions and behaviours with the use of a rigorous quantitative statistical tool.



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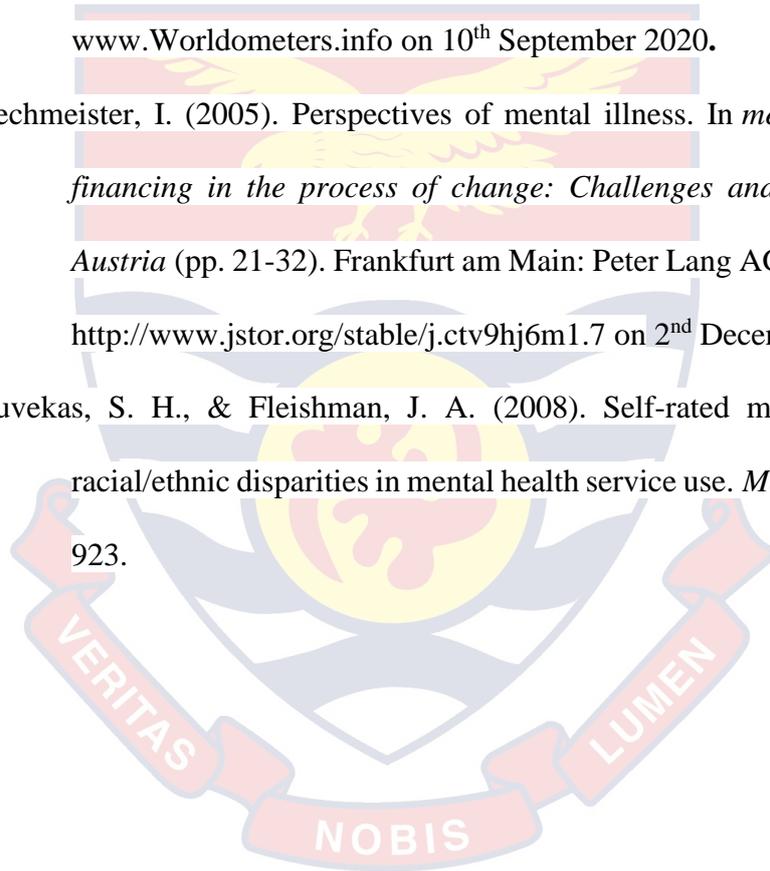
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## APPENDICES

### APPENDIX A: PERMISSION LETTER FROM THE REGIONAL HEALTH DIRECTORATE

the date of this letter should be quoted.

GHS Core values  
PEOPLE CENTRED  
PROFESSIONALISM  
TEAMWORK  
INNOVATION/EXCELLENCE  
DISCIPLINE  
INTEGRITY



REGIONAL HEALTH  
DIRECTORATE  
P. O. BOX 63  
CAPE COAST,  
CENTRAL REGION,  
GHANA  
Tel: 042 32281/2  
Fax: 042 34785  
[rdhs.central@ghsmail.org](mailto:rdhs.central@ghsmail.org)

My Ref. No. CR/G- 263/245  
Your Ref. No...

12<sup>th</sup> March, 2020

**MR. FRANCIS GYAMFI AGYEMANG**  
**DEPT. OF SOCIOLOGY AND ANTHROPOLOGY**  
**FACULTY OF SOCIAL SCIENCES**  
**COLLEGE OF HUMANITIES AND LEGAL STUDIES**  
**UNIVERSITY OF CAPE COAST**  
**CAPE COAST**

**RE: PERMISSION TO CONDUCT RESEARCH ON “FAMILY CAREGIVERS  
PERCEPTIONS ON MENTAL ILLNESS AND MENTAL HEALTH CARE UTILIZATION  
IN GHANA”**

Reference an introductory letter Ref. No. SS/SD/R.1 and dated 27<sup>th</sup> February 2020, seeking permission to conduct the above-mentioned research, I write to grant you permission on the following conditions:

1. A copy of the proposal of the study in full should be lodged with the Research and Development Unit of the Central Regional Health Directorate;
2. Ethical clearance from the **Ghana Health Service Ethics Review Committee (GHS-ERC)** should be obtained for the study;
3. Data collection should commence **only upon receipt of clearance from the GHS-ERC** and a copy of the clearance certificate lodged with the Research and Development Unit of the Central Regional Health Directorate; and
4. A copy of the final report of the study in full should be lodged with the Research and Development Unit of the Central Regional Health Directorate.

By copy of this letter, the Medical Superintendent of Ankafu Psychiatric Hospital is directed to provide the necessary support to make the study a success.

Thank you.

DR. MRS. AKOSUA AGYEIWAA OWUSU-SARPONG  
REGIONAL DIRECTOR OF HEALTH SERVICES  
CENTRAL REGION

CC: - Med. Supt., Ankafu Psychiatric Hospital, Ankafu

**APPENDIX B: ETHICAL CLEARANCE LETTER FROM THE  
UNIVERSITY OF CAPE COAST INSTITUTIONAL REVIEW BOARD**

**SECRETARIAT**

UNIVERSITY OF CAPE COAST  
INSTITUTIONAL REVIEW BOARD SECRETARIAT

TEL: 0558093143 / 0508878309/ 0244207814

C/O Directorate of Research, Innovation and Consultancy

E-MAIL: [irb@ucc.edu.gh](mailto:irb@ucc.edu.gh)

OUR REF: UCC/IRB/A/2016/659

YOUR REF:

OMB NO: 0990-0279

IORG #: IORG0009096



21<sup>ST</sup> MAY, 2020

Mr. Francis Gyamfi Agyeman  
Department of Sociology and Anthropology  
University of Cape Coast

Dear Mr Agyeman,

**ETHICAL CLEARANCE – ID (UCCIRB/CHLS/2020/06)**

The University of Cape Coast Institutional Review Board (UCCIRB) has granted **Provisional Approval** for the implementation of your research protocol **Family Caregivers' Perceptions on Mental Illness and Mental Health Care Utilization in Ghana**. This approval is valid from 21<sup>st</sup> May, 2020 to 20<sup>th</sup> May, 2021. You may apply for a renewal subject to submission of all the required documents that will be prescribed by the UCCIRB.

Please note that any modification to the project must be submitted to the UCCIRB for review and approval before its implementation. You are required to submit periodic review of the protocol to the Board and a final full review to the UCCIRB on completion of the research. The UCCIRB may observe or cause to be observed procedures and records of the research during and after implementation.

You are also required to report all serious adverse events related to this study to the UCCIRB within seven days verbally and fourteen days in writing.

Always quote the protocol identification number in all future correspondence with us in relation to this protocol.

Yours faithfully,

A handwritten signature in black ink, appearing to read 'S. Asiedu Owusu'.

Samuel Asiedu Owusu, PhD

**UCCIRB Administrator**

-----  
**ADMINISTRATOR**  
**INSTITUTIONAL REVIEW BOARD**  
**UNIVERSITY OF CAPE COAST**

**APPENDIX C: ETHICAL CLEARANCE LETTER FROM THE  
ANKAFUL PSYCHIATRIC HOSPITAL**

**ANKAFUL PSYCHIATRIC HOSPITAL**

**OUR CORE VALUES**  
Respect and Dignity  
Confidentiality  
Professionalism  
Compassion  
Equal Treatment  
Teamwork

**In case of reply the number and the date of this letter should be quoted.**  
**Our Ref. No. APH/ADM/197/305**  
Your Ref. No.....



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Tel: +233 50 1490550  
+233 50 1490531  
Web: [www.ankafulpsychiatrichospital.org](http://www.ankafulpsychiatrichospital.org)  
Email: [info@ankafulpsychiatrichospital.org](mailto:info@ankafulpsychiatrichospital.org)  
GPS Address: CK-0552-6233

**18<sup>th</sup> June, 2020**

Francis Gyamfi Agyemang  
Department of Sociology and Anthropology  
University of Cape Coast

**APPROVAL OF ETHICAL REQUIREMENTS FOR STUDY PROTOCOL**

The Ankaful Psychiatric Hospital Research Ethics Review Committee (RERC) has reviewed your request for the conduct of a research study on the topic:

***“FAMILY CAREGIVERS PERCEPTIONS ON MENTAL ILLNESS AND MENTAL HEALTH CARE UTILIZATION IN GHANA”***

The committee noted that the study design does not require the participation of staff members of the hospital and as such you will not be permitted to disrupt any member of staff in the execution of their regular duties. You will be granted access to the waiting areas of the hospital, but not to any sensitive clinical areas.

It is in view of the above that approval is granted to proceed with your research work. This approval is valid for one year, starting **18<sup>th</sup> June, 2020 to 17<sup>th</sup> June, 2021** when it expires. In the event of the research lasting more than twelve (12) months, researcher(s) will be required to apply for a renewal of ethical approval.

The following conditions must be closely adhered to in order to maintain the validity of the approval.

- Report of all adverse events related to this research to the RERC within 24hours verbally and three days in writing.
- Inform RERC if the study cannot be implemented or is discontinued and the why.

- Submission of a final report after completion of the study.
- Inform the RERC and your sponsor (where applicable) before any publication of the research findings.
- The researcher(s) shall not in any way make modification(s) to the study without prior approval from the RERC. Any such amendments will be considered invalid.

Thank you.



**DR. KWADWO MARFO OBENG**  
AnPH-RERC CHAIRPERSON

Cc: All AnPH Research Ethics Review Committee (RERC) Members



## **APPENDIX D: INTERVIEW GUIDE FOR FAMILY CAREGIVERS**

**University of Cape Coast**

**College of Humanities and Legal Studies**

**Department of Sociology and anthropology**

**Research Topic: “Family Caregivers’ Perceptions on Mental Illness and  
Mental Health Care Utilisation at the Ankaful Psychiatric Hospital”**

### **Introduction**

Thanks for your acceptance to participate in this study. Perceptions on mental illness vary contextually and from person to person. This has necessitated through this study to investigate into how these perceptions influence the utilisation of mental health care. Your contribution will help towards the success of this research work and your responses will be used only for academic purposes. Your participation is voluntary and information shared is confidential and anonymous. Therefore, to the best of your knowledge, kindly provide responses to the questions.

### **Section A: Background Information of Family Caregivers**

1. Sex
2. Age
3. Educational level
4. Occupation
5. Marital status
6. Ethnicity
7. Religion
8. Relationship with patient

## Section B: Perceptions of Family Caregivers on Mental Illness

Preamble: How do you perceive mental illness?

9. How do you describe individuals with mental illness?

10. In your opinion, what causes of mental illness?

Prompts on perceived causes:

- Social and environmental factors (stress) - unhappiness, low self-esteem, rejection, overthinking, self-downing and blaming, anxiety and worry, trauma, conflicts, relationship issues, alcohol and drug use, etc.
- Spiritual and supernatural causes – anger of God or god, curses and evil spirits, bewitchment, others...
- Genetic causes: birth defect, transfer from family, others...

11. Do you think mental illness is treatable? If Yes, how? If No, why?

Prompts: this should be linked to his/her perceived cause of the illness.

12. What is the source of these thoughts expressed about mental illness?

## Section D: Experiences of family caregivers with mentally ill patients

Preamble: Taking care of relatives suffering from mental illness comes with a lot of responsibilities and challenges. Let us discuss your experience so far with regards to the illness of your relative

13. How has taking care of your relative's mental illness affected your social and personal life?

Prompt: social exclusion, stigma, shame, exhaustion, stress, emotional, less time for family, friends, church, and education, others...

14. How has your relative's mental illness affected your economic life?

Prompt: financial burden, less time for work, transportation cost, cost of medical bills...others

15. How has your experience(s) of your relative's mental illness influenced your decision to use this facility?

### Section E: Perceptions on Mental Illness and Treatment-Seeking

Preamble: Perceptions that we have on mental illness could influence the kind of treatment to utilise for our mentally ill relatives. So, we are going to discuss how these perceptions influence our decisions on utilising MHC for our mentally ill relatives

16. What kind of treatment options(s) have you resorted to for your mentally ill relative?

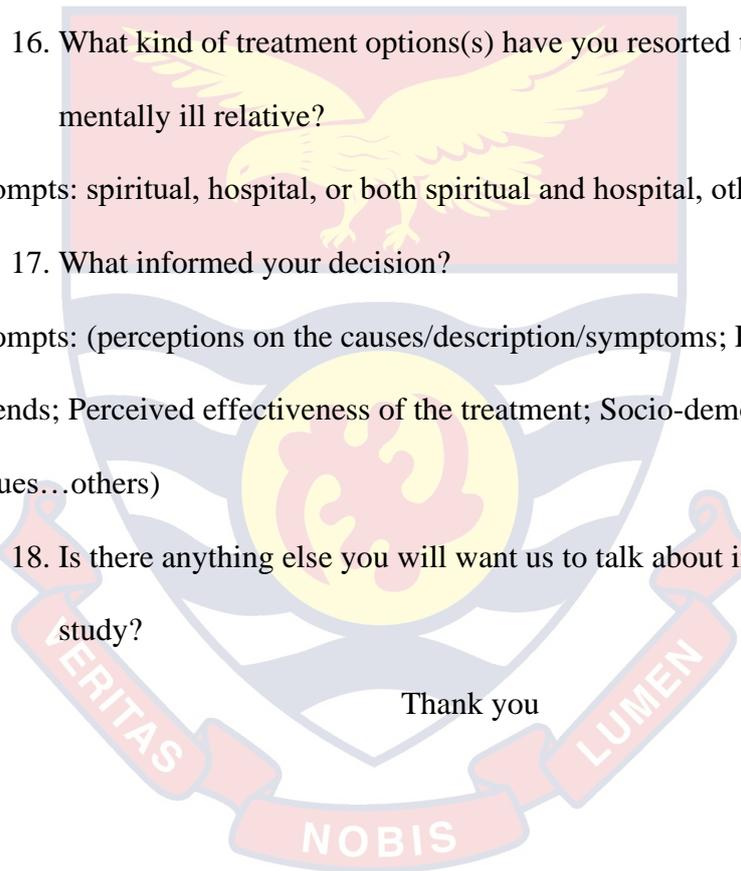
Prompts: spiritual, hospital, or both spiritual and hospital, other means...why?

17. What informed your decision?

Prompts: (perceptions on the causes/description/symptoms; Family and friends; Perceived effectiveness of the treatment; Socio-demographic issues...others)

18. Is there anything else you will want us to talk about in relation to this study?

Thank you



## APPENDIX E: CONSENT PARTICIPANT AGREEMENT FORM

**Title:** Family Caregivers' Perceptions on Mental Illness and Mental Health Care Utilisation at the Ankaful Psychiatric Hospital

**Principal Investigator:** Francis Gyamfi Agyeman

**Address:** Department of Sociology and Anthropology, University of Cape Coast, Ghana

### General Information about Research

The purpose of this study is to explore the perceptions of family caregivers on mental illness and how these perceptions influence the utilisation of mental health care at the Ankaful Psychiatric Hospital in Ghana. The study will gather socio-demographic information and some personal perspectives and experiences that family caregivers hold and have gone through respectively as far as their relatives' mental illness is concerned. The study's findings will depend on interviews of family caregivers who have their relatives suffering from mental illness and are admitted at the Ankaful Psychiatric Hospital. This will be a one-on-one interview where I will ask some questions from participants pertaining to the objectives of the study.

### Procedures

To find answers to the various questions asked based on the research objectives, you are invited to participate in an interview which requires that to the best of your knowledge, you kindly provide responses. Your contribution will help towards the success of this research project. If you do not wish to answer any of the questions posed during the interview, you may say so and the next question will be asked. The interview will take place in a convenient and conducive place with the presence of only the interviewer. In order not to miss any relevant information in

the course of the interview, audio tape recorder will be used to record and notes will also be taken. Information provided will be kept in a locker to avoid-third party access and also be used strictly for academic purpose. Your identity will not be revealed in any part of the research process and after the whole exercise, the transcript will be sent to you for review to ensure that your view was correctly captured.

### **Possible Benefits**

The benefit of the study would be seen at the long-run. However, the study will be useful for understanding and treatment of mental illnesses in Ghana.

### **Possible Risks and Discomforts**

There are no envisioned possible physical risks, but should there be any question that reminds you of any uncomfortable experience, you may refuse to respond or choose to postpone or withdraw from the interview.

### **Confidentiality and Anonymity**

Information that will be acquired from this exercise will be safely protected from any third-party accessibility. Notes and audio recorder will be locked safely in a safe/locker at my office; and transcripts from the interviews will be stored in 'my lock box' app on my personal computer. Also, your name or identity will not be used in any part of the report in the study.

### **Additional Cost**

You will not incur any cost for volunteering to participate in the study; but your time.

### **Voluntary Participation and Right to Leave the Research**

Your participation in this study is completely voluntary, and you have every right to terminate at any point in time.

### **Contacts for Additional Information**

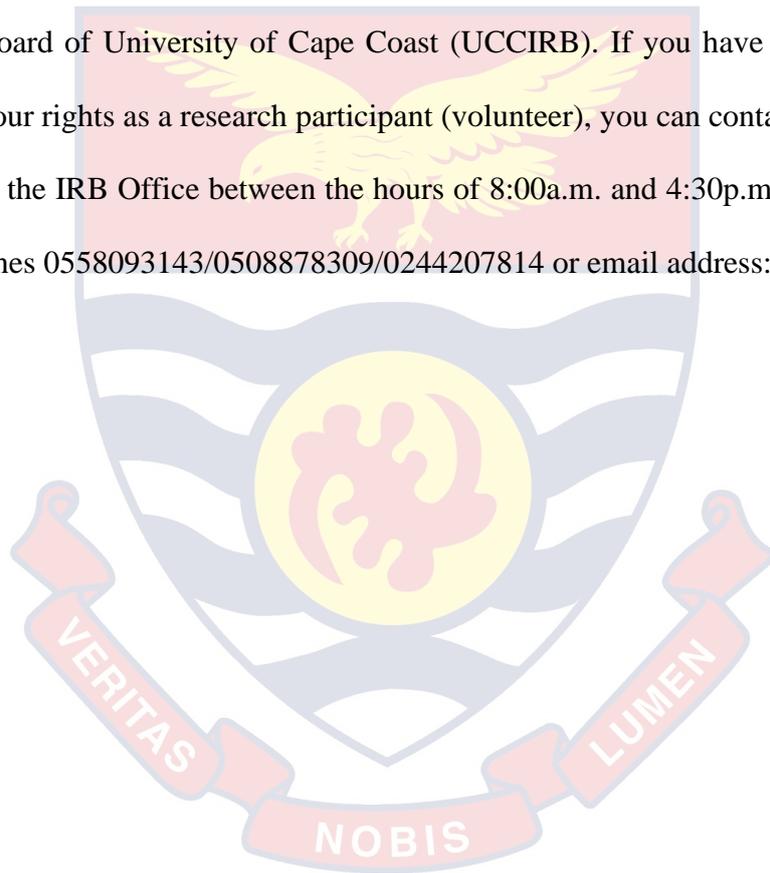
In case you have any other question, suggestion, complaint and/or comment regarding this study, please contact:

Francis Gyamfi Agyeman: 0249605420 (Researcher)

Prof. William Boateng 0247492057 (Supervisor)

### **Your rights as a Participant**

This research has been reviewed and approved by the Institutional Review Board of University of Cape Coast (UCCIRB). If you have any questions about your rights as a research participant (volunteer), you can contact the Administrator at the IRB Office between the hours of 8:00a.m. and 4:30p.m. through the phones lines 0558093143/0508878309/0244207814 or email address: [irb@ucc.edu.gh](mailto:irb@ucc.edu.gh).

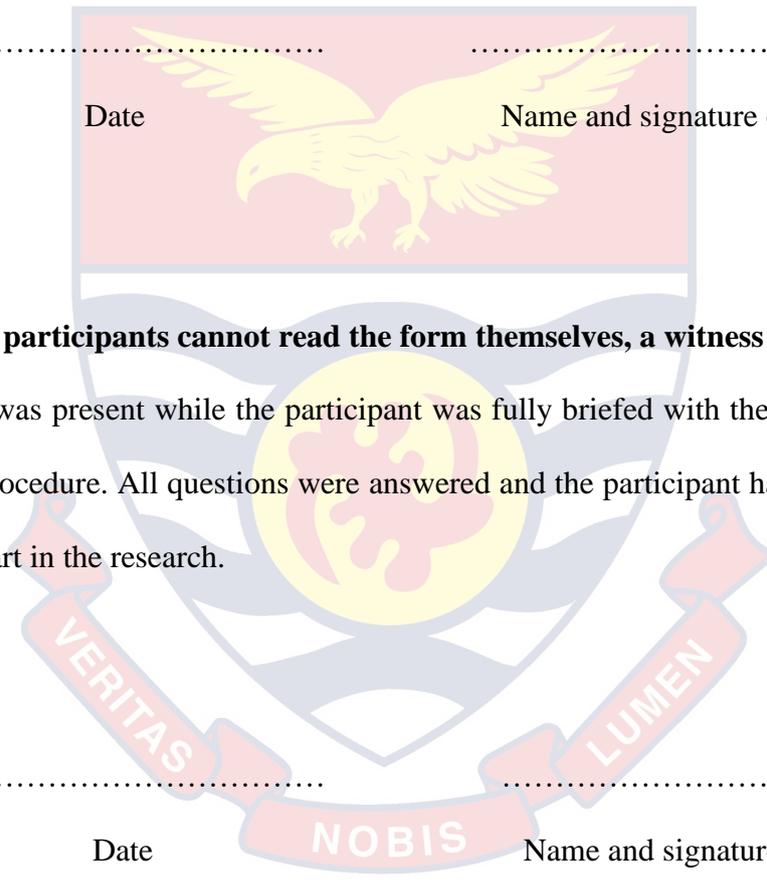


### PARTICIPANT/VOLUNTEER AGREEMENT FORM

The above document describing the process of the research title: Family Caregivers' Perceptions on Mental Illness and Mental Health Care Utilisation at the Ankafu Psychiatric Hospital, has been read and explained to me. I was given an opportunity to ask questions about the research and have been answered to my satisfaction. I agree to voluntarily participate in the research.

.....

Date	Name and signature of participant
------	-----------------------------------



**If participants cannot read the form themselves, a witness must sign here:**

I was present while the participant was fully briefed with the research and its procedure. All questions were answered and the participant has agreed to take part in the research.

.....

Date	Name and signature of witness
------	-------------------------------

I certify that the nature and purpose, as well as possible risks associated with participating in this research have been explained to the above individual.

.....

Date	Signature
------	-----------