



School of Politics & International Relations
Working Paper Series: WP10/2018



Exploring the Phenomenology of Mental Illness in
sub-Saharan Africa: A Case Study of Ghana

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Abstract

A critical juncture has been reached in the field of global mental health: with the recent inclusion of mental illness in the sustainable development goals (SDGs), an opportunity has arisen for individuals in developing countries to receive increased assistance. However, there are a lack of adequate guidelines available as to how mental health resources should be utilized in developing countries, and a lack of understanding of mental illness in non-Western cultures in general. The main aim of this study was to investigate how mental illness is experienced and conceptualised in sub-Saharan Africa, taking Ghana as a case study. Understandings were gained through a phenomenological exploration of the lived experiences of individuals who had been diagnosed with mental illnesses (mainly anxiety, depression, psychosis, and schizophrenia) in Ghana. Purposive sampling was employed to conduct twelve semi-structured interviews in different communities throughout Ghana using interpretative phenomenological analysis (IPA). Results revealed that mental illnesses were often perceived as being of a spiritual or supernatural cause, were regularly interpreted as bodily pain and distress, and had a devastating effect on the ability of individuals to participate in their communities and sustain livelihoods. These results have significant consequences for assessment, treatment, and provision of supports, emphasising the necessity of culturally appropriate policies that will address the unique needs of the population accordingly.

Keywords

Global mental health, interpretative phenomenological analysis, lived experiences, international development, Ghana.

Citation

This paper should be cited as Mathias, Emma (2018) Exploring the Phenomenology of Mental Illness in sub-Saharan Africa: A Case Study of Ghana, SPIRe Working Paper WP10, School of Politics and International Relations, UCD, Ireland.

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An estimated 80% of people diagnosed with mental illnesses live in developing countries (Jacob & Patel, 2014). However, what is understood about the experiences of those individuals is extremely limited at present due to a lack of in-depth research. This makes it difficult to understand what kinds of treatments are most appropriate, how resources should be distributed, and if Western concepts of mental illness are relevant at all in non-Western cultures. The World Health Organisation (WHO) (2013) estimates that up to 85% of people in developing countries do not receive any treatment for mental illnesses at present, and has called for international action to implement their recommendations on mental health legislation, policies and programmes. There is talk of 'scaling up' services for individuals with mental illnesses, but often without due consideration for the appropriateness of the services that are to be implemented. A number of researchers (e.g. Fernando, 2014; Mills, 2014; 2016, Oloyede, 2002; Ventevogel, Jordans, Reis, & De Jong, 2013) argue that a global approach to mental health service provision is likely to do more harm than good, as mental health is socially and culturally determined, and services need to be developed within the cultural and social settings in which they occur.

There has been a lack of research to date into the different ways in which mental health is conceptualised in different cultures across the globe, however, as over 90% of all mental health research is conducted with 10% of the population, mainly with Western cultures (Patel, 2007; Saxena, Paraje, Sharan, Karam & Sadan, 2006). Sharan, Levav, Olifson, de Francisco & Saxena (2007) compiled a report on the state of global mental health research and found that out of the 114 developing countries included in the study, 57% of these countries contributed less than 5 articles to the literature on mental health from 1993-2003. Specifically, there has been a notable lack of mental health research conducted in sub-Saharan Africa (SSA) to date with little empirical data available, especially in rural areas (Pike & Patil, 2006). Presuming that the results from studies conducted with Western populations are directly transferrable to those from different cultural and social backgrounds may lead to inappropriate service interventions if research is not counterbalanced with a substantial amount of high quality studies in non-Western contexts (Fernando, 2014; Kirmayer & Pederson, 2014; Kleinman & Good, 1985; Mills & Fernando, 2014; Ventevogel et al., 2013).

Of the mental health research that has been conducted in SSA to date, the majority has taken a universalist approach, starting from the presumption that categories of mental illness are applicable across the globe. Many of these studies have attempted to adapt psychological measurement scales to assess mental illnesses in SSA, and suggest that it is possible to use psychological measurement scales developed in Europe and the US with populations in SSA, albeit with some tweaking. However, other researchers argue that transferring measurement scales for use in a completely different context may render them inaccurate and of little value as they are not based in local forms of meaning (e.g. Good & Kleinman, 1985; Mendenhall, Yarris, & Kohrt, 2016; Summerfield, 2008; Taitimu, Read & McIntosh, 2018). If services are to be provided which are appropriate for different cultures, then the culture in question will need to be described using concepts which are meaningful to the members of that culture (Oloyede, 2002).

Some researchers have taken a more relativist approach to mental health research in non-Western contexts, employing less biomedically-based, ethnographic research methods to investigate the cultural and social factors involved in experiences of mental illnesses more thoroughly. Results indicate that different cultural explanations are given for mental illnesses in various different cultural settings, and that they are often expressed and conceptualised in different ways across cultures. For example, Ventevogel et al. (2013) conducted research in Burundi, South Sudan, and the Democratic Republic of the Congo using over 31 focus groups with community members (n=251), along with key informant interviews with community leaders and traditional healers. Ventevogel et al. (2013) found that the conditions that participants identified had fluid boundaries, and did not form distinct diagnostic categories. They also found many similarities in descriptions of mental illnesses in each of the regions, albeit with some differences, and that contextual factors were often prioritised when describing the mental state of an individual. Similarly, Monteiro & Balogun (2013) interviewed 115 participants in Ethiopia and found that depression and anxiety were perceived as being determined by social or situational factors amongst community members, healthcare workers and traditional healers. Studies such as these provide invaluable insights into the ways in which mental health is conceptualised amongst members of non-Western cultures, and give us clues as to how best to address these issues within their cultural contexts. However, very few of the studies conducted in SSA include individuals who have been diagnosed with mental illnesses in their participant base, leaving a gap in our knowledge of how mental illnesses are actually experienced by the individuals themselves. This is true also for Ghana, where many studies have gathered data from key stakeholders but not from individuals who are suffering with mental illnesses directly, leaving large gaps in knowledge of the actual lived experiences of those diagnosed with mental illnesses in Ghana.

Case Study Country - Ghana

Ghana is a lower middle-income country in West Africa with a population of approximately 26 million, and is one of only a handful of countries in SSA to have drafted a mental health policy. Although this policy is currently outdated and under-utilised, the government shows some level of commitment to addressing mental health issues. Mental health services are severely lacking in the country, however, and there is a large burden placed on psychiatric nurses (Roberts, Mogan, & Asare, 2014). There are only three psychiatric hospitals in the country and only 1.4% of national expenditure is contributed to mental health services for an estimated 2.4 million people requiring treatment, a mere 2.8%, of whom actually received treatment in 2011 (Read & Doku, 2012; Roberts et al., 2014). The types of treatments that are appropriate, however, are difficult to ascertain due to a lack of research in this area.

To gain an understanding of how distress responses manifest themselves in individuals in Ghana, and hence how cultural factors should influence the development and implementation of policy and services, an assessment of the lived experiences of those individuals is imperative but, as mentioned, this is almost entirely absent from the academic literature at present. The majority of studies carried out have taken a universalist perspective, using psychological measurement instruments developed in Western countries, thus limiting our understanding of the validity of the results. The majority of the studies that have taken a relativist perspective and have used qualitative

research methods to ascertain understandings of mental illnesses in Ghana have been conducted with community members and key stakeholders, but not with individuals who have a mental illness diagnosis. For example, Ofori-Atta et al. (2010) conducted 81 semi-structured interviews and 7 focus group discussions with key stakeholders in Ghana to ascertain how women's mental health problems were understood, and Yendork, Kpobi, & Sarfo (2016) conducted in-depth interviews with members of Charismatic churches in Ghana to assess congregants' knowledge on mental illness. Studies such as these, however, provide more information on stigmatised attitudes towards mental health in the country than they do on how it is actually experienced by individuals, how it impacts on their lives, and what can be done to tackle the issue. One of the few published studies in Ghana to include individuals diagnosed with mental illnesses was that by Read, Adibokah & Nyame (2009) who visited over 40 households in rural Ghana with a family member who was diagnosed with a mental illness, along with visits to shrines and prayer camps, to ascertain the impact that mental illness had on families. Read et al. (2009) suggest that policy development be prepared with the experiences of those diagnosed with mental illnesses at the forefront, and that engaging with individuals directly involved will be essential to effective policy and program development. It will be essential to build and expand on research such as this in order to fully understand the needs and experiences of service users and future service users in Ghana, so that resources and programs can be allocated and implemented successfully.

The Current Study

The current study will address some of the above issues and gaps in the research through the use of a novel methodological technique (IPA) that has not been previously employed for the purposes of assessing conceptualisations and experiences of mental illness in SSA. From a review of the current Global Mental Health literature it became clear that IPA was an underutilised method of inquiry, and that the voices of individuals diagnosed as mentally ill in developing countries have been largely excluded from the academic literature, especially in SSA. This method involves investigating social and psychological phenomena from the perspectives of the people involved by making an inquiry into their lived experiences (Smith, Flowers & Larkin, 2009; Welman & Kruger, 1999). By providing individuals with a voice through which to have their experiences heard and understood, a deeper understanding of these phenomena in different cultures can be gained (Tatitmu et al., 2018). As Kleinman (1988, p.96) contends: “..the patient's story is essential to the work of doctoring”.

The field research for this project was undertaken in Ghana in June and July 2016. The current study utilised 12 semi-structured interviews with people who had received a mental illness diagnosis. This participant number is in line with recommended participant numbers for IPA studies, as the emphasis is centred on gaining a deep understanding of personal experiences through an exploration of narrative accounts. These interviews formed part of a larger project (N=124) that involved a mix of semi-structured interviews and focus groups with adults diagnosed with mental illnesses and their primary carers; interviews with key informants, including members of staff of local NGOs, government employees and community workers; and participant observation in different communities throughout Ghana.

Aims & Research Questions

The main aim of this study was to assess the ways in which mental illness is experienced and conceptualised by individuals diagnosed with mental illnesses in different regions of Ghana. The main research question guiding this study is outlined below, along with three sub-questions.

R.Q.1: How do individuals in Ghana conceptualise mental illness?

- 1a. In what ways do individuals in Ghana experience mental illness?
- 1b. What determining factors do individuals in Ghana attribute to their mental illnesses?
- 1c. What treatment methods do individuals in Ghana find the most effective?

Method

Participants

Twelve participants (seven men and five women) were recruited from urban and rural areas in different regions of Ghana including communities in the Central (Ashanti and Brong Ahafo regions), Northern and Upper East regions. Each of these regions varies in terms culture, religion, and language. Recruitment for the study was conducted with the assistance the staff of an international mental health NGO, Basicneeds Ghana (BNGh), and two local NGOs - the Mission of Hope Society International (MIHOSO) and the Centre for the Development of People (CEDEP) – all situated in different regions of Ghana. Purposive sampling was employed in conjunction with the NGO staff to recruit Ghanaian adults who had been diagnosed with mental illnesses. Those who were experiencing severe levels of psychosis were deemed ineligible for participation for ethical reasons. As 9 of the 10 interviews were conducted in the local language of the participant, translators were employed for the duration of the research. The majority of the participants generally had low levels of education and literacy, many not having completed primary level education and the majority not having completed secondary level education. Many of the participants were unmarried, and some had been married but were separated. The age range of participants was 24 – 42 years, and two of the participants had some assistance from their primary carers in answering the interview questions due to speech impediments and / or difficulty in answering the interview questions alone.

Ethical Considerations

Full ethical permission was sought and approved for the field research phase of this project by UCD's Human Research Ethics Committee (2010). Ethical permission was required as the participants involved in the research were considered part of a vulnerable group due to their diagnosis of mental illness, and topics discussed were often of a sensitive nature. Consent was obtained from all participants, either verbally or in written form. As the majority of the participants were illiterate, the information sheet and consent was summarized by the translator and participants indicated their understanding and agreement to take part in the interviews, and marked the consent form.

Study Instrument

An interview guide was developed by the principal research to elicit information about the perceived nature of mental illness to participants, and how they had been effected by it. There were eight main questions included in the interview guide. These questions were open-ended and sought to ascertain how individuals conceptualised mental health, how it is manifested in their day-to-day lives, and information about the modes of healing they had pursued. The translators were provided with training in the use of the interview guide prior to conducting the interviews.

Procedure

Interviews were conducted in communities in rural and urban areas of Ghana where the participants resided. Upon arrival to the community in which each interview took place, the principal researcher and translator were greeted by a community worker. The interviewee was introduced to the principal researcher, either by the translator or the community worker, and each were seated in a shaded outside area in the community. Initial greetings were exchanged, and the translator informed the participant of the purpose of the study. The interview was conducted in a semi-structured manner using the interview guide. The translator translated each question as it was asked by the researcher, and answered by the participant. When this was complete, the participants were asked if they had any further questions in relation to the study, were thanked for their time and debriefed if necessary. Interviews ran for between 35 to 60 minutes each.

Data Analysis

Interviews were digitally recorded with the permission of the participants, and were later transcribed by the principal researcher and a research assistant. Recordings were also translated by an independent translator proficient in the local dialects (Twi, Dagbani, Gurene) in which the interviews were carried out, in order to assess the specific terms and language utilised by the participants themselves. All potentially identifying details were removed to protect the anonymity of participants and participants were given pseudonyms, which are utilized in the discussion of the results. Interviews were analysed using the IPA method, which initially involved a reading and listening of each interview four times to gain a familiarity with the data. Each reading of the transcript provided the opportunity for new insights to be uncovered. Initial notes were made on each transcript in relation to significant or interesting statements made by the participant. A second margin was then used to note the themes that emerged from the data and the initial annotations. These initial themes were then clustered together to form superordinate concepts, with subordinate themes contained within them (see table 1 below). These clusters were checked against the original transcripts to ensure that they were connected to the original data.

Table 1: *Superordinate and Subordinate Themes*

Superordinate Themes	Subordinate Themes
Somatization	Generalised bodily pain Headache Pressure in the head Racing heart Feeling paralysed

	Sleeplessness
Stigma	Treated as sub-human Beliefs in condition as contagious Excluded from events in the community Unable to work Excluded from regular social practices
Multiple Causes	Spirit possession Magic Religious beliefs
Trade / Livelihood Insecurity	Lack of funds for enterprise Negative effects of unemployment Fears about the future Worries about looking after family
Multiple treatment methods	Medical Spiritual Traditional
Belief in Recovery	Feeling hopeful Belief in God as source of recovery

Results

Lived Experiences

The overall experiences of individuals who had been diagnosed with a mental illness in Ghana were multiple and complex, and centred around their feelings of being stigmatised and rejected by their communities and families; financial pressures with multiple causes and consequences such as an inability to contribute to their family financially, an inability to participate fully in their communities (which in Ghana often involves trading), and an inability to support themselves. Participants described not being ‘themselves’, having different bodily symptoms and pain, being unable to sleep properly, excessive thinking and worrying, and not being able to properly engage with any kind of work. Their experiences of the different modes of healing available in the country varied greatly, with some finding traditional and / or spiritual methods helpful, and others having very negative experiences with traditional or spiritual healers. Some found that medication was helpful, others did not. Detailed results of the analysis are laid out below in relation to each theme.

Somatization

When asked about their symptoms, the majority of service users described physical problems such as a ‘heaviness’ in different body parts, headaches, dizziness, physical pain, and bodily changes. For example, Mawusi describes a heaviness in her

body, Afreya describes dizziness and chest pain, and Botwe describes 'funny feelings' in his waist and legs, and Abina describes severe headaches:

Afreya: Sometimes it gets me to roam...I get up and roam everywhere. Sometimes when I have episode, sometimes I will be walking and I will get dizzy, and I can't see anywhere, I don't know what is in my mind, I don't know what I'm thinking, and I feel very dizzy. And sometimes it affects my chest.

Abina: I will experience severe headache, during the headache my temperature will be high than it should be. At this point I will realize that the episode is about to happen to me. For me, when I was growing up, I did not know what was headache. Is because of that sickness that made me to know what headache is. I was just listening to people complaining of body pains but I did not know how it was. But due to my sickness, I can now tell when my body temperature is high and painful. But it used not to be so.

Many of the participants described 'not being themselves' or being 'out of touch with their senses', and describe a lack of control of their bodily function and movements. Serwa describes not being in her 'senses' and 'overusing' her body:

Sometimes you can be in your senses and at times you will not be in your senses. It is like that. If that happens I am not myself again or I am not free at all in my body. I will not know, like today for instance, I will not know what is going on again. Most especially Mondays and Fridays I am not myself at all. When it subsides, I can do whatever is necessary for me to do normally. But when I am experiencing it, I just work hard. I don't have peace and I overuse my body when I work. It will occur to me, and I will realize that the sickness has happened to me.

Abina also describes not feeling that she is in control of her actions and being detached from reality:

Whenever it happens to me. Like the way I am looking at you I may not be able to recognise you when I meet you somewhere else. Even the person I live with, when they come to me I will not be able to recognise that person either. So whatever harm I have to cause I will do without knowing I have done anything. When you are normal/ok, you eat well because you know very well that you are not sick. The next day you will have peace and whatever you are supposed to do will be done. But you are not of yourself so you will not know what is going on. At times it will happen to me as if I am dreaming.

Stigma

Stigma emerged during the course of the research as a major concern for the majority of the research participants in this study. Stigma appeared to exacerbate the issues of mental health even further due to isolation and a lack of respect from other members of the community. For example, Botwe clearly expresses his perceptions and experiences of the way other members of society view them because of his condition: "I was always told I'm a mad person – a crazy mad person. I can't mix with my colleagues

and I can't work effectively. And when I'm going to work I feel disturbed"; Mawusi states: "We are not counted in society".

This stigma appears to reach into the family home and into the relationships of those effected, for example, Ebo describes his experience of being unable to find a wife and to mix with his peers, and how his peers speak about him in a derogatory way, an experience that was expressed by all of the participants:

At times, now what happens is that, if I am with my colleagues I don't talk. If I want to say anything at all, it will turn to tears, how I suppose to have been...those that I am older than have wives and children. Now if I am with them it does not seem I am with them. Whatever they want to say about me, they just say without taking me into consideration.

Mawusi also describes her troubles in relation to the stigma that is attached to her condition, and how it has impacted her marriage:

...that was because of the illness..my husband thought it strange...and my husband rejected me. I came to my mother and after that I'm still staying with my mother. I really wish to be with my husband...or be with a man...I cannot be with a man because men they have the wrong perception of me....so I can't be with a man...Even the man who have really integrating me into the society it's really difficult but now as I'm OK the man really want to come back..me to come back...but it's not easy because when I was sick he didn't support me...he abandoned me – he threw me out of the house. Now that I'm well the man would like me to come back. It's not the best.

Many participants described being treated as 'not human', and said that members of their community believed that their mental illness was contagious, that there are latent spiritual afflictions that reside within a person even when all symptoms have dissipated, and that "the ancestors are punishing you for your crimes" (Kwaku). For example, Kafui notes that "The way the sickness is, even if you get better, many will not believe that is totally gone till you die". Stigma was often discussed by service users in conjunction with their lack of a trade. For example, Ebo believes that he will gain more respect in his community if he can start his own business:

I want to beg you so that I can get the provisions or the mobile credit, so that I will have something doing but not to sit with my colleagues and be thinking again. As I am thinking what can help me so that in the miss of my colleagues they will not look down upon you is, selling of the credit and the provisions. I was the person who should have been leading. We are two boys... two children but my senior brother has travelled.

Trade / Livelihood Insecurity

Concerns over livelihoods / petty trade were evident from almost all of the interviewees. Many of the participants and their families had invested a lot of money and sold their businesses to pay for treatments, both traditional and medical. Not having the resources and/or the ability to do so appeared to exacerbate the issue and hamper recovery of participants in the present study, many of whom expressed the belief that

they could overcome their difficulties if they were able to (re)establish a trade, and this was often their ultimate aim in the recovery process. Participants expressed boredom and listlessness as they often did not have a day-to-day purpose due to insufficient funds to set up a petty trade. For example, Ebo expressed his desire to be trading so that he could interact with his peers and have a daily purpose, and Serwa emphasises this point in relation to having enough money to look after herself and her family, and also to have something to occupy her time:

Ebo: I want to beg you so that I can get the provisions or the mobile credit, so that I will have something doing but not to sit with my colleagues and be thinking again...As I am thinking what can help me so that in the miss of my colleagues they will not look down upon you is, selling of the credit and the provisions.

Serwa: And tell her, I was having a business at market but when it started happening to me, I don't have money to continue the business again. Since ever I became sick, I don't have anything again. I used all the money in taking care of myself. I was doing business but since I sat in the house, I don't have anything to use for the business. So I am just in the house. We are in the house we are just there doing nothing. That is my worry now, what I will use to cater for my children for them to also be useful in future. It's about how I will do to take care of the children and my sickness.

Supernatural, Spiritual, & Religious Beliefs

The majority of participants believed that their problems were caused by spiritual and/or supernatural factors. For example, Effia, believed that the source of her affliction was a traditional treatment that was prepared using a bird, during which time the healer who had prepared the treatment died:

That in the process of her illness, they went and seek local treatment, and they bath her with the herbs, and that blocked her talking, so she can't talk properly. Because there was a bird among those things that were used to prepare the medicines for, to cure her illness, and she think it's the bird that block the talking of her. But on the process the man died and because of that she carried the behaviour of that animal...that bird. She was talkative before they bathed with the herbs, and after the bird she portrayed a behaviour of such a bird that they caught to prepare the herbs. So when she had a problem with anybody, one person, she include everybody, she will not talk to anybody.

Many of the participants described an occasion that marked the beginning of their condition, many of which involved natural elements such as rain or wind.

Elinam: That it was just like a wind, that he came across, and got affected spiritually, and thank God it has gone. Even though he cannot trace this as the reason, this is a personal God, or he has taken something, or he has never taken something, and he is living in some prayer life now that everybody admire. That he doesn't suspect anything, it was just a wind that he came across – a spiritual wind that came accross him, and that's what he does suspect.

Kafui: But the day that they got to realized that something serious is wrong with me, it was evening time about 2pm and it was about to rain. It was heavy down pour and was in the rain with two children running all over the rain till the rain stops. Immediately the rain stopped I was feeling severe cold and started crying. The rain started in the evening till night. When that happened they realized that, it was not normal and tied me with ropes and was burning some local powder on fire. The following day was Ajura market and they tied me with ropes and took me to bus stop and brought me here.” When we were about to enter Tamale, there I was somehow back to my senses and I asked them to untied me but they refused. But there was a certain man who said they should untied me since I have requested. There that they untied me and brought me to this compound.

Only one of the participants, Kwaku, had a different perspective than the other participants on the causes of mental illness:

Kwaku: People think it is spiritual, attributed to Spiritual.....so when you want to introduce orthodox medication..this is not something that orthodox medication can solve...they prefer to consult traditional healers....they will kill animals....and take their money...and the condition will not improve, and if you have the money and the animals you have given to the traditional healer...if you have used that to procure medications.....his condition would have improved. And at least what you have given to somebody from medical practitioner the traditional practioner would not have gone there. We still have a long way to go because....people believe that mental illness is caused by....or you have committed some crimes....the ancestors are punishing you for your crimes.

Multiple Methods of Treatment

From an analysis of the data, it became evident that mental health is conceptualised as a temporary condition, to be dealt with by whatever means possible – be it religious, traditional, medical - in the majority of cases a combination of all of these things, as well as social support. The majority of participants had engaged with multiple methods of treatments to address their issues over the years, either in combination with each other at the same times or at different times. The main treatments used included medicine and different forms of traditional treatment such as prayers with spiritualists, visiting a Malam (an Islamic healer), and taking herbs from a traditional healer. Different rates of success and failure were attributed to each method of treatment amongst the participants. For example, Botwe attributes his recovery to a combination of traditional and medical treatments:

I seek traditional treatment and medical treatment and about three years now I have not experienced the sickness symptoms. Sometimes I find it difficult buying the drugs....when I go to hospital they ask me to go and buy the drugs, and I don't have money to go out and buy the drugs.

In relation to medication, Serwa says that the medication was somewhat helpful but that from her experience with it she does not feel that it had cured her of her condition, so she is currently seeking traditional treatment from an Islamic healer:

It helps me but, I am not all that satisfied with that. Because it cools it down and comes back again. I am not going for the medicine any more. Tell her that, now I am going to Malam's house. Tell her, is better now but not gone.

Abam also found that the spiritual healer was helpful with his condition:

That he gets the medicine from stalls and hospital, and in the hospital it's not there....the government support is not there. But he goes to the shops and stalls to buy them, and it's a bit difficult but any time he goes the medicine is there. He also take Spiritual baths from Spiritualists. He also take the herbs from the Spiritualist Malam, when he have money. When the malam says go and buy the things that he's supposed to buy, and then he buy it. So he's getting access to the Spiritual medicines depends the money that he have...Anytime he has seizure and the herbs got in his mouth the seizure ceases.

Kwaku, on the other hand, did not have success with traditional treatments, but did find medical treatment helpful:

Kwaku: When I was sick they try the traditional medicine, all kinds of traditional medicines, so many things, but it couldn't help me. At that point medical help, mental health nurse came to my aid then. I was then OK. When it happens like that it was through the intervention of this company ...the intervention of the doctors who came to my aid. Sure I was lock up at one place....they (his family) chain me up to a place...locks in a room...I was locked up for some number of months...whilst I was fed there. I do everything like that. So it came to the intervention of the nurse – the doctor who came then started giving me drugs, injections. Then with the help of God I became OK, and everybody sees that I'm now OK. Then they release me. I'm OK but I can't say completely that I'm OK but if I have the medication I'm OK...If I'm given the medication I'll be OK.

Abina describes being treated badly by a traditional healer, and has found some improvement in her condition with medication:

Abina: I was suffering from the mental retardation and we were treating it the local way and was not getting better, and I heard of some philanthropists giving out medicine at Central Hospital, which we were taking and finally heard of the philanthropist helping people with such medicine.... It will go again, if I have the medicine and take it. So if I take it, sleep and wake up. When I was not getting the medicine that is what I said. We were suffering a lot. Because they can take you to a Malam's house and they will beat and injure you still, it will not stop. But when the medicine arrives I do see a lot of improvement because without the medicine I could not attend any gathering. I swear God. I have never been in a gathering even when I gave birth, I could not dress up. I just won't be myself. But looking at me now, I look like a human being.

Belief in Recovery

The majority of participants felt hopeful despite their afflictions, and there was a general attitude and belief that a full recovery was possible and expected. Reference to

religious and / or spiritual beliefs was common in relation to recovery and hopefulness. Serwa: "I am praying that the sickness should go completely. I was not born with the sickness. So is my prayer that it should go and leave me totally, is only that it hasn't gone yet". Mawusi believed that "because of God she can predict tomorrow, so she's always hopeful that she's well and things will be alright with a little support given to her. She has never thought that it's worthless this life".

Discussion

The main aim of this study was to explore how mental illnesses are conceptualised amongst members of different communities in Ghana. The use of IPA in this context revealed interesting findings, which are interpreted and discussed in relation to previous research findings below.

One of the most striking findings of the present study was the overarching role of stigma in the lives of those interviewed. From a theoretical standpoint, it is possible that the huge stigma surrounding mental illness in Ghana has an impact on how it manifests in individuals, for example through somatization. Many participants found that even after recovery they may still be stigmatised within their communities due to fears from others that the affliction is contagious or that evil spirits are still dwelling inside a person. This is an area that has been under-researched in Ghana and in SSA in general, not only in the context of dealing with mental illnesses, but also of how it manifests. It is possible that the fact that the majority of participants in this study described physical symptoms to express and communicate their psychological distress (a phenomenon known as somatization (Kleinman, 1988)), is due in part to the stigma attached to mental illness in Ghana. A number of other researchers have also found somatization to be high within populations in many non-Western cultures (e.g. Binitie, 1975; Kirmayer, 1984; Mumford, Saeed, Ahmad, Latif, & Mubbashar, 1997; Sayed, 2003). Kleinman (1988) contends that a combination of social condition, interpersonal problems, and psychological characteristics produce somatization and that these processes are usually not in the conscious awareness of the individual. This aspect of symptomology and interpretation of distress is significant as it has an impact on the assessment and measurement of distress in Ghana, as physical symptoms may often be overlooked or misunderstood in terms of their psychological significance.

Another area that may be overlooked using traditional psychiatric measurement instruments is the role of livelihoods (in this case in the form of petty trade) in the exacerbation of distress. Participants in this study appeared to be deeply affected by their lack of ability to participate in trade in their community, a finding similar to Canavan et al. (2013) who evaluated the connections between unemployment and psychological distress amongst 5,391 adults in Ghana. Canavan et al. (2013) found an association between psychological distress and unemployment in this context, with participants with moderate psychological distress being twice as likely to be unemployed, especially amongst men. The results from the present study suggest that this association is also common amongst women. Boyce et al. (2009) also found that mental health was positively affected by the maintenance of employment after illness amongst populations in Ghana. The present study provides some insight into the nature of this association, as the majority of participants were involved in a vicious cycle of distress and unemployment. Again, a connection can be made here with stigma, as not having a trade in this context appeared to be highly stigmatising. The social norm in Ghana is to have an independent trade (due in part to a lack of formal employment opportunities and

training). The social and cultural significance of not having a trade in this context cannot be understated: it appears to play a much more complex than simply being 'poor', and presents the individual to their community in a negative way.

Although having a trade was perceived as exacerbating the conditions of participants in this study, the majority attributed the beginnings of their distress to supernatural, spiritual, and religious events. Similar findings have been unearthed by other researchers using qualitative methodologies to investigate mental health in SSA. For example, Read et al. (2009) found that shrines and churches were popular places for individuals with mental illnesses to visit due to beliefs that the root causes lay in witchcraft, sorcery, and the workings of evil spirits. Ventevogel et al. (2013) found that participants mentioned supernatural, psychosocial, and natural causes for mental illnesses in all four of their study areas in Burundi, South Sudan, and the Democratic Republic of Congo, and Ofori-Atta et al. (2010) found that witchcraft was an oft-cited cause of mental illness in women in Ghana, from the perspective of key stakeholders.

Although it may seem rational that the perceived causes of distress will impact automatically on the type of treatment sought, in the current study the help-seeking process was not as straightforward as expected. There was a wide range of choices and outcomes evident for each individual participant in relation to the success or failure of the different treatment options available to them. The majority of participants had tried multiple different treatments, some of which resulted in success, and others in failure. Theoretically, it would make sense that the ways in which mental health is conceptualized in a certain culture predicts the treatment pathways, but it appears that choices are not always that straightforward. Other researchers have also found that a number of different healing avenues have been explored by sufferers and their families. For example, Labys, Susser & Burns (2016) conducted qualitative interviews with 32 individuals who showed symptoms of psychotic behaviour in rural South Africa and found that many of these participants had consulted a variety of different service providers, including medical traditional, and spiritual healers. Johnson et al (2017) also found that neither stigma nor problem conceptualisation predicted treatment choice amongst adults in Uganda, and that contextual factors and issues of accessibility were better predictors of treatment and help seeking. Their participants also sought a diverse range of treatments, with a diverse range of beliefs evident. Within Ghana, Read et al. (2009) found that with many people they interviewed with a diagnosis of mental illness had negative experiences of traditional healers. The fact that participants in the present study had widely variable experiences with traditional healers indicates that more research is required into this aspect of healing in Ghana.

It was also interesting and significant that many participants shared stories of recovery, and expressed a general belief that recovery was possible and expected. There appears to be a strong belief in Ghana that recovery is possible and will occur with time, whereas in Western cultures it is often perceived as a lifetime affliction. It is theoretically possible that this could help to explain the results of the World Health Organisation studies that found higher recovery rates for schizophrenia in developing than developed countries (e.g. Sartorius, Shapiro, & Jablensky, 1974). If this belief in recovery can aid in the recovery process, this has huge implications for how mental illness is conceptualised and treated.

Strengths & Limitations of the Study

By employing the phenomenological method, the perspective of individuals who would usually be denied a platform for communicating their experiences in the academic literature was exposed, and produced a deeper understanding of how mental illnesses are conceptualised in Ghana. This approach revealed aspects of mental illness in Ghana, such as the somatization of symptoms and the role of stigma and livelihoods, that would likely have been overlooked using quantitative research methods. Insights were also gained into the different treatment pathways and healing avenues that individuals pursued, and into their beliefs about the source of their ailments, and their belief in recovery.

It is possible, however, that some of the participants' responses were affected by the fact that the primary researcher was from a different cultural background, especially in rural areas where many of the research participants had not had many interactions with people from outside of their communities. In addition to this, conducting the majority of interviews in a language that was not familiar to the primary researcher means that some of the idiosyncrasies that would usually be observed when using the IPA method were possibly overlooked. Finally, despite the variations in research sites around Ghana, it is difficult to know how relevant the results are in relation to other countries in SSA without conducting similar research in different countries.

Future Directions

Further research studies using the IPA method in SSA will provide a clearer picture of how mental illness is conceptualised in different cultures and contexts, and will provide suggestions as to how best to support sufferers in Ghana. Future studies could also investigate the significance of some of the unexpected revelations of the conceptualisations of mental illness that were uncovered in this study. For example, the high recovery rate amongst the participants in this study could be related to the general belief in recovery that was evident from speaking to participants from all of the different groups involved. It will be important in the course of mental health research in non-Western cultures to acknowledge that there are likely to be different perceptions of mental health illnesses and different ways of addressing these issues. One way of ensuring that services are appropriately designed is to conduct qualitative research that provides information on the lived experiences of members of communities in different cultures, and to analyse cultural and conceptualisations of distress.

Conclusions

After a long battle to have mental illness considered as a serious issue on an international level, the inclusion of mental illness in the newly developed SDGs initially appears to be a positive step towards tackling this issue in developing countries. Upon closer inspection, however, there are some major gaps in our current knowledge of mental illness in SSA that need to be urgently addressed before progress can be made. Variances in conceptualisations and experiences of mental illnesses mean that it is difficult for policy-makers and programme developers to prescribe appropriate mental health services without having a substantial amount of knowledge of the culture in question and how mental health is conceptualised within different that culture. The results of this study and other studies investigating how mental illness is conceptualised in SSA have major implications for the supports and infrastructure required. Assuming

that mental health is conceptualised in the same way across all cultures may be counter-productive in efforts to attempt to address the issue, and integrating the findings of qualitative research into the development of mental health policies and programmes in SSA will be crucial to their success.

Acknowledgements

The author would like to thank all of the research participants for their contribution to this project, and the staff at Basicneeds Ghana, the Mission of Hope Society International (MIHOSO) and the Centre for the Development of People (CEDEP) for their assistance in recruiting participants and for assisting with the data collection phase of this project.

Declaration of Conflicting Interests

The author declares no potential conflicting of interest with respect to the research, authorship, and/or publication of this article.

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