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Perceptions and Beliefs about Mental Illness (Schizophrenia) among Adults in Zaare Community

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Abstract
The burden of mental illness like schizophrenia is increasing and is particularly severe for people living in rural communities. Ghana adopted a community-based rehabilitation (CBR) for persons with mental illness to address the problem comprehensively. However, negative attitudes towards the mentally ill, stigmatization and discrimination constitute a serious barrier to CBR. The objective of the study was to assess societal beliefs and perceptions about people with schizophrenia, among the adult population in a rural community (Zaare) in the Bolgatanga Municipality. The study used a mixed method where both qualitative and quantitative techniques were employed. A sample size was determined using a systematic approach. The respondents held fairly positive views about the mentally ill, despite a few negative authoritarian and socially restrictive attitudes and views. Though participants appeared to be knowledgeable about the possible physical, social and environmental causes of mental illness such as accidents and genetic factors, 94% of all participants thought mental illness could be due to witchcraft/evil spirits, and 66% felt that it could be a consequence of divine punishment. This is an indication that stigma and discrimination against the mentally ill were still widespread among the respondents. The widespread belief in supernatural causes is likely to act as a barrier to designing effective anti-stigma educational programmes and as a result frustrating the implementation of CBR. There is a need in the Bolgatanga Municipality and elsewhere to develop strategies to change stigma attached to mental illness at both the rural and urban community levels. This paper is one of the first to report to be made on attitudinal research on mental illness in the Bolgatanga Municipal area and the Zaare community.
Keywords: Perceptions, Beliefs, Attitude, Schizophrenia (mental illness), Zaare

INTRODUCTION

Increasing, health and socio-economic burden of mental illnesses and disorders have become a major concern in both developed and developing countries. Globally, it is estimated that more than 450 million people suffer from mental or behavioural disorders and one in four families has at least one member with a mental disorder (WHO, 2003). According to WHO (2012), mentally ill people often lack access to education, healthcare and opportunities to earn a decent living, which limit their chances of economic development and deprive them of social protection and recognition within the community. They often have their human rights violated, including being subjected to unhygienic and inhuman living conditions, physical and sexual abuse, neglect, social isolation, as well as stigma and discrimination in health care facilities, in homes and the community at large (Bhugra, 1989).

In many developing countries, people with mental health problems like severe forms of schizophrenia and even mental healthcare professionals attract negative perceptions and are often stigmatized (Sartorius & Schulze, 2005 cited in WHO, 2006), despite increasing evidence of the importance of improving mental health care and support services to ensure that the mentally ill are integrated into the socio-economic life of their families, communities and society at large (Sadik et al., 2010). After all, people who developed severe mental health illnesses like schizophrenia tend to have similar life goals as people without these conditions (Dumont et al., 2006). For instance, the mentally ill everywhere in the world want to be respected and also lead a life as normal as possible. As such they desire to live with their families, have adequate education and a meaningful source of income for living dignified lives, satisfy social and intimate relationships, and participate in community life with full rights.

One way of achieving integration of mentally ill people into the society is through the concept of Community-based Mental Health Practice (CMHP) (WHO, 2001). As Rössler (2006) noted, the role of the community in the prevention, treatment and rehabilitation of the mentally ill has been widely acknowledged across the world. CMHP is a comprehensive approach to mental health care, which requires involvement and commitment from the local community, mental health care service providers and intermediary level stakeholders like social and community development workers (BasicNeeds, 2009).

In line with this thinking, Ghana adopted a new mental health policy with the passing of the mental health Act, 2012 (Act 846) that seeks to promote mental health care and rehabilitation in a humane environment (GoG, 2012). The Act sought to promote a culturally appropriate, affordable and accessible mental health care delivery at the community level. The aim is to gradually move away from institutional care of the mentally ill to community care that promotes integration and increase the ability of patients to live with their families. However,

a positive social environment (an environment in which the PwS feel comfortable to live a normal life) at the community level is needed to achieve these policy goals. It is within this context that public perceptions, especially local beliefs and attitudes toward mental illness are important if treatment and rehabilitation is to be carried out at the community level.

While the knowledge and perception of mentally ill patients and their relatives regarding mental illness has been reported somehow from the southern parts of Ghana, to date there is little or no research on perceptions and beliefs about mental illness from northern Ghana, a culturally distinct part of the country. This paper is therefore, one of the first to report findings relating to attitudinal research on mental illness from northern Ghana. The goal of this study therefore was to assess the perception and beliefs about mental illness (Schizophrenia) among adults in Zaare. The specific objectives of the study are:

i. to identify the causes of mental illness, with a focus on schizophrenia
ii. to assess general perception and beliefs about mental illness in the study area

STUDY AREA

The Bolgatanga Municipality is one of 13 districts in the Upper East Region. It is centrally located in the region and falls approximately between latitudes 10°30' and 10°50' North and longitudes 0°30' and 1°00' West (see figure 2). Bolgatanga serves as both the municipal and regional capital. The Municipality is bordered to the north by the Bongo District, south and east by the Talensi and Nabdam Districts, and to the West by the two Kassena-Nankana Districts (Kassena-Nankana West and Kassena-Nankana East). It covers a total land area of about 729 km^2. It is one of two municipalities in the region (BMA, 2012).

The population density is relatively higher than the national figures, with much of it clustered around the municipal capital (Bolgatanga Municipal Assembly [BMA], 2012). The Municipality has a population of 131,550 in 2010, of which 62,783 are males, representing 48 percent and 68,767 being females, representing 52 percent. About half (50%) of the population is rural and 44 percent of the people under age 18 years (Ghana Statistical Service, 2012). The ethnic composition of Bolgatanga is cosmopolitan, but the indigenes are the Gurune speaking people (BMA, 2012).

The number of health facilities in the municipality is relatively satisfactory compared with the situation in the rural districts of the region such as Bongo. The Bolgatanga Regional Hospital, AfriKids Clinic and the Presbyterian Eye Clinic are modestly equipped. There are a few other public and private clinics in the municipality, though poorly equipped and under-staffed. The Catholic and Presbyterian Churches operate mobile outreach clinics. As at mid-2012, there were 13 CHPS zones in the Municipality (GHS/UERD, 2012). There are also a few pharmacy shops, located in the Bolgatanga Township and many licensed chemical stores. Malaria cases still rank the highest OPD attendance in the municipality (GoG/UNDP, 2010). The Bolgatanga Regional Hospital has a psychiatric unit that provides limited OPD care to people with mental health illnesses in the municipality and beyond. Community health nurses and workers are also expected to provide various forms of care and services like health education, early detection of persons with mental health problems and treatment of some forms of mental health illness at the community level, including referrals (GHS/UERD, 2012).

The study was conducted in Zaare-Ayorebisi, a rural community in the Bolgatanga Municipality. Zaare is a peri-urban and rural community to the north of Bolgatanga, the Municipal capital. The community has six sections, namely Zaare-Akubisi, Zaare-Amoabisi, Zaare-Aurugubisi, Zaare-Avombisi, Zaare-Avutubisi and Zaare-Ayorebisi. The Ayorebisi section, which is more rural, was purposively selected for the study.

METHODOLOGY AND DATA PROCESSING

The study used a mixed method where both qualitative and quantitative techniques were employed. A sample size was determined using a systematic approach. There were about 100 dwellings in the study community. Each residence contains an average of three households. To obtain a representative sample of the residents, half (50%) of the residences were considered for the study. The sample frame of 100 was divided by the sample size of 50 and every 2nd dwelling was subsequently selected. But because of the need to randomly start any systematic sampling, 1 and 2 was randomly selected. The selected number was 1. Thus, the first dwelling was chosen on the sample frame, and subsequently every 2nd dwelling. Therefore, the procedure was followed till the 50 dwellings were selected.

In each of the 50 dwellings, an adult who was at least 18 years old took part in the study. For all the 50 dwellings selected for the study, there was at least one adult who had knowledge about mental illness, Thus, 50 participants were covered in this study; 26 women and 24 men.

Focus group discussions, structured and semi-structured interview questions, and observation were employed to collect data. The Statistical Package for Social Scientists (SPSS) software was helpful in analysing the data gathered through structured and semi-structured interview questions.

RESULTS

Participants were adults within a fairly widely age range mainly 20 and 60 years (Table 1), with generally some formal education. About 48% of the respondents were male and 52 % were female. While 16% of respondents were below 20 years of age, 14% were above 50 years, and a little more than 52% were aged 21-40 years. On marital status, 30% reported being single and 44% were married. Almost half (48%) of respondents had no formal education and 46% had basic education to the primary, Middle School or Junior High school levels (Table 1).

With regard to religion, a little more than half (52%) were Christians, 32% were traditional believers and 16% were Muslims.

General knowledge of mental illness (schizophrenia)

The majority (82%) of respondents associated mental illness with 'madness or insanity', followed by hallucinations, and emotional problems and brain disorders. A 20-year old male respondent explained that "*people who take dangerous drugs such as 'wee' can go crazy, and sometimes people are punished by God for wrong doing making them mad".* As presented in Figure 2, majority of the respondents have heard about schizophrenia, within the past three months.

As indicated in Table 2, majority (88%) of the respondents have never participated as community volunteers for any organization providing mental health services. However, majority (80%) of the respondents knew someone with schizophrenia, even though only 46% of them reported knowing a person who has been treated with schizophrenia disorders. Asked whether a close relative has ever had a mental health disorder, 12% of the respondents reported having a family member suffering from schizophrenia.

Contacts with the mentally ill

As presented in Figure 3, 14% of respondents have never had any contact with a person with mental illness, 22% reported seldom (once/twice) contacts with a mentally ill person, 28% have had contact with a mentally ill person sometimes (once a month). The views of the respondents from this finding indicate that most respondents have at least had contact with a person with mental illness.

Almost all **(**94%) of the respondents were concerned about schizophrenia and other mental health problems. This suggests that community people may be supportive of community-based rehabilitation and treatment of persons with mental illness.

Knowledge of the causes of schizophrenia

Participants shared a common view that more than one thing could cause mental illness. Almost all the respondents (98%) agreed that traumatic events like accidents can cause mental illness, 96% cited substance abuse as one of the causes, and 94% reported that people become mentally ill due to the activities of evil spirits as well as stress. However, two-thirds (66%) of the participants reported that punishment from God can also cause mental illness.

Perceptions about People with Schizophrenia (PwS)

The beliefs and perceptions that people have about different types of mental illness are likely to influence their acceptance of the mentally ill in the community. These could therefore, serve as barriers or incentives to CBR of the mentally ill. Three of five 62% of respondents were of the view that PwS were mentally retarded. While almost all 96% of respondents agreed that PwS can co-exist with others in the community, only 22% thought they can work productively on their farms. Generally, almost all participants 92% were of the view that PwS can be completely treated with orthodox medicine and, again 68% agreed that anybody can get mental illness like schizophrenia in the course of their lives. In contrast, only 10% blamed the PwS for their own conditions.

Attitudes and practices towards mental illness

Most of the participants (70%) will not like to have a conversation with persons with mental illness. More than half (54%) of interviewees would not maintain friendship with someone with mental health disorders. Perhaps this could be due to the fact that the behaviour of mentally ill persons is perceived to be unpredictable. Again the results revealed that 74% of the respondents think persons with mental illness cannot marry. Similarly, majority (67%) were not willing to stay in the same room with persons with mental illness. Asked if participants were willing to be associated with a member of the family who was mentally ill, almost two- fifth (38%) would not be ashamed to mention that someone in their family had mental illness. On the participants views on the need to support the integration of persons with mental illness into the community 64% were supportive of such a process. On the contrary, three-fifth (62%) were of the view that persons of mental illness should be chained or locked up in the room, even though majority (78%) did not support the view that community members should avoid all contacts with the mentally ill. In addition, 60% thought that persons with mental illness should not be allowed to make decision in their families.

Care and treatment of people with mental illness

Regarding the care and treatment of persons with mild forms of mental illness like schizophrenia, Popularly

(78%) of study participants supported the idea that people with mental illnesses can recover if their condition is reported early for treatment, 68% felt comfortable discussing a mental health problem of a family member with a community health nurse or community health worker, and almost all (90%) accepted that people with mental disorders should be put in an institution to be treated and supervised (Table 6).

Availability of mental health services

With regards to community-based treatment and rehabilitation (CBR) of the mentally ill, twenty-two (44%) of respondents have heard of the approach. Respondents who have heard about CBR were further asked about their source of information. About 63% of study participants reported hearing about mental health care services from either a family member or a friend, followed by in a health facility (41%) and radio (23%). Fewer respondents (9%) reported community development workers as their source of information on mental health issues (Table 7).

Improving mental health care services

Study participants made a number of suggestions to improve mental health services in the community. A few suggested that the need to equip psychiatric units in the area very well, and the need to establish more psychiatric clinics in the communities. The general public should be informed to report early to health workers for early treatment. Study respondents noted that most of the mental illnesses are caused by substance abuse and therefore the law enforcement bodies should deal with hard drug dealers and the users. Community members should be well educated so as to help integrate people with mental illness into the community.

People with the severe forms of mental illness should be sent to psychiatric hospitals for supervision and treatment rather than chaining them against trees or in their own rooms without proper care. A friendly environment should be created for mentally ill people so that they can feel comfortable visiting any health centre for advice.

DISCUSSION

There is high awareness of mental health problems and disorders among the participants. Perhaps, this is due to increased awareness on mental health issues in recent times through radio, television and outreach workers. It could also be due to the activities of NGOs like Basic Needs Ghana, which is implementing community-based health rehabilitation and support programmes in the Bolgatanga Municipality and other parts of the region. Mental health information can also reach the people through community health workers and social workers through their outreach programmes.

Violence/destructiveness, talkativeness, and weird behaviours were the most commonly mentioned perceived indications of mental illness by participants. This finding suggests that one has to exhibit behaviour that draws public attention and is thus socially disturbing, to be recognized as having a mental disorder. This finding is similar to that documented by White in Tanzania (1991) and Asuni *et al*. (1994) among Yoruba patients in Western Nigeria. It is noteworthy that hallucinations and delusions that are habitually mentioned in the literature as prototypes of gross psychotic states were not mentioned by the respondents as attribute of mental illness, possibly because such traits are not as tangible as hostile attitudes.

Virtually all the respondents agreed that traumatic events like accident, substance abuse, stress and evil spirits as well as poverty and brain disease could cause mental disorders. The results on knowledge of the causes of mental illness indicate that the respondents have fairly good knowledge of the physical, social, environmental and psychological causes of mental illness, and this could be due to sensitization on the issues regarding mental illness by community outreach and health workers. Adewuya et al 2008, found that urbanity, education, occupational status, age, and familiarity with mental illness are important independent correlates of multiple perceived causation of mental illness. Our findings are contrary to a study in India of community beliefs about causes and risks for mental disorders, (Kermode et al 2009), found that the most commonly acknowledged causes were a range of socio-economic factors, while neither supernatural causes nor biological explanation were widely endorsed. However, belief in demons as the cause of mental health problems is a well-known phenomenon in many cultures of the world (Pfeifer,1994) and thus in this study these factors (evil spirits and curses) were ranked high by study participants. Our finding is also similar to Adebowale and Ogunlesi (1999) who found that "supernatural causes" were the most acceptable etiological factor among both mentally ill patients and their relatives in southwest Nigeria.

The high awareness of causes of mental health illness among the participants could be supportive of community level efforts to tackle the causes of mental health illness since the people are already aware of the causes of these problems. However, it is important to note that a sizeable proportion of respondents endorsed supernatural forces like witchcraft, possession by evil spirits, curses and divine punishment from God as possible causes of mental illness. These beliefs could be responsible for the continued stigmatization, discrimination and isolation of the mentally ill.

Participants generally have positive perceptions about the mentally ill. This is encouraging because community-based rehabilitation of the mentally ill as required by the mental health bill is supposed to integrate patients into a community where they can live and possibly work to be self-independent in the community. If

people generally have positive perceptions about the mentally ill; it would help to secure the support of community people towards CBR programmes. The tolerant attitudes also mean that the number of non-professional and professional care givers would increase once the patient is being rehabilitated within the community. Our findings is similar to the findings of Aultman and Villegas (2004) who noted that the needs of the mentally ill include biological, social, spiritual and cultural, and some of these needs can only be met at the community level, thus contributing to the overall care of the patients. However, it is worrying that majority of the respondents thought PwS and others with mental health problems were dangerous and violent, PwS are mentally retarded, and only a few of the respondents think that PwS can work productively on their farms and that PwS should be blamed for their conditions. These findings suggest authoritarian and social restrictiveness perceptions regarding the mentally ill, which may not be supportive of CBR initiatives.

The findings on attitudes towards the mentally ill appear to contradict the generally permissive perceptions of the PwS. The attitudinal findings suggest that majority of the participants were more likely to maintain a social distance (social restrictiveness) from persons with mental health disorders. This indication is interaction with the mentally ill in the community will be limited, and at best community members may prefer custodial rehabilitation and treatment in mental hospitals. Another possible explanation could be that respondents wanted to look socially accepted in their perceptions of the mentally ill, even though their attitudes may remain largely negative. That only a few participants will visit a health facility with emotional problems could be due to inadequate access to psychiatric health care providers in the Zaare area. It was also clear from the results that many participants would feel hesitant to have a conversation with persons with mental illness. This indicates that people with mental health problems may not get social, psychological and emotional support to be integrated back into the community. The results also indicate that more than half of the participants will find it difficult to maintain friendship with a person having mild forms of mental disorders. All these are indications that many people may still stigmatized and discriminate against people with mental health problems. Doku et al. (2008) and Barke, et al. (2010) indicated that generally it is clear that people with mental illness in Ghana are widely stigmatized and discriminated against at the institutional, family and community levels, and this is often extended to their care-givers and health care providers, partly due to poor knowledge and attitudes of the general public about mental health conditions. It is therefore not surprising that only about few participants pointed out that they would not be ashamed to identify themselves with a family member who has a mental health problem. Positively, it is encouraging to find that majority of the participants were not in favour of avoiding all contacts with the mentally ill in the community. This is an indication that changing people's attitudes positively could enlist their support for CBR implementation.

CONCLUSION AND POLICY IMPLICATION

Generally, there is high awareness of mental health illness among the participants, and that is very encouraging as this will facilitate early report of mental health cases to the health centres for early treatment.

There is also a very high awareness of the causes of mental illness, and this high awareness could be supportive of community level efforts to tackle the causes of mental health illness since the people are already aware of the causes of mental illness.

The study participants also demonstrated generally positive perceptions about mental illness. This is encouraging, even though the positive perceptions appear not to have been translated into attitudinal change.

Most respondents appear to have negative attitudes toward the mentally ill, and this could entrench stigmatization and discrimination against PwS. This is an indication that stigma and discrimination against the mentally ill were still widespread among the respondents. The widespread belief in supernatural causes is likely to act as a barrier to designing effective anti-stigma educational programmes and as a result frustrating the implementation of CBR.

There is also high awareness of mental health care services near the study community, and this is encouraging because people will visit the available or the nearest health facility for advice of their conditions if the right conditions were created.

There is now the general consensus in Ghana on the need to shift from the mental health care delivery based on the traditional large psychiatric hospitals to modern comprehensive community-based approaches of care, treatment, rehabilitation and habitation of the mentally ill. The main reasons are that accessibility to mental health care of people with longer-term mental disorders is much better with community-based services than with the traditional psychiatric hospitals; community-based services are associated with greater user satisfaction and increased met needs. In addition, they also promote better continuity of care and more flexibility of services, making it possible to identify and treat early enough.

However, it is important to address negative attitudes toward the mentally ill in order to make community-based care a reality. Therefore, based on the findings and conclusions of this study, the following recommendations are made:

The Bolgatanga Municipal Directorate of Health Services and its partners must motivate and provide

incentives to Community Health Nurses to sustain the high awareness creation on mental ill issues at the community level and extend this to more communities in the municipality. There is the need to provide more knowledge and increased awareness on the causes of mental illness and also dispel the myths around the causes of the disorders.

The newly created Mental Health Authority (MHA) and the Ministry of Health should work together to look for funding from other sources, rather than relying solely on central government budget allocations to address the inadequate mental health staff and facilities at the community level as it appears budget for mental health services are insufficient, perhaps due to discrimination of persons with mental disorders and low budgetary allocation.

The Bolgatanga Municipal Assembly should provide resources from its own internally generated funds to support community-based mental health service delivery, especially in the area of preventive health care.

The Bolgatanga Municipal Assembly should consciously take measures to promote the integration of mental health services with the general municipal health system, socio-economic and social services provision, including improved co-ordination of welfare and employment creation to reduce poverty. This should be followed by adequate training of staff across the various sectors.

More importantly, the study recommends the need for all stakeholders to focus more attention on strategies that will address negative attitudes and behaviours toward the mentally ill, aimed at reducing stigmatization, discrimination and open violence towards the mentally ill and service providers as well as care-givers. Reducing stigmatization will also motivate more health bnkxprofessionals to go into mental health care delivery. In doing this, key community opinion leaders and authorities must be involved.

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Figure 1: Map of Upper East Region showing the study community

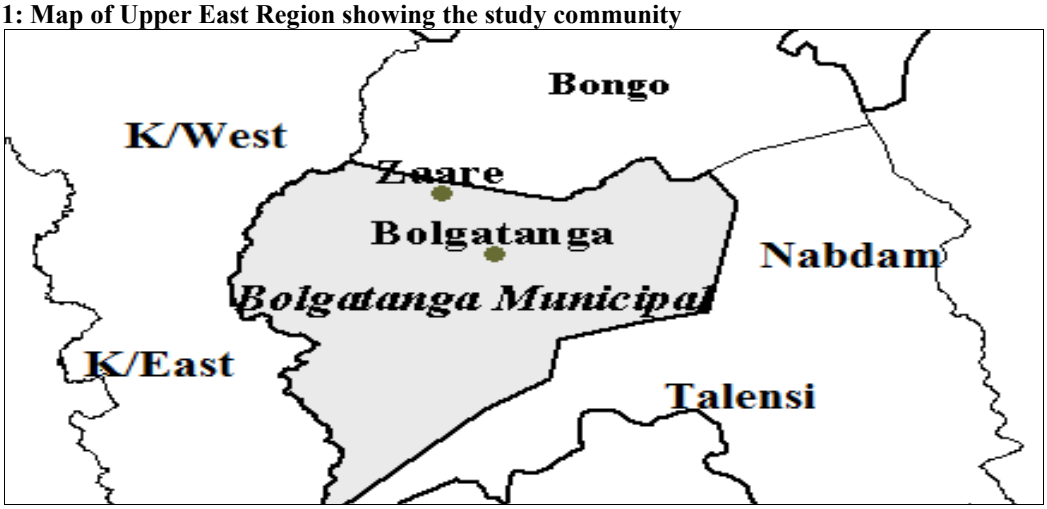

Table 1: Percent distribution of respondent characteristic

Characteristic			**Characteristic**		
Sex:	**Freq**	**%**	**Marital status**:	**Freq**	**%**
Male	24	48	Single	15	30
Female	26	52	Married	22	44
Total	50	100	Divorced	5	10
Age:	**Freq**	**%**	Widowed	8	16
<20yrs	8	16	Total	50	100
21-30yrs	12	24	**Education** :	**Freq**	**%**
31-40yrs	14	28	Illiterate	24	48
41-50yrs	9	18	Primary/JHS/MLSC	23	46
>50yrs	7	14	Sec/SHS/Post-sec	3	6
Total	50	100	**Total**	**50**	**100**

Figure 2: Knowledge about mental illness

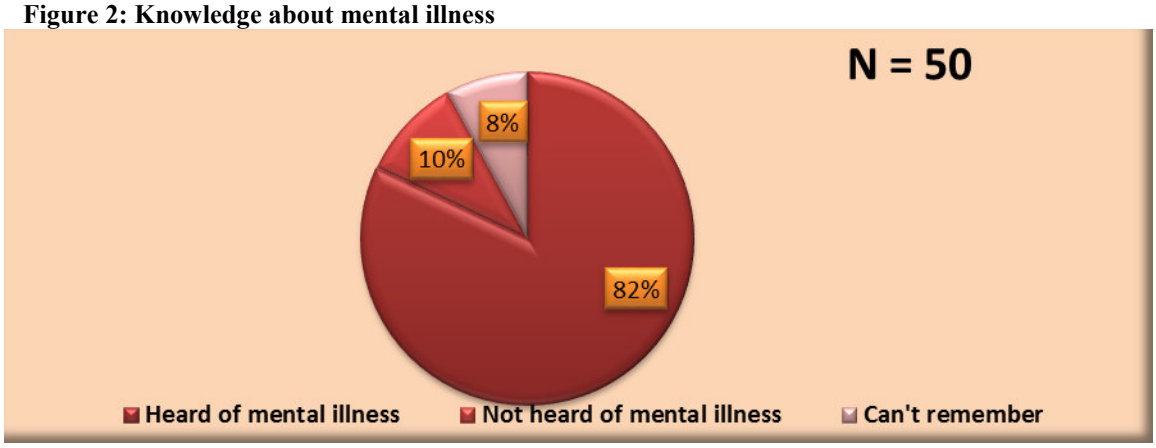

Figure 3: Contacts with the mentally ill

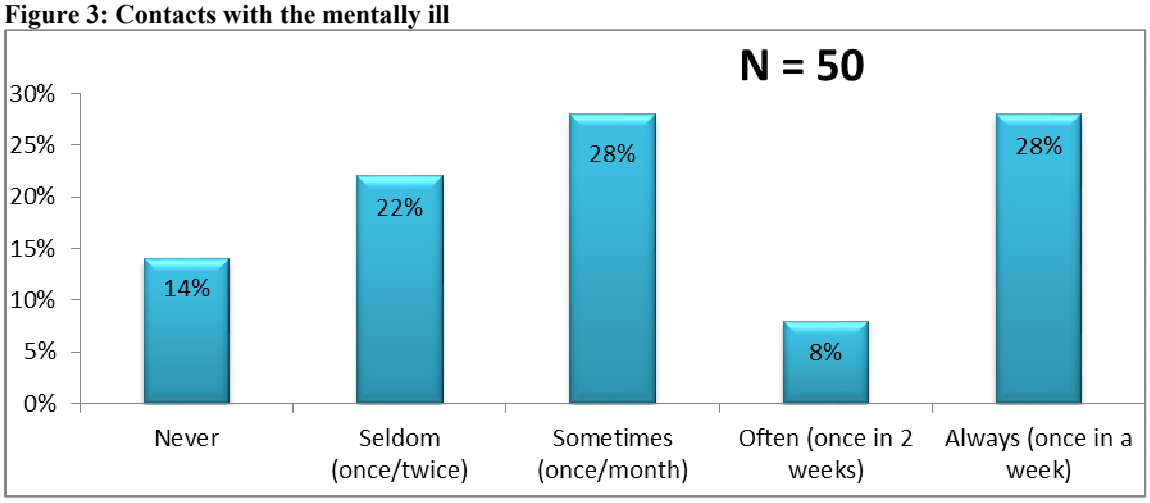

Table 3: causes of schizophrenia disorders

Characteristic	N = 50	%
Accidents/traumatic events *(agree)*	49	98
Substance abuse *(agree)*	48	96
Evil spirits*(agree)*	47	94
Stress*(agree)*	47	94
Poverty*(agree)*	45	90
Brain disease*(agree)*	45	90
Genetic inheritance *(agree)*	42	84
Punishment from God*(agree)*	33	66
Other: Curses	19	38

Table 4: general perceptions on schizophrenic disorders

Characteristic	N = 50	%
PwS can live with others in community*(agree)*	48	96
PwS are dangerous and violent *(agree)*	47	94
PwS can be completely treated with medications *(agree)*	46	92
Traditional healers can treat people with schizophrenia *(agree)*	43	86
PwS should be respected for what they are *(agree)*	40	80
Virtually anyone can be mentally ill with schizophrenia*(agree)*	34	68
PwS are mentally retarded *(agree)*	31	62
PwS are not capable of friendship *(agree)*	31	62
PwS can work productively on their farms*(agree)*	11	22
PwS are to blamed for their condition *(agree)*	5	10

Table 5: Attitudes and practices towards the mentally ill

Characteristic	N=50	%
Will visit a psychiatric nurse with emotional problems (*agree)*	16	32
Will be afraid to talk with someone with PwS (*agree)*	35	70
Will maintain friendship with someone with schizophrenia (*agree)*	20	40
Thinks people with mental illness can marry and have family (*agree)*	12	24
Will live in the same room with someone with mental illness (*agree)*	12	24
Will be ashamed to identify with a mentally ill family member (*agree)*	30	60
Mentally ill persons have the same rights like others (*agree)*	34	68
PwS should be supported to integrate into the community (*agree)*	32	64
PwS should be allowed to make decisions in their families (*agree)*	17	34
Community members should avoid all contacts with the mentally ill (*agree)*	9	18

Table 6: Care and treatment of PwS

Characteristic	Freq	%
Majority of PwS would recover if reported early for treatment *(agree)*	39	78
Comfortable discussing a mental illness problem of a family member with a health worker *(agree)*	34	68
Mentally ill persons be put in an institution to be treated and supervised *(agree)*	45	90

Table 7: sources of information on mental health services

Characteristic	N = 22	% of cases
Radio	5	23
Television	4	18
Health facility	9	41
Family member/friend	14	63
CHW/Volunteer	4	18
Community development worker	2	9
NGO Outreach worker	3	13

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