Addressing Mental Health Issues in Ghanaian Communities: From Personal Experience to Professional Obligation

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In Ghana, the struggle between traditional beliefs and modern medicine continues to leave mentally ill persons without proper treatment. Gaining an understanding of the role culture plays in Ghanaian beliefs about mental illnesses from a historical and current context encourages readers to assess how to best address this relevant and growing topic.

Introduction

My initial interest in the mentally ill in Ghana began as I overheard a conversation between two psychiatrists during my field placement at the Comprehensive Psychiatric Emergency Program (CPEP) at Stony Brook University Hospital in September 2005. The doctors were discussing odd diagnoses, and mentioned the term "incubus," a disorder associated with sleep terrors. Their conversation reminded me of a family friend who had a similar disorder, and believed that the family of her ex-husband had "witched her." Despite being educated both abroad and in this country, it never occurred to friends and family that she was experiencing symptoms of a mental disorder. Rather than pursue appropriate treatment by licensed clinicians, close family members collaborated monetarily and purchased a one-way ticket to Ghana so she could be treated by the only doctor that could help her: a fetish priest. This mentality is not uncommon in people from African countries. "In most parts of the continent, people's attitudes towards mental illness are still strongly influenced by traditional beliefs in supernatural causes and remedies" (Gureje & Alem, 2000, p.1). After she was "healed" and her symptoms were suppressed, she returned to the United States. Her symptoms recurred several years later, when additional forms of paranoia and hallucinations caused her to be hospitalized and given treatment. However, despite the physician's diagnosis, the family still insisted that spirits were the cause of the problem, not mental illness.

Pondering her issue made me wonder how many Ghanaians were walking around their villages with undiagnosed conditions, many of which could be treated with today's vast array of psychiatric medications and mental health services. Lack of knowledge about mental illness and proper treatment stems back to cultural beliefs about witchcraft, "juju," and other supernatural beings that are believed to be the cause of such disorders. As a result, a significant portion of the population is left undiagnosed, subjected to alternative treatment practices, and/or cast out by society.

This narrative was designed for professionals interested in international social work and related disciplines, policy makers, and practitioners. It addresses experiences of mental illness within the Ghanaian community. By addressing the challenges involved with providing culturally competent services to this unique group, practitioners can begin to give those in the social welfare arena a blueprint for ensuring proper treatment of all vulnerable populations.

Personal Background

Culture--a set of beliefs and practices amongst a group of people--often determines how a group thinks, acts, and behaves. These beliefs are passed down from generation to

generation despite outside influences and modernization. I am the child of two Ghanaian parents who were born abroad and came to the United States in their early teens and twenties with the goal of bettering their lives, the lives of family members back home, and the lives of the children they would eventually have.

Growing up in the suburbs of New York City and Long Island, I was very much caught between two worlds: one as a Ghanaian child named *Naa Aku* who ate jollof and plantains, wore braids wrapped with thick black thread that promised to make my "hair grow," listened to traditional highlife sung by my acclaimed Uncle E.T. Mensah, and sojourned to my parents' hometown in Ghana fully equipped with inoculations and filtered water to protect me from the diseases my American body could not handle. The other as an American child named *Lucinda*, who had an American passport, developed a passion for soul food from her elderly southern babysitter, who only spoke English (my mother claimed that when they tried to teach me Ga I got too confused), and went through most of my elementary and middle school years as the only African American girl in her class.

Experiencing life as a second-generation Ghanaian American— which seemed to be a blessing and a curse—has afforded me the ability to explore and view the world through two distinctly different social and cultural lenses. While I believe that all people are similar in their desire to advance their conditions and those of their loved ones, I cannot help but feel that growing up in a Ghanaian household instilled in me a world view that has expanded my values and beliefs far beyond those of my contemporaries who grew up without dual global and cultural perspectives. It is with this dual lens that I have found myself challenged when faced with addressing social welfare issues such as mental health.

Attitudes toward Mental Illness

Turn on any local broadcasting station in Ghana, or pop in any newly released DVD of a highly acclaimed Ghanaian film (think the Ghanaian version of "Bollywood," frequently referred to as "Nollywood" or "Gollywood") and you will find those who exhibit symptoms associated with mental illness portrayed as someone who has "gone mad" or has been "cursed." Since the beginning of time, spirituality has played an integral part in African culture. Therefore, most major life events are associated with something spiritual. "Religion has always been central to people's lives in Africa" (Dickinson, 2002). In addition to Christianity and Islam, several still practice African Traditional Religion (ATR). "Presently they are around 20% of the total population of Africa, which is estimated to be around 760 million" (Nnyombi, n.d.). ATR, often referred to as voodoo or juju, believes in spirits and the supernatural or magical powers of the seen and unseen.

On early trips to Ghana as a young girl, I recall being taught to believe in the existence of witches who presented themselves as different creatures (such as birds), and attacked people at night unless they prayed really hard. Although comical in retrospect, many people living in educated urban townships and in rural villages still subscribe to these beliefs. Therefore, fetish priests or witchdoctors exist yet today. It would not be uncommon for someone such as the homeless man I observed frequently walking around town unclothed and rambling obscenities to be sent to a traditional healer for treatment because he was a "crazy man."

Experiences with Symptoms, Diagnoses, and Treatment

"Traditional healers and religious leaders (such as priests) provide a significant proportion of the care received by the mentally ill" (Gureje & Alem, 2000, p. 3). In Ghana, a majority of the patients in psychiatric hospitals came to them as a last resort, despite the fact that all mental health treatments in Ghana—hospitalizations, prescriptions, individual and group therapies—are free. The patients are more trusting of the treatment provided by fetish priests than doctors who specialize in treating the mentally ill. "One goes to a church, a tabernacle or a mosque for worship, but one goes to the fetish priest of a secret cult to seek medical care, psychological cure, or religious comfort" (Kwabena-Essem, p.1). "For

example, in Ethiopia about 85% of emotionally disturbed people were estimated to seek help from traditional healers because there were only ten psychiatrists for the population of 61 million" (Gureje & Alem, 2000, p. 3). So the multitude of traditional healers available throughout sub-Saharan Africa helps tremendously with the treatment of the increasing number of mentally ill. "Ghana has about 45,000 traditional healers" (World Health Organization, 2007). Traditional healers are always available. "Traditional healers are in the neighborhood, and they're open 24 hours" (Lindow, 2006, p. 43).

The family friend mentioned at the beginning of this article was sent to traditional healers in the United States before being sent to one in Ghana. At the age of thirteen, I accompanied family members to the healer's house located in Queens, New York. The adults spoke quietly in a Ghanaian dialect I couldn't understand, while she was instructed to say certain prayers. For reasons still unbeknownst to me, my brother and I were instructed to drink a concoction of bay leaves boiled in water. Yet her symptoms never went away and, without notice, she was sent home a "healed woman."

Several years later, as a graduate student in social work interning in the psychiatric emergency room, I learned that the woman's symptoms had returned with a vengeance. Convinced that terrorists were going to attack her and family members, her hostile behavior once again became a concern to those in the community. Having witnessed similar cases in my field placement, I advised members of her family to seek psychiatric help. Experience and education in that area taught me that without taking appropriate precautions, failure to act quickly would result in an arrest, hospitalization, or harm to herself or others. Just as I anticipated, police were contacted for a disturbance in the household, and she was hospitalized for evaluation. After receiving medication and being discharged, I queried her son (also a second-generation Ghanaian American educated in the United States) about the diagnosis. Interestingly, he still insisted there was something *spiritual* attacking her.

Despite modernity and education, the majority of Ghanaians and others in similar cultures still resist accepting bizarre behavior as being symptomatic of mental illness. A study conducted in Liberia found that even psychiatric nursing students believed mental illness came from three major categories:

1. A punishment for wrongdoing
2. The result of being "witched" by another person
3. Illness that is passed down through the family (Hales, 1996, p. 3)

Performing unacceptable acts such as adultery, stealing, drunkenness, and disobeying elders can be viewed as wrongdoing and susceptible to punishment by the "gods." Offending these spirits will cause one to become mentally ill, and is only treatable by a fetish priest or zoe.

In addition to being punished by the "gods" for wrongdoing, being "witched" or having someone put "juju" on an individual are other ways Africans believe people can become mentally ill. It is not uncommon for beautiful or successful people who are mentally ill to believe that "others in their village went to the zoe to have a sign thrown on that person because they were jealous" (Hales, 1996, p. 5). One of the students interviewed in Liberia wrote:

> *"One man in our village took mentally ill when he was a young boy. He was the son of a rich man with over 20 wives. The boy was the first son of the head wife and was his father's most loved. All the other wives were jealous and decided to witch him to get him mad. They took a piece of his clothes to a zoe who used the clothes to make the boy go mad" (Hales, 1996 p. 5).*

Lastly, the concept of these symptoms being passed down through the family is similar to the medical theory that mental illness runs in families. However, in this case it is believed that illness can only be passed down from a birth mother to child for her wrongdoing, or the entire family is witched for one member's unacceptable behavior.

As an educated woman familiar with the field of mental health, I can come up with a logically academic rationale for the examples given above. But, as a second-generation American who understands the depths of Ghanaian cultural beliefs (some of which could be comparable to certain western spiritual beliefs), I can begin to address the challenge of providing culturally competent practices that will be accepted by individuals, families, and communities who belong to this immigrant population.

Implications and Recommendations for Social Work

Eager to understand the complexities involved in addressing the stigma toward mental health in Ghana, I consulted with social workers at a psychiatric hospital in Ghana during my visit in 2006. It was not easy to arrange talks with the employees at the Accra Psychiatric Hospital. Fearing I was a representative from a western media outlet, people either refused to talk to me, or knowledgeable personnel happened to be "out of the office." After pleading in the local language (with the help of an uncle who accompanied me), I assured them that I was just an inquisitive student eager to learn and was subsequently able to speak with an administrative aide.

Through our conversations, as well as several follow-up visits to Ghana, I witnessed a slow transformation in approaches to offset obstacles faced by the mental health profession. Today, Ghanaian mental health professionals are collaborating with traditional healers. Community nurses and doctors have been going into villages, educating traditional healers about symptoms, and pleading that they send their patients to the hospital instead of subjecting them to inhumane treatments that have not been proven to work. "Only very few traditional methods have empirical databases to support their effectiveness and safety" (Gureje & Alem, 2000, p. 3). Recently, although more patients have checked into hospitals, families still insist that the fetish priest is the only thing that will truly work. Routine bed checks have been deemed necessary because family members, at the instruction of the traditional healers, will sneak patients out to ingest special concoctions instead of the prescribed medications. This delays discharge time, which keeps the already doubled-up beds from newer patients who are also in desperate need of care. This is a clear indication that more collaborative work is necessary to educate communities about mental illness.

Additionally, there are only .03 social workers in Ghana per 100,000 people (World Health Organization, 2007). As with most countries, social workers are amongst the least paid in the helping professions, which discourages people who would be valuable assets to the field. Those sent abroad to study and conduct research often fail to return, depriving the country of knowledge that could be used for future developments. As is the case with other educational programs, social workers need to be provided with an incentive to practice in Ghana.

In the United States, collaboration with traditional healers is not as simple or accepted. Identifying traditional healers in Ghanaian neighborhoods here in the U.S. will pose challenges. As these immigrant populations increase, social workers will need to identify better methods for addressing mental health issues of those with this cultural background. These groups can now be found in metropolitan cities such as New York, Massachusetts, Maryland, and the District of Columbia. The 2009 NASW Center for Workforce Studies report indicates that the "nation will experience significant demographic shifts that will likely result in a population characterized more by its diversity than by any other factor" (NASW Center for Workforce Studies, 2009, p.2).

The Council on Social Work Education, along with curriculum policy listed in the Educational Policy and Accreditation Standards, now "requires programs to prepare students to recognize the global context of social work practice" (CSWE, 2001; Healy, Asamoah, & Hokenstad, 2003 p.V). Programs such as the Howard University School of Social Work specifically address the importance of educating students on strengths and challenges of immigrant populations in their mission statement guided by the principles

of the Black Perspective. The Black Perspective consists of six (6) principles stressing the importance of understanding the strengths and challenges working with marginalized and oppressed peoples, regardless of race, color, creed, sexual orientation, or national origin:

> Principle 6: *An international dimension with a special emphasis on Africa and the Caribbean area is intrinsic to the School's Black Perspective. The School of Social Work has a mission to educate international students for positions of direct social work practice and leadership roles in social welfare administration and policy in their home countries. A second aspect of the international dimension is our School's commitment to developing that area of social work practice dealing with refugees and other displaced populations — both those individuals displaced within their own countries and those displaced across national borders. A final aspect of the international dimension is the School's desire to foster in its graduates a sense of involvement and commitment to other parts of the world as an element of their professional identity. This is especially important for those areas where issues of social justice and social welfare for people of color are crucial.*(Howard University School of Social Work, 2002.)

As we seek to better understand the best approaches to working within the Ghanaian community and ultimately other immigrant populations around the areas of mental health, I revisit the examples from this article and pose the following questions to readers as food for thought:

1. As a social worker, what methods would have been more effective in suggesting the woman's family members sought professional clinical assistance during her psychiatric episode?
2. If the woman was *healed* because she believed she was healed, how can social workers utilize the strengths associated with belief systems to assist with treatment practices?
3. How can social workers utilize the role of familial decision making to better serve *their* clients?
4. As witnessed in Ghana, how can social workers in the United States best combine traditional beliefs with western practices to best meet the needs of the client?
5. How can the experiences of social workers from various cultural groups be best utilized to educate other practitioners about the unique strengths and challenges associated with corresponding groups?

Conclusion

This narrative concludes with the above questions to stimulate discussion about mental illness not only in the Ghanaian community, but in other diverse communities, as well. Discussion is the first step in finding resolutions to the dilemmas social workers face when serving such populations. Academic discussion has been lacking about the practices and beliefs that have strengthened and challenged these communities, possibly out of concern that groups will be portrayed as barbaric, or that painful family secrets would be revealed.

The experiences shared in this narrative are by no means a general portrayal of what happens in all Ghanaian households. However, while the scenarios may differ, one thing remains the same: we are a proud group of people who, like many other immigrant groups, encompass strength as a community. By discussing these issues as a community, we can shed light on the obstacles and construct practical services that are sensitive to the values of the groups being serviced, ensuring that their needs are being met.

References

• Council for Higher Education Accreditation. (2001). Statement on good practices and shared responsibility in the creation and application of specialized accreditation standards. Washington, D.C.: Author.

• Dickinson, D. (2002). Zanzibar: Mental Health Case Study. *BBC News Africa Live in Dar es Salaam.* Retrieved on December 2, 2010, from: http://news.bbc.co.uk

• Gureje, O., & Alem, A. (2000). Mental Health Policy Development in Africa. *Bulletin of World Health Organizations.* 78(4).

• Hales, A. (1996). West African Beliefs about Mental Illness. *Perspectives in Psychiatric Care,* 32(2).

• Healy, L., Asamoah, Y., Hokenstad, M.C. (2003). Preface. *Models of International Collaboration in Social Work Education.* Alexandria, VA: Council on Social Work Education, Inc., pp. v-vi.

• Howard University School of Social Work (2004). Social Work Mission. Retrieved on April 20, 2011, from: http://www.howard.edu/schoolsocialwork

• Kwabena-Essem, N.(n.d.) "A New Look at Juju." Djembe Magazine. Retrieved on November 29, 2010, from: http://afgen.com/juju.html

• Lindow, M. (2006) Calling All Healers. *Time Magazine.* Retrieved on December 1, 2010, from: http://www.time.com/time/magazine/article/0,9171,1214944,00.html

• NASW Committee on Racial and Ethic Diversity (2001). NASW Standards for Cultural Competence in Social Work Practice. Retrieved on November 15, 2010, from: http://www.socialworkers.org

• NASW Center for Workforce Studies (2009). Workforce trends affecting the social work profession. Washington, D.C.: Author.

• Nnyombi, R. (n.d.) African Traditional Religion (ATR). Retrieved on December 2, 2010, from: http://afgen.com/atr.html

• Powers, J. (2002) Insanity, Difference, and Cross-Cultural Psychiatry in African History. Retrieved on December 1, 2010, from: http://www.suite101.com/print_article.cfm/african_history/97192

• Van Arsdale, P. (1993) Mental Health and Psychiatry in Africa: An Annotated Bibliography. *Africa Today* 1(1).

• World Health Organization (2005). Mental Health Atlas: Ghana. Retrieved on October 15, 2010, from: http://www.who.int/mental_health/evidence/atlas/profiles_countries_e_i.pdf

• World Health Organization (2007). Ghana: A very progressive mental health law. Retrieved on October 15, 2010, from: http://www.who.int/mental_health/policy/country/GhanaCoutrySummary_Oct2007.pdf

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