CHILD AND ADOLESCENT MENTAL HEALTH INTERVENTION: THE PERSPECTIVES OF SOCIAL WORKERS AND RELIGIOUS HEALERS IN GHANA

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ABSTRACT

The involvement of social workers and religious healers in the treatment and management of child and adolescent mental health disorder (CAMHD) is not a new phenomenon in most African contexts such as Ghana. CAMHD is a global burden, and it is projected to be more in Low and medium-income countries (LMICs) than in High income countries (HICs) in the near future due to the lack of attention and support accorded mental health care in LIMCs. This exploratory qualitative study is conducted to fill the knowledge and research gap in the role of social workers and religious healers in the treatment and management of CAMHD and explore ways to curb stigma and discriminations related to mental illness.

This study involved social workers, traditional healers, pastors and Imams. I employed purposive sampling and snowball techniques in the selection of 17 participants for this study. Participants were drawn from four regions in Ghana, Greater Accra, Central, Eastern and the Volta regions. The aim of the study is to explore and describe the role of social workers and religious healers in the treatment and management of CAMHDs. Data collected were analysed using ATLAS.ti 9.0. a computer software that supports qualitative data analysis.

The findings from the study reveal that social workers and religious healers play distinct roles and hold divergent views on mental illness etiology which is largely shaped by their health and illness explanatory models. However, social workers and religious healers share similar views on stigma and discriminations due to mental health and offer similar measures to curb stigma and discriminations. Findings of the study proffer recommendations for social work practice, social work education and policy implementation, and suggests implication for social work practice.

Keywords: Child, Adolescent, Social worker. Religious healer, mental health, Ghana

LIST OF ACRONYMS USED

CAMH	Child and Adolescent Mental Health
CAMHD	Child and Adolescent Mental Health Disorder
DSM-V	Diagnostic and Statistical Manual, Fifth Edition
EMs	Explanatory Models
HICs	High Income Countries
ICD-10	International Classification of Disease, Tenth Revision
IFSW	International Federation of Social Workers
LMICs	Low and Medium Income Countries
NASW	National Association of Social Workers
TBS	Traditional Belief System
TH	Traditional Healer
WHO	World Health Organization

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POINT OF DEPARTURE

"It is their choice. I see nothing wrong with it. If I were in her shoes, I would do the same"

She stopped taking my calls. After trying for two days, I decided to pay them a visit. She spoke to me through the window. This was a home I visited twice a week in the last one month. Today, I was not welcome. In a subtle voice Kwakye[1] said, "I have decided to take her to our pastor. I don't need your help anymore." I stood still in disbelief. When I enquired the reason for her decision, Kwakye said her daughter's problem was spiritual, a problem for the church to handle and not for a mental health practitioner which they had been visiting for about a month. She pulled the window blind together and disappeared. As I turned to leave, "one more thing madam," I heard Kwakye's voice, "I don't want people to laugh at us. The church is better."

Kwakye and Adwoa her 11-year-old daughter lived in a compound house. One day, Kwakye came home from her fruit hawking and found Adwoa sobbing in the corner of the room where she sleeps. This was not unusual, so Kwakye ignored Adwoa. At about 3.00am when Kwakye woke up to use the bathroom, Adwoa was still sobbing. Now that was strange. Adwoa's temperature was high and Kwakye decided that she was taking her to the hospital. She woke her partner who was fast asleep to give them a ride on his motor bike to the community health centre, but he refused, saying that Adwoa was up to her usual naughtiness.

Hospital examination revealed that Adwoa had been severally abused sexually. This came as a shock to Kwakye. Her partner who is not Adwoa's biological father has constantly abused Adwoa and threaten to throw her and her mother out if she told her mother. A former service user referred Kwakye to our agency. Adwoa has become so withdrawn and would not speak to anyone. She did not want to go to school anymore. She did not also want to be around people, and she cried a lot. I was assigned to work with Adwoa, to follow up on their visits to the psychologist twice every week.

As a social worker involved in domestic violence and child abuse issues, I have come in contact with service users who either suddenly disappear to seek help elsewhere or outrightly refuse a referral to see a psychologist. Seeking help with religious healer was not something strange to me but this particular case got me really worried. I started reading articles on alternative treatment for mental disorder and in one of my searches, I stumbled on a documentary titled "The World's Worst Place to be Disabled". This documentary is about how religious healers treat persons living with disabilities and mental disorders in Ghana. This further triggered my interest to explore the role of religious healers in the treatment and management of mental illness. I decided to include social workers to help people in my context understand that social workers play a role in mental health care delivery. Social work, though not new in Ghana, remains an unpopular field. Most people in Ghana think of humanitarian services such as handing out food and brokering as the only role social workers play in helping people.

Therefore, this study explores and describes the role of social workers and religious healers in CAMH intervention in Ghana

[1] All names used are pseudonyms

CHAPTER 1
INTRODUCTION

Children and adolescents' mental health (CAMH) determine how functional children and adolescents are in society. According to the World Health Organisation (WHO), children with sound mental health can attain high psychological and social functioning and wellbeing, and they can be productive and handle developmental challenges (WHO, 2005). Thus, early detection and intervention are eminent to enable children to participate fully in society.

1.1 Background

According to the World Health Organisation (WHO), mental health is fundamental to an individual's well-being just as physical health. Mental health is defined as "*A state of well-being in which the individual realizes his/her own abilities, can cope with normal stresses of life, can work productively and fruitfully and is able to make a contribution to his/her community"* (WHO, 2011b, p.7). The WHO suggests common mental disorders in children and adolescents include intellectual disability, Attention Deficit Hyperactive Disorder (ADHD), conduct disorders, epilepsy, depressive illness and substance abuse (WHO, 2011a). Most mental health disorders in adults begin in adolescence (before the age of 14); hence if mental health problems are not properly managed in children and adolescents, it can affect adult's social functioning and participation in the workforce (WHO, 2005b; Knopf, Park, & Paul Mulye, 2008).

1.1.2 The Global Burden of Mental Disorders

Mental health issues account for the larger disease burden among children and adolescents (Mokitimi, Schneider, & de Vries, 2018). Subudhi (2014) posits that due to the high rate of mental health problems globally, promoting mental health care in most parts of the world has been a challenge. The percentage of persons with mental health problems globally is alarming. WHO (2011a) reports that an estimated 14% of the global burden of disease is due to mental disorders, and 16% in people aged 10-19 (WHO, 2018; Hinton, 2019). In children and adolescents, mental health problem is estimated to affect 10%-20% worldwide.

LMICs have been predicted to experience a higher burden of mental disorders than High-Income Countries (HICs) for several reasons, such as the high number of children and adolescents entering the age of risk for developing certain mental disorders, disasters and conflicts especially in war-torn countries, poverty and rapid urbanisation (Desjarlais, Eisenberg, Good, & Kleinman, 1995 in Twesigye & Kagee, 2016). Rapid urbanisation comes with challenges such as overcrowding, rise in homelessness, poverty and disruption in family ties that can lead to loss of social network and support that can negatively affect an individual's mental health (Desjarlais et al., 1995 in Twesigye & Kagee, 2016). According to the WHO, there is a wide gap in funding in LMICs, where stigma is prevalent towards persons with mental

disorders ((WHO, 2011b). Most children and adolescents in LMICs do not have access to treatment due to lack of resources and training for CAMH personnel (Natala et al., 2018). The World Psychiatric Association asserts that the scarcity of resources and the lack of trained staff hinders the development of mental health programmes in Africa. Inefficient use and unequal distribution of these sparse resources result in a 76%-85% treatment gap in LMICs (WHO, 2011b). A treatment gap refers to "the absolute difference between the true prevalence of a disorder and the treated proportion of individuals affected by the disorder" (Kohn, Saxena, Levav, & Saraceno, 2004, p.859). If suitable interventions are not available to children and adolescents with mental health problems, the problem would linger and negatively impact children's and adolescents' productivity and prospects (WHO, 2005). The lack of access to treatment and the prevalence of stigma due to mental disorders informs people's choice in help-seeking. Due to people's behaviour with help-seeking for mental problems in LMICS, there is a current discourse on the need to incorporate indigenous practices of health care into the formal health care system (Asamoah, Osafo, & Agyapong, 2014). Besides problems with access and stigma, adults also seek intervention for children and adolescent with mental disorders based on their perception, explanation and understanding of the cause of mental disorders.

Several factors contribute to mental illness, and different authors have listed these to include genetic/biological, psychological, and socio-cultural (Salifu Yendork, Kpobi, & Sarfo, 2016; Subudhi, 2014). Regardless of the advancement in medicine, in most African countries and some other parts of the world, cultural and traditional beliefs still influence people's perception of factors that contribute to mental illness/disorder. The belief of some Africans in tradition, magic and the supernatural influence their understanding of mental illness as a spiritual problem (Cooper, 2016). Different studies from different countries in Africa reveal that mental illness and disorders are understood to be caused by curses, witchcraft, sorcery, spell casting and spiritual invocations (Deribew & Tamirat, 2005; Ngoma, Prince, & Mann, 2003; Opare-Henaku & Utsey, 2017; White, 2015) Disobedience to taboos is seen to be another way of becoming mentally ill, (White, 2015). According to Subudhi (2014) people sometimes misconstrue mental disorders to be a curse from one's present and/or previous life as studies based on the Indian context argue. Such understanding of mental disorder as caused by supernatural influence has contributed to affected families' intervention choice.

1.1.3 Situation of Mental Health Service in Ghana

The World Bank (2013) classifies Ghana as one of the LMICs. Among countries in this category, Ghana has a high treatment gap of 98% compared to 76-85% in other LMICs (WHO, 2011b). According to the WHO estimate, of the 21.6 million people living in Ghana, 650,000 suffer from a severe mental disorder and a further 2,166.000 from moderate to mild mental disorders. Using the World Health Organisation Assessment Instrument for Mental health System (WHO AIMS), Roberts, Mogan, & Asare (2014) report that mental health services in Ghana are underfunded, with only 1.4% of the health care budget allocated to mental health. The national health insurance scheme does not cover mental disorders, and persons with mental

disorders do not have access to social welfare support benefits like financial support (WHO, 2011b).

There are only three public and four private psychiatric hospitals in Ghana (Fournier, 2011). Two of the public and two of the private hospitals are in the Greater Accra region, one public hospital in the Central region and the remaining two private hospitals located in the Ashanti region (Fournier, 2011). The total number of staff in mental facilities in Ghana per 100,000 population is 7.3, with 0.07 psychiatrists and 0.08 psychologists per 100,000 population (WHO 2011b). with the public hospital understaffed and private hospital expensive, many people resort to more ever-present and affordable religious healers (Ewusi-Mensah, 2001; Fournier, 2011).

Empirical evidence on the prevalence of child and adolescent mental disorder is very limited in Ghana (Kusi-Mensah, Donnir, Wemakor, Owusu-Antwi, & Omigbodun, 2019). This limitation, to a large extent, reflects the low priority placed on CAMH, by the state; it also shows the vulnerability of children in Ghana. For example, a report by WHO on the mental systems in Ghana reveals that out of the 123 mental outpatient facilities in Ghana, none are for children and adolescents only, even though children make up 14% of patients seen in the outpatient facilities. The report also demonstrates that more children are treated in outpatient facilities than in day treatment facilities (WHO, 2011b). Kleintjes, Lund, & Flisher (2010) suggest that the lack of investment in CAMH is due to the stigma and low priority given to mental health in general.

1.1.4 Informal Alternative Mental Health Care in Ghana

The Central Intelligence Agency (CIA) (2021) posits that Ghana is a country with diverse religions though it is considered a secular nation. The authors submits that the three most popular religions in Ghana are Christian (71.2%), Islam (17.6%), and Traditional religion (5.2%). Ofori-Atta et al. (2010) submit that the different religions provide informal mental health care to their members and in the communities where they are in Ghana. Roberts et al. (2014) suggest that in Ghana, faith-based facilities such as prayer camps and healing centres operated by religious leaders provide mental health care to individuals and families with persons with mental disorders. The authors explain that across the 10 faith-based facilities surveyed in Ghana, 1253 people were treated in 2011 and 8% of those who received treatment were children and adolescents. Faith-based practitioners surveyed do not use international classification of disease tenth revision (ICD 10) but healers stated that they treated and diagnosed schizophrenia (25%), Substance Abuse (19%), mood disorder (6%), epilepsy (5%), and others (45%), with witchcraft and spiritual attack included in 'others' (Roberts et al., 2014). Similarly, these authors surveyed 10 traditional healers' facilities with 749 persons with mental disorders treated in 2011 and found that 8% of those treated were children and adolescents. Robert et al. reveal that just like the faith-based healers, traditional healers did not use the ICD 10 diagnoses but had diagnosed and treated schizophrenia (19%), mood disorders (10%), epilepsy (8%) and other mental disorders (48%). Their study also reveals that of the 20 religious healers surveyed, only two (a faith-based healer and a traditional healer) had received training in psychiatric care in 2011 (Roberts et al., 2014).

1.1.5 Health and Child Welfare in Pre-colonial and colonial Ghana (mid 1800s-mid 1900s)

In the Gold Coast (now Ghana), like most sub-Saharan African countries, there is a long tradition of health care as the responsibility of traditional and religious healers (Adu-Gyamfi, 2010). According to Brenya & Adu-gyamfi, (2014) the belief that good health, which included mental well-being, is generally associated with increased productivity of food and poverty reduction meant that rulers in pre-colonial Ghana adopted traditional means to manage the healthcare of the people. A study by Adu-Gyamfi (2010) reveals that the Asantes tasked themselves with providing health care in pre-colonial Ghana, so Asante indigenous healers, comprised of priests and priestesses who managed health care before the coming of the Europeans (before the 1900s) (Brenya & Adu-gyamfi, 2014). Every disease was portrayed as the wrath of God, ancestors, or deities due to sin or an evil spirit's action (Adu-Gyamfi, 2010). With this understanding, illnesses were managed through "Magico-Religious" beliefs, with traditional indigenous priests and priestesses as health care providers (Twumasi, 1979). The curative means included exorcism, spells, herbs, barks of trees (Adu-Gyamfi, Brenya, & Nana Egyir, 2017).During this pre-colonial period, social issues, which included child welfare issues, were the responsibilities of extended family members (Nukunya, 2003) and the entire community, as it was believed that "It took a village to raise a child" (Frimpong-Manso, 2014, p.411). Traditional African societies were collectivist, where members feel a sense of obligation to their collective community (Ibrahima & Mattaini, 2017). Then in the 19th and 20th centuries came a new social order brought about by the invasion of the Europeans into Africa (Kreitzer, Abukari, Antonio, Mensah, & Kwaku, 2009).

According to Brenya & Adu-gyamfi (2014), during the colonial period, the Europeans came with a different understanding of the treatment and management of health care, they also came with a different child welfare provision (Frimpong-Manso, 2014; Ibrahima & Mattaini, 2017), and attempted to replace the understanding of contracting, treating illness and solving child welfare issues from traditional to Westernized methods. These new understandings were based on scientific approaches to health care delivery. The new health care method introduced included health education, immunisation, and modern medical facilities. This period also introduced Western ideologies of child welfare delivery

In Ghana, social work is often described as two parallel systems: Western influenced and Traditional African System (TBS) (Asamoah, 1997; Midgley, 1981). Western influenced social work came with formal education and sending of Africans to the West for training in order to return and work as social workers in Africa after they complete their training (Avendal, 2018; Gray, Kreitzer, & Mupedziswa, 2014). The Western social work replaced the traditional way of handling social issues in Ghana.

Despite the introduction and the influx of Western ideologies, medicine, formal health education families still rely on religious (pastors, imams, and traditional priests) healers for treatment and management of CAMH issues due to the cultural understanding underpinning the origins of such ailments and the limited availability of the modern medicines (Ewusi-Mensah, 2001).

Regardless of the cultural beliefs and introduction of Western ideologies, people with mental disorders still suffer discrimination and are widely stigmatised. According to WHO (2005b) children and adolescents are incapable of advocating for themselves in cases of discrimination and stigmatisation related to mental health disorders. Hence it is imperative to understand social workers and religious healers' roles in management of stigma and discrimination in CAMH issues in Ghana to contribute to knowledge on the topic which can contribute to creating better understanding of the importance of shunning discriminatory practices such as social exclusion which arise from stigmatisation and discrimination.

1.1.6 Mental Health Act, 2012 (Ghana)

The hope of improvement of Ghana's mental healthcare system started with the mental health Act and the establishment of the Mental Health Authority (G. H. Walker & Osei, 2017). In 2012, the parliament of Ghana passed a new Mental Health Bill which gave legal backing to the establishment of the Mental Health Authority. The Act sought to create a system of community-based mental health that was modern to uphold the rights of persons with mental disorders. This Act's focus was probably premised on the fact that mental health resources revolved around three public psychiatric hospitals within the country (Roberts et al., 2014). These limited resources also meant the limited provision of services to all categories of the public requiring some form of mental health services.

According to the Mental Health Act, 2012, the mental Health Authority is set up to achieve four main objectives: the proposal of mental health policies and ensuring its implementations. Furthermore, the authority will be mandated to implement all policies existing and the proposed ones. Additionally, the authority is mandated by the Act to promote mental health and provide humane care, which includes treatment and rehabilitation in the least restrictive environment. Lastly, they promote culturally appropriate, affordable, accessible, and equitably distributed, integrated, and specialized mental health care that will involve both the public and private sectors. These four objectives of the mental health authority spell out their focus clearly and guide their mission and activities within the mental health care system.

Embedded in the Act (Act 846) are the functions of the authority, including governance, tenure of office, how they are to conduct themselves, the extent to which they can exercise their power and even have an integrated mental health system. The guidelines outlined in the Act set the tone for a comprehensive care system, especially within the country. Court processes and recommendations, among other matters, are discussed by the mental health authority that will be set up. It spells out the care and rights of children with mental disorders, the provision of vulnerable groups and issues on admission and treatment of children with mental disorders. With the establishment of the authority, the hope is that Ghana's issues about mental health care become better than it is. The authority is also set up to ensure that stigma and discrimination towards persons with mental disorders are reduced.

1.2 Problem Statement

The prevalence of mental difficulties in children and adolescents have been demonstrated by several researchers (Kleintjes et al., 2010; Kusi-Mensah et al., 2019; Mokitimi et al., 2018; WHO, 2011a) and requires prompt and proper interventions to help reduce adult mental issues, as research demonstrates that most adult mental health problems starts during childhood and adolescence (Kleintjes et al., 2010; WHO, 2011a). In Ghana, although the prevalence of CAMH problems abound, there is little known on the role of practitioners in the treatment and management of CAMH problems. The area of CAMH this research seeks to explore is the intervention of social workers, and religious healers.

The African Charter on the Rights and Welfare of the Child (ACRWC) emphasizes the health of the child. Article 14 stipulates the promotion of the right of the child to enjoy the best attainable state of physical, **mental** and spiritual health. Furthermore, article 14 highlights the involvement of various stakeholders in society in ensuring the totality of a child's health. Some of the named stakeholders include, parents, children, community leaders, community workers and Non-Governmental Organizations. Through engaging Article 14 of the ACRWC, I would say that understanding the role practitioners play in promoting the right of the child to enjoy the best attainable mental health in Ghana is important.

In Ghana, there are several studies addressing various facets of CAMH such as:
Situational analysis of CAMH which explores the reasons why policy makers should prioritize and invest in mental health and pay attention to CAMH (Kleintjes et al., 2010) and Prevalence and patterns of mental disorders among primary school age children in Ghana, which focuses on the impact of mental disorders on academic performance of children in primary school. The study reveals that children with mental disorders performed very low academically (Kusi-Mensah et al., 2019) and cultural issues around mental health which explores the knowledge of the lay Akan (a major ethnic group in Ghana) person on mental illness. Findings reveal that a typical Akan person understands mental disorder from a cultural perspective, that is, curses and spiritual forces (Opare-Henaku & Utsey, 2017). There is very scanty research on the role of social work in relation to CAMH and this study seeks to fill that gap in literature.

The field of social work though not new in Ghana, is an underutilized profession. This study will contribute to providing knowledge to the field of social work practice in CAMH in Ghana. This study will also provide knowledge for international social work in understanding cultural contexts of social work practice in Ghana. The findings of this study will hopefully help reduce the stigma and discrimination of children and adolescents with mental disorder also motivate further research in the field of CAMH in order to improve the quality of mental health of children and adolescents in Ghana.

1.3 Objective of the study

1.3.1 General objective

The overall aim of this study to understand the interventions of formal and informal systems in the performance of core cultural/adaptive tasks in the face of the mental illness of children and adolescents. Further, given the continuing problem of stigma that the mentally ill face in Ghana, this study also seeks to understand the role of professional and other healers in addressing this issue.

In view of this, the following objectives guide this study.

1.3.2 Specific Objectives

1. To explore social workers' and religious healers' perspectives on the causes of CAMHD in Ghana.
2. To investigate the intervention of social workers and religious healers in the treatment of CAMHD in Ghana
3. To understand how social workers' and religious healers address the issues of stigma and discrimination in CAMHD in Ghana.

1.4 Research Questions

1. What are social workers' and religious healers' perception of the cause of CAMHD in Ghana?
2. What are the roles of social workers and religious healers in the treatment of CAMHD in Ghana?
3. How do social workers and religious healers address the issue of stigma and discrimination due to mental disorder in Ghana?

1.5 Significance of study

This study explores the intervention of social workers, Indigenous Traditional Healers (ITHs), Christian Faith Healers (CFH) and Islamic Faith Healers (IFH) in the treatment and management of CAMHD in Ghana, with focus what social workers and spiritual healers believe are the causes of mental disorders in children and adolescents and how stigmas related to mental problems can be managed.

The findings of this study will be very relevant for professional practice, research and policy. With the findings from this study, both national and international social workers will get an understanding of the rationale behind service users' choice of intervention in CAMH issues in Ghana and drive changes by creating awareness through advocacy, lobbying, sensitisation and education in help-seeking behaviours in CAMH issues. Policy makers will also see lapses in policies that affect failure in collaboration between professionals and the religious healers, and the provision of child and adolescent mental health care units in outpatient facilities.

This study will contribute to existing body of knowledge in mental health, particularly CAMH in Ghana. Further, this study may broaden research scope into CAMH and fill the gaps in the area of CAMH, especially in understanding the role of social workers.
Finally, this study is part of a fulfilment for the award of a Master's Degree in Social Work with Families and Children

1.6 Organisation of study

This study is organised into six chapters. Chapter one introduces the research area and provides information on global mental health and the gives an insight into treatment and management of mental health in Pre-colonial and colonial Africa, then narrows down to the current situation in Ghana.
Chapter two reviews literatures on child and adolescent mental health. It reviews literature on the roles of social workers and religious healers, causes of mental disorders, types of mental disorders and stigma in relation to CAMHD.
Chapter three discusses the relevant theoretical perspective which underpins the study.
Chapter four presents the methodological framework. It presents the research design adopted for the study, target population, criteria for inclusion and method of data collection and analysis, as well as ethical considerations.
Chapter five presents the findings, analysis of data, and discussion.
Chapter six presents the conclusion and appropriate recommendations.
There are also the appendices where the interview guide, the consent form and letter of introduction are presented.

1.7 Definition of terms

Mental Disorder - Mental disorder is "a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress, disability or significantly increased risk of suffering, death, pain, disability or an important loss of freedom" (DSM-IV-TR 2004, p. xxxi). for the purpose of this work, mental disorder will be used interchangeably with mental illness and mental problem.

Social Work **-** Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing. (IFSW, 2014).

Traditional Healer - A traditional healer is a person recognised in his community as competent in the provision of health services through the use of plants, animals and mineral substances and other methods based on socio-cultural and religious ideologies and on the knowledge,

attitude and beliefs that are common in the community on general weel-being and the causes of disease and disability (World Health Organization (WHO), 1978)

Clergy - refer to pastors, prophets, deacons and other church leaders with religious responsibilities in their churches conferred on them through ordination (Young, Griffith, & Williams, 2003)

Imam - Iman is an Islamic leader who lead worship in Mosque and also provide informal mental health to support persons within their communities (Abu-Ras, Gheith, & Cournos, 2008)

For the purpose of this work, **Religious Healers** will be used to collectively to refer to Traditional healers, Clergy/pastors and Imams.

***Explanatory models (EMs*)**- refer to the "notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process" (Kleinman (1981, p. 105).

A ***health care system*** is "a special cultural system that is concerned with the socially organized responses to disease. Moreover, in every culture, illness, the responses to it, individuals experiencing it and treating it, and the social institutions relating to it are all systematically connected" (Kleinman, 1981, p. 24).

For the purpose of this work, social workers and religious healers will collectively be referred to as **practitioners.**

CHAPTER 2
LITERATURE REVIEW

In this chapter, I review and discuss literature relevant to this study. The literature reviewed were retrieved from different sources such as the online databases of the University of Gothenburg Library, Google scholar, which was a major search engine and literature obtained from library shelves and colleagues on topics relevant to this study. Terms used in my search include child/children, adolescent/youth, mental disorder/illness, social work, religious/spiritual healers, and stigma/discrimination. Themes covered in this literature review include The causes of CAMH problems; The role of social workers and religious healers in CAMH, the stigma and discrimination associated with mental disorders. Some of the literature reviewed includes Ogundele (2018), whose work focuses on the biological and environmental causes of mental disorders in children, the work of Walker (2013), which focuses on the involvement of social workers in child and adolescent mental health; K. Ae-Ngibise et al. (2010) whose work focuses on the use of traditional and faith healers in the provision of mental health care in Ghana; Asamoah et al. (2014) whose work focuses on the role of Pentecostal clergy in mental health care delivery in Ghana; Ally & Laher (2008) whose work focuses on Muslim faith healers' perceptions of mental illness and Baffoe (2013) and Corrigan (2004) whose work focuses on stigma and its effect on mentally ill individuals.

2.1 CAUSES OF MENTAL HEALTH DISORDERS

Children and adolescents are exposed to several situations that may negatively affect their mental health. The WHO asserts that some children and adolescents are in a difficult situation such as experiencing physical, emotional and sexual abuse, experienced or witnessed violence and warfare, suffer from intellectual disability, slavery or homeless, migrate from rural to urban areas, live in poverty, engage in risky sexual behaviour, addiction to substances or infected by diseases (WHO, 2005c). The WHO explains that difficult situations can be risk factors for developing mental health disorders in children and adolescents, citing an example of the development of PTSD in a child that is sexually exploited. In the same vein, (Meier, 2017) posits that transition from childhood to adulthood comes with usual developmental stressors or persistent life stressors with the possibility to affect children's emotional health negatively and later successes and productivity in adulthood. Also, changes in family structure and life put so much strain on the family, influencing children and adolescents' mental health. Increase in divorce rate, single-parent household, and cohabitation contribute to changes in family pattern and relationship (Walker, 2003). The author asserts that social exclusion, marginalisation and disempowerment due to poverty, alcohol and drug abuse and rise in streetism among youth contribute to alienation in youths. Walker explains that external and internal family stressors such as domestic violence, child abuse, rise in teenage pregnancy are all strains placed on modern family life (Walker, 2003). Similarly, Sheehan (2017) suggests that a family's socioeconomic situation, such as poverty and low family income, can have an adverse effect

on the mental health of children and adolescents, affecting their self-esteem and impacting their growth development as well as their participation in society.

Genetic and environmental problems are also identified as factors that may cause mental health disorders in children and adolescents. Ogundele (2018) asserts that genetic and environmental problems increase the risk of developing emotional and behavioural disorders. The author suggests that genetic and environmental factors such as perinatal, maternal, family, parenting are all risk factors that can contribute to developing emotional and behavioural problems in children and adolescents. Using an example, Ogundele explains that anxiety can be transmitted from a mother to her child through behaviour modelling (Ogundele, 2018). In a similar vein, Tonge (1998) agrees that genetic and environmental factors have an adverse effect on children's mental health. The author asserts that parental anxiety, maternal depression, family history of anxiety are risk factors for developing mental health disorders in children and adolescents. Tonge further explains that major depression is a familial disorder caused by the interaction of genetic factors (Tonge, 1998). Rector et al. (2016) posit that problems with brain chemistry and brain activity, genetic and substance abuse are all biological factors known to increase anxiety in children and adolescents.
Some developmental disorders are found to have causes linked to biological and psychosocial factors, while the cause of some disorders like ASDs is still widely unknown, even though there are speculations on parental factors WHO (2016). The WHO submit that factors that increase the risk for developmental disorders and causing developmental delays include biological factors such as nutritional deficiencies, hearing and visual impairment, recurrent and chronic illness, alcohol and drug use during pregnancy, birth complications, consanguineous parents, and psychosocial factors such as, mother's depression, poor stimulating environment, and harmful traditional practices (WHO, 2016). However, for a developmental disorder such as ADSs, the (WHO, 2013) suggests that though there is no known cause of ASDs, prenatal, perinatal, and environmental factors such as parental age and certain gene mutation are identified as risk factors.

2.1.1 Perspective of Traditional Healers (TH) on the Causes of CAMHD

Just as biomedical and western ideologies, there are cultural and traditional explanations and understanding of the causes of mental disorders in children and adolescents. (Ngoma et al., 2003) posit those traditional healers and biomedical professionals have a different understanding of the nature and cause of mental disorders.

Traditional healers' perspective on the aetiology of mental health disorders informs their role in treating mental disorders. In most African settings, mental disorders are perceived as a misfortune placed on one by witches and angry ancestors (Ngoma et al., 2003). Most traditional healers believe that diseases in general (physical and mental) result from evil attacks or spirits; some traditional healers believe that ancestors who feel offended or neglected by relatives could punish such relatives with diseases (White, 2015)).

Committing a taboo is also perceived as a reason to contract a mental illness. Traditional healers usually view mental illness due to witchcraft or spiritual punishment for taboo violation (Green, 1980). In line with this, White (2015) explains that some traditional healers suggest that disobeying taboo is a way through which people can be ill, as taboos form an essential part of traditional African belief. Taboos are objects, symbols or a way of life forbidden by a group or community (Isiramen, 1998, p.186). In Ghana, some communities have food, and meat-related taboos and the consequence of disobeying such taboos is illness on the offender or the entire community (White, 2015). The author further explains that taboos have moral and ethical meaning, and when an individual violates the taboos, even secretly, the person will be punished openly, and in some cases, an entire community bears the brunt of the offence (White, 2015).

Several studies from different parts of Africa have reported on traditional healers' perception of the cause of mental disorders. For example, in an exploratory study on the use of traditional and faith healers in the treatment of mental illness conducted in Ghana, Ae Ngibise and colleagues found out that traditional healers view mental illness as spiritual manipulation using 'juju/voodoo (black magic that can cause harm), supernatural forces and evil spirits. Their study also reveals that mental illness is a result of curses placed on an individual for stealing (Ae-Ngibise et al., 2010). Another study from Ghana submits that traditional healers perceive mental illness to be due to evil spirit possessing an individual (Kpobi, Swartz, & Omenyo, 2019). The authors report that this perception informed the traditional healer's treatment method to heal the individual (Ibid). Similarly, Crawford & Lipsedge (2004)), from their study of Zulu traditional healing conducted in South Africa, submit that traditional healers in South Africa perceive sorcery as a common cause of mental illness. The authors report that a person who feels offended can practice sorcery using traditional medicine bought from a witch doctor to inflict mental illness on an offender (Crawford & Lipsedge, 2004). Ovuga et al. (1999), from their study with 29 Traditional healers in Uganda, reports that all the traditional healers interviewed believe that evil spirits, witchcraft and curses are responsible for mental illness. The authors also report that five of the traditional healers suggested that high fever in an individual can cause mental illness. They further report that two traditional healers stated that environmental factors such as stress, accident, fatigue and alcohol abuse might cause mental illness (Ovuga et al., 1999).

2.1.2 Perspective of Christian faith healers on the Causes of CAMHD

As documented by several authors, for example, Koenig (2005), the intervention of the church in the mental health of individuals is as old as ‘Methuselah’. The church has a long history of involvement in mental health care delivery. Clergy perception of the cause of mental illness may depend on location, denomination and ethnic/racial orientation. For example, in a qualitative study of beliefs among clergy conducted in the UK, (Leavey, 2010)reveals that the clergy have divergent views on the causes of mental health disorders resulting from racial difference and difference in church denominations as well. This study comprised 19 clergy, some from mainstream churches (Anglican and Catholic) and six from Pentecostal churches. The author explains that of the six Pentecostal pastors, one was a white UK-born and the others,

Africans. The study found that the Pentecostal clergy believe mental illness to be a result of supernatural and evil forces. However, the mainstream clergy did not support that mental illness resulted from supernatural or evil forces but instead, they believe mental health to be a result of natural and psychological factors. The author, however, submits that some evangelical clergy in the mainstream churches believe that sin is corrosive and can affect an individual spiritually, thereby affecting such an individual's mental health. Leavey further explains that the mainstream churches still retain the services of exorcists who receive referrals of persons with mental health problems from other parish priests (Leavey, 2010).

Studies from the US also reveals how mental disorder is perceived. For example, in an exploratory study on how African American clergy conceptualised mental disorders, Conley & Wolfe (2011) reveal that Africa-America clergy perceive chemical imbalance in the brain, stressful life situation, genetic problem, parental upbringing, underlying physical and mental problem to be the most common causes of mental health disorders. In a similar vein, Stanford and Philpott, in their study of Baptist senior pastors' perception of mental health conducted in the US, report that Baptist senior pastors perceive mental illness due to biological, psychosocial and spiritual factors. The authors listed biological factors to include chemical imbalance in the brain, excess use of drugs and alcohol and inherited genes, psychosocial factors are inconsistent parenting and social pressure, and spiritual factors include spiritual poverty, demonic possession, personal sin and lack of faith. The authors also report that the pastors perceived biological factors as more important than psychosocial and spiritual factors (Stanford & Philpott, 2011).

In Africa, Agara and colleagues found in their study in Nigeria that 93% of the clergy interviewed perceive mental illness to be a result of witchcraft, 86.7% as a result of cannabis use, 73.3% as punishment from sin, 66.7% as punishment from ancestors, 63.3% as genetic and 56.7% as complication from physical illness (Agara, Makanjuola, & Morakinyo, 2008). In Ghana, Asamoah et al. (2014) submit that Pentecostal pastors believe that mental illness results from diabolical manipulation of the soul of a victim. In the Pentecostal pastors' opinion, a person consists of body, soul and spirit; the biomedical model can treat the illness of the body, but any illness that affects the soul or spirit is a manipulation of the devil and can only be treated by spiritual interventions. The authors explain diabolical forces to mean demonic intrusion in the affairs of humans (Asamoah et al., 2014).

2.1.3 Perspective of Islamic Faith Healers on the Causes of CAMHD

Islamic views on the causes of mental health are limited as there are few studies on Islam and Mental health. A few studies report Muslims views on the causes of mental health disorders.
A critical tenet of Islam is adherence to the Holy Qur'an for total well-being. For good physical and mental wellness, Islam considers submission to Allah's will and the development of a good conscience crucial (Farooqi, 2006). According to Farooqi (2006) Islamic explanation of the cause of mental health disorder is that mental illness is a result of doubt and dissociation due to an individual's need or life's pressures that conflict with the teachings of the Prophet and the Holy Qur'an. The author asserts that immorality due to deviation from Islamic tenets and

practices result in mental illness. However, there are beliefs in supernatural causations of mental illness. Yousofi (2011) asserts that supernatural causes to every form of illness are acknowledged and regarded within Islam.

In a study conducted in 22 Mosques in New York, Abu-Ras and colleagues report that 84% of the respondents believed that devil possession could cause an individual to have a mental disorder and 98% believe life stressors as a risk factor for mental problems (Abu-Ras et al., 2008). (Pridmore & Pasha, 2004) submits that in Saudi Arabia, mental illness is perceived as a result of Allah's punishment or inflicted by an evil spirit. The authors also explain that the majority of the Muslims in Pakistan believe that mental illness is a result of demonic possession, and people with mental illness are kept bound, beaten and certain parts of their bodies burnt (Pridmore & Pasha, 2004)

In a study conducted in South Africa on Muslim faith healers' perception of mental illness, Ally & Laher (2007) report that Muslim faith healers first distinguished between mental and spiritual illnesses. Their study reveals that spiritual illness presents with physical and psychological symptoms that are mental illnesses. The authors assert that the Muslim faith healers believe that mental illnesses are caused by an individual's ability to cope with daily life pressures, trauma and chemical imbalance and that the causes of spiritual illnesses are black magic (*Jaadoo*) and ill will (*Nazr*). The authors further explain that black magic is extracted from plants with the help of Jinn through voodoo, making the person possessed ill and, in some cases, act abnormal (Ally & Laher, 2008).

2.2. Role of Social Workers in CAMH Care

Central to the social work profession is social justice, human rights, collective responsibility and respect for diversities (IFSW, 2014). According to Allen (2014), social work is essential in mental health care delivery. The author opines that social workers have a vital role in improving citizens' mental health and delivering mental health services (Allen, 2014). Social work is one of the five significant professions in mental health delivery service (Watkins, 1982), and social workers practising in all domains of child welfare constantly meet children and adolescents with mental health problems (Walker, 2003)). In CAMH, social workers play a vital role which includes a collaborative assessment and diagnostic processes with clients, their families and other relevant members of the child's network like school (Coogan, Deaton, O'Connell, & E, 2009). The authors submit that social workers work in a team with highly skilled mental health professionals promoting empowerment, equality and social justice for individual, and their families. They further posit that social worker in CAMH service assist with difficulties such as depression, anxiety, conduct disorders, Obsessive-Compulsive Disorder (OCD), Attention Deficit Hyperactivity Disorder (ADHD), emotional and behavioural problems, learning difficulties, autism, psychosis and other mental problems that affect children and adolescents (Coogan et al., 2009).

Social workers have a long tradition of using their professional skills to work with individuals and groups (Allen, 2014), especially in protecting human rights, promoting self-determination, and helping people make a change. Social work involvement in mental health is not a recent phenomenon. Social workers have been playing a role in mental health since the late 1800s and early 1900s (Lubove, 1965). Social workers began involving in mental health in the United States in 1906, with a social service department established in Massachusetts General Hospital to enable social workers to work with people with mental problems (ibid). Psychiatric social workers were primarily involved in the aftercare of discharged mentally ill patients (Aviram, 2002). In the article 'Social Work in Psychiatric Setting', Morton Teicher, the chief psychiatric social worker, states that "psychiatric social worker helps the patient to use the self he is at any particular time to effectively as possible in the various local situations with which he must deal (Teicher, 1952, p.6).The author suggests that the social worker acts as liaison person with agencies and other community resources, assuming casework services with patients and their families. Teicher further submits that the role of psychiatric social workers include social rehabilitation of patients, follow-up service to patients and families after discharge (Teicher, 1952). Teicher explains that social workers are actively involved in every phase of treatment process from admission which is the first phase, to making discharge plans which are focused on concerns of the final phase and then, the final phase, discharge. The author argues that the social worker is very active at this final phase with "planning carefully and painstakingly, not hurriedly" (Teicher, 1952, p.8).

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Generally, the services provided by social workers in mental health setting include referrals, advocacy, individual therapy, behavioural intervention, substance abuse treatment and group therapy, crisis intervention, family and patient support and psychosocial assessment (National Association of Social Workers, 2011). In line with this, a survey with 339 social workers in Canada found that the services provided by social workers in mental health service delivery include: assessment and referral (88%), supportive counselling (84%), crises intervention (71%), psychotherapy (56%), advocacy (55%), case management (52%), education (46%) and discharge planning (38%) (O'Brien & Calderwood, 2010). According to NASW in socialwork.org, over 40% 0f mental health volunteers trained by the American Red Cross are professional social workers.

2.3 Role of Religious Healers in CAMH Care

Studies from different parts of the world have shown that spirituality, tradition and religion play important roles in mental health care delivery (Adelekan, Makanjuola, & Ndom, 2001; Burns & Tomita, 2015; Drury, 2020; Kpobi, Swartz, & Omenyo, 2019a; Weber & Pargament, 2014). In Africa mainly, religious belief determines people's choice of treatment (Osei, 2001) and tradition and faith healing continue to play a significant role in treating mental illness (Ae-Ngibise et al., 2010). In treating neuropsychiatric disorders, traditional methods are seen by religious healers as preferable to biomedical methods (Alem, Jacobsson, Araya, Kebede, & Kullgren, 1999). The preference of traditional methods over biomedical in treating mental

health issues is typical in several African countries (Ae-Ngibise et al., 2010; Alem et al., 1999; Asare, 2017; Crawford & Lipsedge, 2004; Green, 1980)

2.3.1 The Role of Traditional Healers (TH) in CAMH Care

Traditional healers play a significant role in mental health care. This role focuses mainly on how traditional healers diagnose and treat people with mental illnesses (Adelekan et al., 2001; Crawford & Lipsedge, 2004). Traditional healers identify the cause of illness and apply the appropriate treatment (Crawford & Lipsedge, 2004). In treating their patients, traditional healers do it from their homes or visit the patient's home, but in a case where the illness is considered severe, the patient moves in to stay with the traditional healer (ibid). According to Okello & Musisi (2015) traditional healers' role is treasured in rural areas in Africa, especially with the traditional healer assuming the role of a primary health care provider. In Ghana like some African countries, traditional healers significantly outnumber allopathic mental health practitioners and they are found everywhere, in both rural areas and urban areas (Ae-Ngibise et al., 2010). Since they are members of the community, traditional healers are always available to help patients especially given the chronic, relapsing or episodic nature of most mental problems (Green, 1980). Besides being assessable, traditional healers are in most cases affordable (Adu-gyamfi & Anderson Eugenia Ama, 2019; Ae-Ngibise et al., 2010). In some cases, traditional healers receive whatever patients present to them after treatment (Ae-Ngibise et al., 2010). Adu-gyamfi & Anderson Eugenia Ama, (2019) submits that payments are usually affordable and may not necessarily be money but could be items like chicken, eggs and other items that facilitate the healing process. This act of receiving items other than money is not the same with all traditional healers. The charges for traditional healers may sometimes be higher than a Western method practitioner, but patients do not pay in full unless they are cured (Okello & Musisi, 2015). The role of traditional healers in mental health care include, diagnostic, treatment and referrals.

Diagnostic role

Traditional healers first diagnose before they commence treatment. There are different ways to diagnose a patient. In diagnosing, the traditional healer starts first by examining the patient's socio-cultural background in other to decide on the pattern of treatment (Adu-gyamfi & Anderson Eugenia Ama, 2019; Okello & Musisi, 2015). Behaviours and symptoms are observed to determine if a person is mentally ill or not (Mufamadi, 2001). Several studies reveal that behavioural observation is diagnostic tool (Adelekan et al., 2001; Crawford & Lipsedge, 2004; Kpobi et al., 2019a; Ovuga, Boardman, & Oluka, 1999). Adelekan and colleagues (2001), in their study on attitudes of Traditional Mental Health Practitioners in four Local Government Areas of Kwara State, Nigeria, reveals that behaviours that traditional healers recognise to diagnose mental illness include talking to self, laughing to self, deteriorating personal hygiene, undue sadness and social withdrawal. Among the Zulus of South Africa, Crawford & Lipsedge (2004) report incomprehensible speech, inability to understand others, strange, inexplicable behaviour, unprovoked aggression and repeated running away from home

as behaviours used by traditional healers to diagnose mental illness. Among other behaviours mentioned above, Ovuga et al. (1999), from their study in Uganda, reports restlessness and taking off clothes by patients as behaviours traditional healers identified before treatment.

Treatment role

In treating their patients, the roles of traditional healers vary. Traditional healers make sacrifices to appease the gods before they begin treatment (Adelekan et al., 2001). Such sacrifices involve rituals which are usually necessary to treat mental illness and may involve wearing special cloth, self-flagellation, public removal of substances from the patients head, and purification with water or magical medicines(Green, 1980). A study from Uganda reveals that the traditional healer's therapeutic cuts on the patient's head or body are a common practice in administering of herbs to the patient (Ovuga et al., 1999). The authors also reports that patients are treated by administering herbs infused water into their nose, ears and for bathing their entire bodies. A cross-sectional study of patients in two health care setting in Tanzania conducted by Ngoma et al. (2003) reveal that traditional healers perform rituals linked to the maintenance or restoration of community well-being, with treatment focusing on human relation and social interaction. The authors report that patients are provided with social and moral support to prevent relapse. Kpobi et al. (2019) submits that traditional healers use prayers, ritual objects and prescribed behaviour in Ghana to prevent relapse. Another research from Ghana reveals that traditional healers use selected plants, roots and stems to produce herbal medication for treating patients (Tabi, Powell, & Hodnicki, 2006). Where the cause of a mental disorder is due to evil intent or wickedness perpetrated by the patient, some healers insist on confession before they begin treatment (Ae-Ngibise et al., 2010; Green, 1980). Confession, as they believe, facilitates treatment and leads to permanent cure or lifting of a curse (Green, 1980). With success in treatment, (Mufamadi, 2001), asserts that traditional healers exaggerate their successes in treating persons with mental illness. According to the author, most of the healers in her study claimed 100% success in healing persons with mental illness only a few admitted failures to treat some of the illnesses.

Traditional healers can sometimes use extreme measures in their treatment. For example, Adelekan et al. (2001) submits that some traditional healers beat mentally ill patients, not as a form of treatment but as a means of getting them to comply with treatment. These authors also noted that when traditional healers beat patients for treatment, it is usually with a cane that has been pre-soaked in traditional medicine. Some traditional healers use physical restraints for violent patients by tying or shackling them to a bed to administer medicines or tranquillizing herbs like Rauwolfia alkaloids that have tranquillizing properties and widely in use in Africa (Green, 1980).

Referrals

One crucial role of traditional healers is the referral of patients. A few traditional healers do hospital referrals and some others choose to refer patients to other traditional healers who they think can handle a particular disorder better (Adelekan et al., 2001; Crawford & Lipsedge,

2004; Ovuga et al., 1999). Some traditional healers neither refer patients to the hospital nor to other traditional healers (Ovuga et al., 1999).

2.3.2 The Role of Clergy in Mental Health Care

The role clergy play in mental health care has been documented by various researchers (Ae-Ngibise et al., 2010; Clemens et al., 1978; Moran et al., 2005; Taylor et al., 2000; Weaver, Flannelly, Flannelly, & Oppenheimer, 2003). Several researches list counselling, referral, providing emotional and social support, exorcism, praying, and use of holy oil as part of the role of clergy in mental health service delivery (Ae-Ngibise et al., 2010; Asamoah et al., 2014; Frontus, 2015; Moran et al., 2005). Clergy perceive their role in mental health care delivery as counselling and referrals to professional services as appropriate (Frontus, 2015). Besides providing mental health assistance of counselling, clergy act as gatekeepers to the formal mental health care system by referring individuals with mental illness to mental health professionals (Ibid).
Pastoral counselling is the most critical mental health activity of churches (Mollica, Streets, Boscarino, & Redlich, 1986). In a survey of 99 African American pastors in Connecticut, Young, Griffith, and Williams report that urban ministers were functioning as pastoral counsellors, with an average of more than six hours of weekly counselling (Young et al., 2003). In the analysis of eight American Psychological Association (APA) journal, Weaver and colleagues reveal that clergy, on average, report using 15% of their 40 to 60 working hour week on pastoral counselling (Weaver et al., 1997). In their survey of 179 Catholic, Jewish and Protestant priests in the catchment areas of four hospitals in New York and Connecticut, Moran et al. (2005) reveal that clergy spent an average of 6 hours a week doing pastoral counselling.

In caring for members with mental health problems, clergy provide more holistic counselling, such as spirituality (encouragement through the word of God) and facilitating access to community resources (Frontus, 2015). By providing counselling guided by scripture and involving church members with mental health problems in religious activities, clergy support and care for members with mental health problems (Ibid). According to Young (2010), with the Protestant Christian group, counselling goes with prayer, meditation and bible study, and the patient's religious belief to help change unhealthy cognitions, behaviours, and emotions.

The clergy's role in referring members with mental health issues is also evident in some research. For instance, Mollica et al. (1986), from their study on the counselling activities of pastors, report that pastoral counsellors referred individuals with mental health problems to mental health professionals but, in their referrals, placed greater emphasis on private psychiatric professionals. Frontus (2015) suggests that clergy make referrals when the mental health issue is very severe and need professional care. Clergy may refer church members with mental health issues to other ministers or pastoral counsellors whom they presume to be capable of providing care and support for a particular problem (Young et al., 2003)). On referrals based on religion, Stanford & Philpott (2011) assert that senior Baptist pastors refer church members with mental health problems to mental health professionals who they are sure

are Christians. This referral choice is due to the belief that Christian health professionals will not ignore the faith of persons with mental health problems in treating and caring for them (Ibid).
Asamoah et al. (2014) identify two significant roles played by clergy in Ghana. (1) Spiritual diagnosis and (2) Engaging in deliverance and healing. These authors identify that deliverance involves exorcism. Onyinah (2002) suggests that deliverance is an exorcistic activity of expelling an evil spirit. When it comes to mental health care intervention, deliverance is a known role mainly among Pentecostal clergy in Ghana, giving the belief that mental problem results from demonic possession (Asamoah et al., 2014)). Clergy in Ghana also uses variant methods and items such as prayer, fasting, anointing oil or holy water in the treatment and management of church members' mental health problems (Ae-Ngibise et al., 2010).

Although pastors play care and support roles in working with people with mental health issues, research also reveals some negative actions of clergy that prevent members from seeking help. For example, Frontus (2015) study reveals that members left their church when the clergy can identify that member have some mental health problem. Young and colleagues also assert that Ministers seek out members who have emotional issues and severe behavioural problems (Young et al., 2003). A study by Young (2010) reveals the pastors confirm that they seek out members who may need help due to mental problems.

2.3.3. Role of Islamic priests/healers

Islam views a person as a combination of four interacting components, which are mind (*Aql*), body (*Jism*), self (*nafs*) and the soul/spirit (*Ruh*) (Ally & Laher, 2008)). These four components constantly interact to maintain an equilibrium in the human body; hence illness, disease and disorders occur when there is a distortion of any of the four components (Ibid). In such situation, Muslims adopt multiple practices such as prayer, ablution, reciting the Qur'an, supplication and invocation, asking Allah's forgiveness, fasting at Ramadan and other times and remembering Allah, following Islamic teachings to cope with stress, relieve anxiety and other adverse mental problems (Abdel-Khalek, 2011). Muslims believe that mental illness is a result of punishment from God, possession of evil spirit (*Jinn*), the effect of evil eye and transfer of evil by someone who is jealous or has malicious intentions (Yousofi, 2011).

The Imam is the spiritual leader of the mosque and the local community (Ali & Milstein, 2012). The authors submit that in serving the mosque and the local community, the Imam leads prayers, delivers the sermon, conducts various religious activities, and provides religious and spiritual guidance. The *Maulana*, *Sheikhs*, or *Matawaas* are mediums of treating mental illnesses, as they can chase out evil spirits or evil eye (Syed, 2003). Ummah Welfare Trust (2019) suggest that evil eye can be treated by praying *ruqyah* in water for the victim to bath with for 10-20 days. While chasing out evil spirit is through exorcism (Ally & Laher, 2008). To exorcise, the Imam or Mallam who is an exorcist, recites specific Quranic verses and splashes water on the body parts considered possessed or affected (Ally & Laher, 2008). Imam and other Islamic healers use herbal remedies, massage therapy and *taaweez* (amulets with

Quranic verses), water in which specific Quranic verses read into, and special prayers such as *Zikr* and *Duas* made into (Bulbulia & Laher, 2013).
In an explorative study of Muslim faith healers' perception of mental illness conducted in South Africa by Ally &Laher (2007), the Muslim faith healers report that mental illness spanning from spiritual causes will need spiritual treatment. According to the authors, the spiritual treatment includes reciting specific verses from the Holy Qur'an when diagnosing and treating such mental illnesses, blowing the recited verse on the client or on natural products like water, honey, salt, olive oil for the mentally ill person to use for cooking or to drink. The study reveals that Quranic verses are also written on paper for the mentally ill persons to carry on themselves always. The study further reports that when the mentally ill persons read the *namaaz* (daily prayer) and the Holy Qur'an regularly and correctly and observe the *Zikr* (constant remembrance of the Almighty), their cure will be faster, and there will be no relapse (Ally & Laher, 2008).

Wani & Singh, in their study which examines the effect of psycho-spiritual therapy in managing craving, withdrawal symptoms and mental health problems in 40 Muslim male cannabis users, reveal that Islamic psycho-spiritual therapy is effective in reducing craving withdrawal symptom and mental health problems related to cannabis use. Their study also reveal that cannabis users showed significant changes and improvement in disorders such as anxiety, depression, loss of behavioural and emotional control, and psychological stress, indicating that Islamic religious values and beliefs play a significant role in managing mental illness due to drug adherence (Wani & Singh, 2019). Dedication to the principles circumscribed in the Qur'an and Hadith are adequate for the prevention and treatment of emotional disturbances as actual commitments to directives in the Qur'an promotes the quality of life and mental state of people (Abu-Ras et al., 2008).

Abu-Ras and colleagues, in their study with 22 Imams and 102 worshippers in New York City, found that 94% of the worshippers viewed Imam as a counsellor, 97% perceived Imam as a source of religious guidance, and 95% believed that persons with mental illness could heal by using the Qur'an and Hadith only. Their study also found that the number of worshippers seeking help from Imam due to mental health issues such as anxiety, depression, suicidal thoughts and drug and alcohol problem tripled or increased fivefold after the September 2011 attack in the USA (9/11) (Abu-Ras et al., 2008). Ally & Laher (2008) found in their study comprising six Muslim faith healers that treating cases of spiritual illness can yield a positive outcome with adherence to Qur'anic principles. The authors posit that daily prayer and proper recitation of the Qur'an can be very effecting in total healing.

2.4 Stigma and Discrimination

Stigma and discrimination towards persons with mental disorders are rife with negative consequences for sufferers and their families. The WHO (2011a) assert that persons with mental illness and their families experience so much stigma and discrimination. Sufferers often report the stigma and discrimination due to mental disorder as more damaging than the

conditions (Thornicroft et al., 2016). People with severe mental illness have a 'double-edged challenge (P. W. Corrigan & Watson, 2002). The authors explain that on one edge is the tussle that comes with the disorder and the second, the stereotype and prejudice from people's interpretation of mental disorder. Goffman (1963) suggests that stigma is a mark that is deeply discrediting. It is a sign of disgrace or dishonour that singles a person out from the others (Byrne, 2000).

Several factors account for the stigmatisation of persons with mental disorders. Stigma emerges from superstitions, ignorance, lack of knowledge and empathy, old belief system and the tendency to exclude people with the perception that they are different (Avoke, 2002; Baffoe, 2013). Stigma prevents people from living a normal and productive life, as most people with mental disorder encounter stereotyping, fear, shame, social exclusion, avoidance behaviour, embarrassment, isolation and discrimination (Baffoe, 2013; Byrne, 2000; Crabb et al., 2012) and often report stigma worse than the condition itself.

On the other hand, discrimination is a treatment of people on the perception that they belong to a group (Letamo, 2005). Just as stigma, discrimination brings about exclusion from participating in society, ridicule, devaluation of self-worth leading to oppression and denial of rights to access employment and housing (Baffoe, 2013; Dako-Gyeke & Asumang, 2013). People suffer discrimination due to the stigma associated with their mental condition and outrightly avoided due to the severity of the mental disorder (Dako-Gyeke & Asumang, 2013). Stigma and discrimination can prevent persons with mental disorders from seeking help, instil a feeling of hopelessness in them and prevent well-meaning individuals from advocating for resources for persons with mental disorders (Baffoe, 2013). Stigma and discrimination are massive barrier to the prevention of suicide (Byrne, 2000), the reason most sufferers of mental disorders hide their condition and the reason social re-integration of persons recovering from mental illness is a problem (Crabb et al., 2012).

Several studies reveal that parents of children with mental illness also suffer discrimination as community members and friends begin to avoid them due to their children's mental disorder (Dako-Gyeke & Asumang, 2013; Larson & Corrigan, 2008). Though biological and genetic factors have replaced the concept of poor parenting as the cause of mental illness, people generally still blame a child's mental disorder on poor parenting, thereby causing family members of children with mental disorders to experience a feeling of shame for their children's mental illness (Larson & Corrigan, 2008).

Persons with mental disorders are stigmatised and discriminated against for several reasons. McDaid (2008) suggests that the perception that persons with psychotic condition are dangerous leads to avoidance and social exclusion. Dako-Gyeke & Asumang (2013) found in their study that misconception of the genetic causation of mental illness led to break up of marriages and intimate relationships, with partners believing that the other partner who suffered a mental illness would transfer the genes of mental illness to a future child. In a similar vein, Avoke (2002) submits that the old belief systems about disability led to the killing of several children in several Ghanaian cultures. Children with a learning disability were labelled children from river and forests and were claimed to be returned to the river or forest when they are killed secretly by the fetish priest (Avoke, 2002).

There are two forms of stigma as outlined by Corrigan & Watson (2002). Public stigma and Self-stigma.

Public stigma is the dishonouring behaviour of the general population towards a group based on stigma about the group (Rüsch, Angermeyer, & Corrigan, 2005)). In this case, persons with mental disorders. Corrigan (2004) submits that people who are publicly labelled as mentally ill are in harm's way due to the stigma. Public stigma, riddled with stereotype, prejudice and discrimination, can interfere negatively in the lives of people labelled as mentally ill (Corrigan 2004). The author asserts that public stigma can rob people labelled mentally ill of privileges crucial for leading a fulfilled life. He further explains that as a result of societal prejudice, people with mental illness cannot find employment and decent housing (Corrigan, 2004). Rüsch et al. (2005) gave instances of how labelling can create a substantial stereotypical view, causing demarcation between the 'labelled' and 'others'. According to these authors, when people are referred to by their mental illness, it creates a considerable demarcation and such labelling causes stigma on the individual with mental illness. They further assert that this labelling that causes demarcations are stereotypes, prejudice and discrimination (Rüsch et al., 2005). According to Rüsch et al. (2005), stereotypes are opinions that people hold of different groups. They assert that when these opinions, especially negative ones, are endorsed and cause harmful reactions towards the labelled group, it is prejudice, and the result of prejudice is discrimination (Rüsch et al., 2005

Due to public stigma, persons with mental disorders usually find themselves in the criminal justice system rather than the health care system (Rüsch et al., 2005). (Corrigan, 2004) explains that when police rather mental health system responds to a mental health crisis, it contributes to the prevalence of persons with mental health issues in jail. Situations like what Corrigan (2004) explains above is what creates the impression that persons with mental illness are criminals. Corrigan, Kerr, & Knudsen (2005) posit that inadequate funding of the mental health care system results in the criminalisation of persons with disorders.

Self-stigma is the loss of self-esteem and self-efficacy resulting from internalising societal stigma (Corrigan, 2004). When individuals in a stigmatised group internalise the stigmatising attitude, they develop self-stigma (Rüsch et al., 2005). People with mental illness internalise the stigmatising idea of the wider society and believe that they are incapable and valueless due to their health condition, thereby losing their self-esteem and self-efficacy (Corrigan, 2004).

Corrigan et al. (2005) assert that people know mental health stigma before the onset, and upon diagnosis, the knowledge of the stigma may affect the individual's sense of self in two ways: (1) the individual on their own may limit their social network as they already expect rejection due to the stigma of mental illness. (2) The individuals perceive the stigma as self-relevant and see themselves as valueless as described by others. The authors suggest that the former leads to isolation, unemployment and a difficult economic situation (Corrigan et al., 2005). However, the situation does not hold for every person diagnosed with mental illness as some, rather than suffer self-stigma, become 'righteously angry' (Corrigan & Watson, 2002).

Righteous anger empowers mental illness persons, making them active participants in their treatment process and, most times, empowering them to advocate for improvement in the quality of mental health service delivery (P. W. Corrigan, 2002).

Corrigan & Watson (2002) assert that stigma is deep-rooted within society's social structure. The authors suggest that stigma is evident in how law, social services and justice systems are structured and how resources are distributed (Corrigan & Watson, 2002).

2.4.1 Combating Stigma and Discrimination Pertaining to Mental Disorders

There are several campaigns and movements globally against every form of stigma and discrimination towards persons with mental disorders. According to Rüsch et al. (2005), in countries like Australia, Germany, New Zealand and the USA, consumer groups have actively targeted stigma in order to improve the lives of individuals with mental disorders. The authors note that these consumer groups employ strategies such as public education, movements for legal protection for the mentally ill in areas of housing and employment, protest campaign through email, school education and programs, art exhibitions and anti-stigma campaigns (Rüsch et al., 2005). Corrigan & Penn (1999) suggest three strategies to fight stigma against persons with mental illness: protest, education, and promoting contact.

Public Health Agency of Sweden (2019) submits that protest involves taking action and opposing public statements that depict stigma towards mentally ill persons. Rüsch et al. (2005) similarly suggest that protest is mainly used where stigmatising public statements are made, such as in the media and advertisements. The authors assert that most of these protests have successfully changed stigmatising public statements. They also report that a German consumer group use email to alert members of stigmatising advert and media, and about 80% of the discriminating cases this German group has protested against were successfully stopped, and faulting companies and media institutions apologised (Rüsch et al., 2005).in terms of the use of education to combat stigma towards mentally ill persons, Corrigan & Watson (2002) posit that education provides information that enables the public to make an informed decision about mental illness. The authors explain that people with a better understanding of mental illness are less likely to stigmatise persons with mental illness. Education entails creating awareness by disseminating information about a mental disorder that contradicts unjustifiable fear of persons with mental illness (Public Health Agency of Sweden, 2019). Educating people can be done through books, videos and structured teaching programs (Rüsch et al., 2005). The authors assert that education program content matters. They explain that neurobiological models of mental illness dominate Western psychiatry and biological cause of specific mental illness are part of the message; this approach will help reduce the shame and blame associated with such mental illness (Rüsch et al., 2005). A South African study on Psychiatric stigma and discrimination found that educating service users, family and community members about mental disorder would reduce the stigma and discrimination on persons with mental illness (Egbe et al., 2014). The authors assert that education can be done through awareness programs, health talks at clinics, media outreach, pamphlets, prints and electronic media, church and community gatherings.

Interacting constantly with persons with mental illness may discount stigma (P. W. Corrigan & Watson, 2002). Interaction with persons with mental disorder may enhance the education on stigma reduction (Rüsch et al., 2005). Similarly, Egbe et al. (2014) posit that care and support with education are essential in reducing the stigma associated with mental disorders. In a study on reducing psychiatric stigma in UK secondary schools, Pinfold and colleagues report that personal contact with education reduced stigma towards persons with mental illness (Pinfold et al., 2003). Rüsch et al. (2005) suggest that certain factors can create a favourable

environment for interpersonal and stigma reduction. According to the authors, these factors include equal status among participants, cooperative interaction and institutional support for contact initiative. For example, cooperation during work offers a better chance to bridge the gap between sufferers and those likely to stigmatise them (Rüsch et al., 2005).

In conclusion, this chapter reviewed earlier literature on social workers and religious healers' perceived causes of mental disorder, social workers' and religious healers' roles in the treatments and management of child and adolescent mental health disorders, the stigma and discriminations of persons with mental disorders and ways to curb stigma and discrimination against persons with mental disorders.
The next chapter discusses the theoretical perspectives adopted by the study.

CHAPTER 3
THEORETICAL FRAMEWORK

An important aspect of qualitative research is the theory which the research adopts. According to Bryman (2012), a theory is a backdrop and reason for conducting research (p.20). Bryman submits that theory provides the framework for understanding social phenomena and interpreting research findings (Bryman, 2012, p.20). this study adopts Kleinman's (1978) Health Care System Model and Health Care Explanatory Model (EM) and Theory of Social Stigma by Goffman (1963) and Link & Phelan (2001)

3.1 Health care System Model and Health care explanatory model (Kleinman 1978)

The health care system model is a medical model proposed by Arthur Michael Kleinman, a psychiatric anthropologist. Kleinman (1978) posits that health care activities in any given society are complex and involves various health care systems, which Helman (2007) refers to as medical pluralism. Amzat & Razum (2014) suggest that medical pluralism describes the coexistence of diverse medical traditions situated in different worldviews. For example, different religious and traditional healers (Amzat & Razum, 2014; Gabe, Bury, & Elston, 2004, p.183). The health care system model was founded based on the theory of social construction of reality by Berger and Luckman in 1966 (Kleinman, 1980). The theory of social construction of reality has been redefined into related fields like social constructivism (Teater, 2014, p.76). According to Teater, social constructivism believes that people create their reality against a backdrop of shared understanding, values, beliefs and practices. Teater postulates that people come to know their world through how they relate with others and institutions, and this experience is not uniform but differs from person to person (Teater, 2014). Social constructivism also acknowledges that historical, social and cultural contexts inform how people construct their reality, which means that reality evolves from people's social interactions within historical, social and cultural contexts (Fabrega, 1996)

Kleinman (1978) conceptualises health care systems as a cultural expression of linking beliefs about illness causation, the experience of symptoms, specific patterns of behaviour that healers notice to establish the cause of illness; decision concerning treatment alternative; actual therapeutic practice and the assessment of therapeutic outcome. Thus, the health care system asserts that the interaction between patients and healers is culturally constructed (Kleinman, 1980). Illness and treatment, which are the most crucial aspect of the health care system, are culturally constructed based on the understanding of illness causation by members of a particular culture (Helman, 2007), in this case, religious healers and patients, which means that the health care system results from the meaning given to illness and the response that follows per the meaning.

Kleinman (1978) posits that health, illness, and health care as part of a cultural system in which these elements need to be understood together. Kleinman suggests that health beliefs and behaviours, illness beliefs and behaviours and health care activities are regulated by the same set of socially approved norms. To consider one in isolation of the other causes a distortion in the knowledge of the nature of each and how they function in a particular health care system and leads to error when compared against different cultures (Kleinman, 1978)

Kleinman (1978) suggests that health care systems perform some cultural and psychological adaptive task in the face of illness. The author highlights six core adaptive tasks of the health care system (p.87).

1. Cultural construction of illness as a socially learned and sanctioned experience.
2. The cultural construction of strategies and evaluative criteria to guide choices amongst alternative health practices and practitioners and to evaluate the process and, most importantly, the outcome (efficacy) of clinical care.
3. The cognitive and communicative process involved in the management of sickness, including labelling, classifying and providing personally and socially meaningful explanations.
4. Healing activities *per se*, including all types of therapeutic interventions from diet, drugs, and surgery to psychotherapy, supportive care and healing rituals.
5. Deliberate and non-deliberate health enhancing (largely preventive) and health lowering (sickness producing) behaviours.
6. The management of a range of therapeutic outcomes, including cure, treatment failure, recurrence, chronic illness, impairment and death.

Kleinman (1978) postulate that these adaptive tasks are what health care healing is all about. The author suggests that although each function applies in all health care systems in almost all societies, there are differences in how specific tasks are performed by the entire health care system, whereas other tasks are performed by particular sectors or subsectors (Kleinman, 1978).

Kleinman posits that most health care systems contain three social arenas in which people experience and react to illness. These three social arenas are popular arena, professional arena and folk arena (Kleinman, 1978). Kleinman suggests that the popular arena consists of the family context of illness and care provision; also included in this arena is social network and community. In both Western and non-western context, 70% to 90% of illness are managed in the popular arena, and it is in this arena, decisions are made on where or with whom to seek help (Kleinman, 1978). The folk arena comprises non-professional healing specialists classified as a sacred and secular group (Kleinman, 1978). According to Kleinman, Eisenberg, & Good (1978), in all cases of illness the popular arena and the folk arena, which include self-treatment, family care, self-help group, religious practitioners, and heterodox healers, provide a considerable amount of health care. The authors suggest that understanding the extensive health care provided by the popular and folk arenas should serve as a clear understanding that the professional arena, which is made up of professional, scientific medicine and professionalised indigenous healing traditions, cannot and should not be expanded to take over health care management (Kleinman et al., 1978).

Kleinman (1980) theory of explanatory models (EMs) proposes that people have variant understanding underpinning health and disease. EMs are “notions about an episode of sickness and its treatment that are employed by those engaged in the clinical process” (p.105). the healers’ EMs discloses the meaning they attach to illness regarding the cause, the effect of the illness on sufferers and the treatment method. Amzat & Razum (2014) submit that qualitative research aims to understand the EMs of illness and disease held by persons in a community in disclosing the cultural understanding and knowledge of illness and disease. Tirodkar and colleagues assert that regardless of the effort towards educating physicians in the biopsychosocial model, which acknowledges physical, behavioural and psychological dimensions of illness (Tirodkar et al., 2011), medical practitioner’s EMs of illness are still mostly biomedical because they emphasise biological and physical as the cause of illness (Tirodkar et al., 2011; Weiner, 2007). However, individuals who are ill may have a different EM. Studies such as Tirodkar et al. (2011) found that EMs are largely influenced by an individual’s social and cultural context and experiences. The type of EM held by religious healers informs their health management processes. Tirodkar et al. explain that EMs does not only affect the choice of healer an ill person will visit, but it will also affect the treatment methods that will follow. These treatment methods include the social and spiritual rituals that recovery from illness would involve (Tirodkar et al., 2011).

This theory has been found useful in studying other African contexts (Ae-Ngibise et al., 2010; Crawford & Lipsedge, 2004; E. C. Green, 1980; Kapur, 1979; Ngoma et al., 2003).

In summary, Kleinman’s health care system and health care explanatory model as a cultural system built on historical and cultural understandings is essential to the objectives and questions this research seeks to answer. In the health care system model, healers’ (and their patients), social workers (and their service users) perspectives are understood as their social reality. The health care system model suggests that healers and social workers create a social reality based on their socio-cultural context and hold other health care EMs.

3.2 Theory of Social Stigma

The theory of social stigma developed by sociologist Erving Goffman (1922-1982) in his book, Stigma: Notes on Management of Spoiled Identity. Goffman's concept of stigma is applied in every academic field and has led many scholars into conceptual refinements. For this study, Goffman's theory of social stigma and Link and Phelan (2001) Conceptualizing Stigma are discussed.

Goffman (1963) conceptualises social stigma as an attribute that is deeply discrediting. According to Goffman, stigma degrades a sufferer "from a whole, and usual person to a tainted discounted one" (p.3). Jones et al. (1984) refer to stigma as a mark that links a person to undesirable characteristics. From these definitions, Link and Phelan (2001) suggest that the 'attribute' or 'mark' is visualised as something in a person rather than a tag that others fix on the person. In Goffman's opinion, stigma disqualifies individuals from being socially accepted. He suggests that there are three different types of stigma. Goffman's first terms, bodily abominations, comprise various physical deformities (Goffman, 1963). Amzat & Razum

(2014) suggest that physical deformities such as scars and medical conditions such as obesity, autism and dwarfism could amount to social degradation. Goffman's second type of stigma is the blemish of individual character constructed as unusual or antisocial. Amzat & Razum suggest that this second type of stigma makes up behaviours such as mental illness, addiction, alcoholism, suicide attempts, and radical political behaviours perceived as a deviation from socially accepted societal norms. Falk (2001) refers to this type of stigma as achieved stigma, where the individual's behaviour is the source of the stigma. The third group is the tribal stigma of race, nation and religion. Goffman posits that this third type of stigma can be transmitted through lineages and can contaminate all family members. Kusow (2007) refers to this third type of stigma as a group or collective stigma. Goffman suggests that similar features are found in all instances presented in the three types of stigma: stigma depriving individuals of interactions they might receive easily.

"In all of these various instances of stigma, however, including those the Greeks had in mind, the same sociological features are found: an individual who might have been easily in ordinary social intercourse possess a trait that can only obtrude itself upon attention and turn those of us of whom he meets away from him, breaking the claim that his other attributes have on us" (Goffman, 1963, p.5).

Though important aspects of stigma are captured in Goffman, Link & Phelan (2001) developed four interrelated components that incorporate other aspects of stigmatisation, not just those located within the individual (Schormans, 2014). These four interrelated components, which Link & Phelan (2001) suggest stigma exist at their convergence, include: people distinguish and label human differences, dominant cultural beliefs link labelled persons to undesirable characteristics to a negative stereotype, labelled persons are placed in distinct categories as to accomplish some degree of separation of "us" from "them", labelled persons experience status loss and discrimination that lead to an unequal outcome

3.2.1 Distinguishing and Labelling Differences

Link and Phelan (2001) notes that many human differences exist but are ignored due to their social irrelevance. Some differences are relevant but inconsequential, while some other differences are highly noticeable, identified, and labelled. Categorising people have been oversimplified and overlooked because of the label on those categories (Link & Phelan, 2001). They suggest that human differences that are noticed are socially selected, and this selection motivates the choice of using 'label' rather than 'attribute', 'mark' or 'condition' as the latter words locate the element being referred to in the stigmatised person and conceals its identification as a product of a social process. 'Label', as the authors submit, is something that is affixed; label leaves the validity of the labelling an open question (Link & Phelan, 2001)—for example, discussing the stigma experienced by an adolescent with conduct disorder because of being labelled stubborn and disrespectful. Link and Phelan reveal how categories are culturally created and sustained with this component.

3.2.2 Associating Human Differences with Negative Stereotype

This second component posits that label linked to stereotype produce stigma. According to Link and Phelan (2001), this component highlights the connection between label and stereotype and is mostly central to the psychological understanding and definition of stigma. Amzat &

Razum (2014) suggest that labelled differences are associated with undesirable attributes within a particular context. For instance, a person labelled "mentally ill" may be linked to a stereotype of being physically dangerous. "The visibility of a potential discreditable attribute contributes to stigma (Amzat & Razum, 2014, p.167). Crocker, Major, & Steele (1998) assert that labelling and stereotypes are often "automatic" and promote "cognitive efficiency". The intuitive nature is revealed in some experiments showing that classification and stereotype are used to make fast and unconscious decisions (see Link, Cullen, Frank, & Wozniak 1987). For example, crossing to the other side of the road at the sight of a mentally ill person. The decision to cross is automatic due to the stereotype of people categorised as mentally ill.

3.2.3 Separating 'Us' from 'Them'

This component involves a separation of those considered 'normal' from the stigmatised (Amzat & Razum, 2014)). "Linking of labels to undesirable attributes become the rationale for believing that negatively labelled persons are fundamentally different from those who do not share the label" (Link & Phelan, 2001, p.370). the authors suggest that labelled people are perceived to be notably different, and stereotype can easily be achieved, as there is little or no harm in tagging "them" with all manner of characteristics (Link & Phelan, 2001). The labelling, in this case, is on the perceived difference seen between "them" the stigmatised and "us" the normal. Studies from Ghana (Baffoe, 2013; Dako-Gyeke & Asumang, 2013) reveal that people with mental illness are avoided because they are perceived differently. The "us" and "them" concept is commonplace in Ghana, as these studies reveal.

3.2.4 Status Loss and Discrimination

"With this component of the stigma process, the labelled person experiences status loss and discrimination" (Link & Phelan, 2001, p.370). Link and Phelan suggest that this component contains aspects of stigma that is of major concern as it produces consequences of a downward placement of stigmatised people in a status hierarchy. The authors assert that stigmatised persons are associated with undesirable characteristics that reduce their status in the stigmatisers' eyes. When children and adolescents are stigmatised due to mental disorder, they are worthless in the eyes of their stigmatisers, which leads to depriving them of opportunities that they would ordinarily have. Such children and adolescents are often not accorded the same treatment as others. Baffoe (2013) reveals from his study in Ghana that children born with specific disabilities were not given an opportunity at life. Such children were killed even before their life begin. They lose their status as humans due to their disability (Baffoe, 2013).

Link & Phelan (2001) note that stigmatisation is dependent on access to social, economic and political power that allows people to identify differences, construct stereotype, separate labelled persons into categories and exclude and discriminate against people. Hence, stigma is applicable when elements of labelling, stereotype, separation, status loss and discrimination co-occur in a power situation that allows them to unfold (Link & Phelan, 2001, p.367).

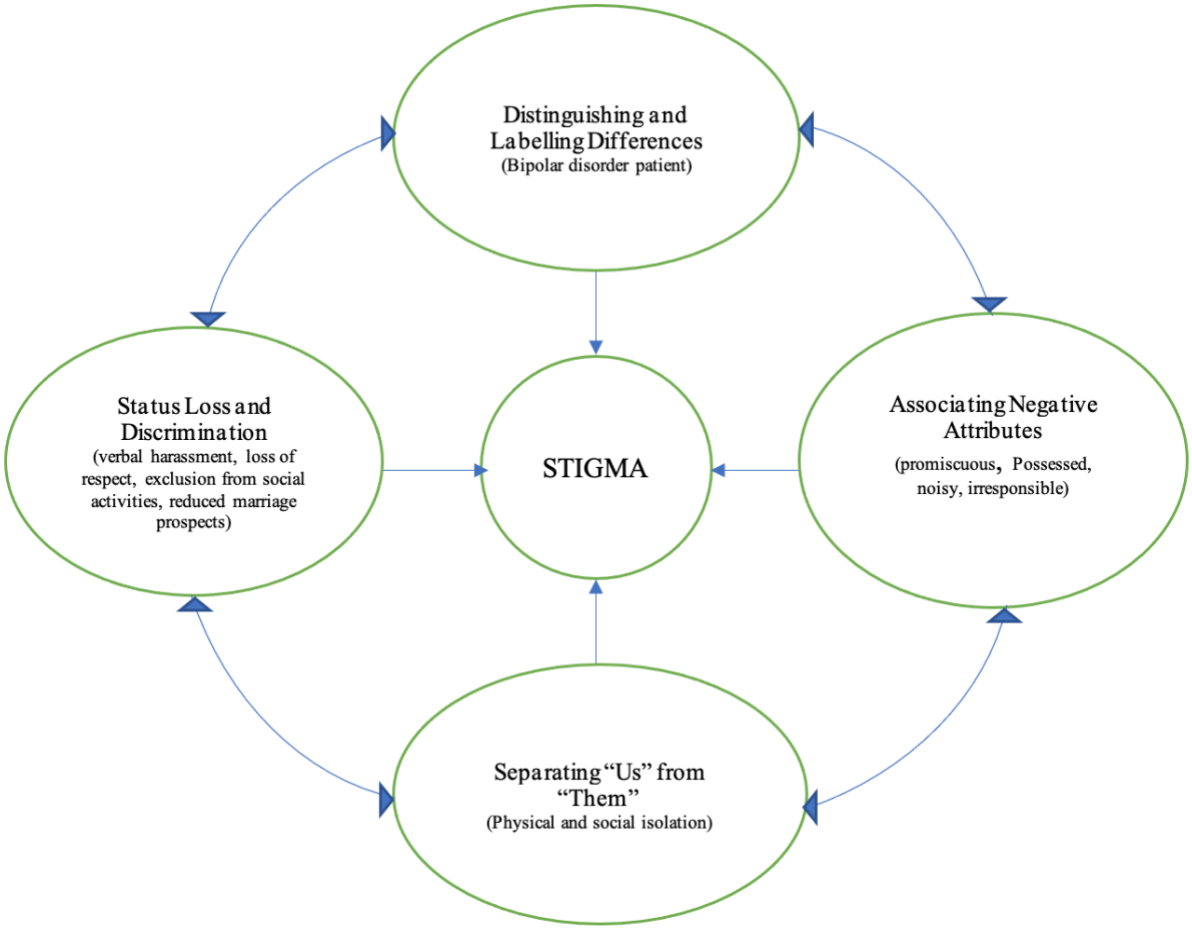

Figure 1: Component of Stigma according to Link & Phelan (2001)

CHAPTER 4
METHODOLOGY

In this chapter I reiterate my study objectives, describe my research design, study area and sampling technique. And criteria for inclusion of participants for this study. Also in this chapter, I discuss methods of data collection and analysis, ethical consideration, reliability and limitation of the study.

Specific Objectives

1 To investigate the involvement of social workers and religious healers in the treatment and management of CAMH in Ghana.
2 To explore social workers, and religious healers' perspectives on the causes of CAMH in Ghana.
3 To understand the role of social workers and religious headers play in managing stigma and discrimination in relation to CAMH issues in Ghana.

4.1 Research Design

Social phenomena do not exist independent of their participants; therefore, social phenomena have different meanings for different participants. The primary purpose of qualitative research is to explore the nature of those meanings through an in-depth study of the phenomenon's natural context (Gall, Gall, & Borg, 1999). A qualitative research design was used to examine the questions this research seeks to answer. According to Bryman (2012, p. 401), qualitative research provides a detailed account of the phenomenon being investigated, and qualitative researchers provide excellent descriptions when reporting the findings of their research. Qualitative research approach produces a detailed description of participants' feelings, opinions and experiences and interprets the meaning of their actions (Denzin, 1989). The researcher's focus is to understand from the practitioners' own words their role, what, in their opinion, is the cause of children's and adolescent's mental disorders, and how they manage stigma in the treatment and management of CAMH problems.

An interpretive approach is an epistemological position for this study. The interpretive approach emerged as an outgrowth of "Verstehen Tradition" (a German term for empathy) (Frankfort-Nachmias & Nachmias, 2008). "Unlike the natural scientist, the social scientists must grasp both the historical dimension of human behaviour and the subjective aspect of human experience" (ibid). The interpretivist position stresses understanding the social world through observing how that world is interpreted by its participants (Bryman, 2012:401). This position helped the researcher interpret how practitioners make sense of their experiences with working with children and adolescents with mental disorders by listening to their perspectives to understand the role they play, what they think are the causes of mental disorders and how their intervention aid in the management of stigmas associated with mental disorders.

4.2 Study Area

The study area for this thesis was initially the Greater Accra region of Ghana only. Although the Greater Accra region was the major region, due to the scarcity and difficulty of finding traditional healers with experience working with children and adolescents, the Volta region, Eastern region and the Central regions were included as the traditional healers for this study were found in those regions. The easy access to leaves and roots for herbal medicine and the peace and tranquillity in rural areas may contribute to the scarcity of traditional healers in Accra, where urbanisation and industrialisation have led to deforestation and scarcity of the plants needed for producing herbal medicine medicines.

Ghana is in West Africa. Greater Accra is home to Ghana's two major mental health hospitals, the Pantang Hospital and the Accra Psychiatric Hospital. The third, the Ankaful Psychiatric Hospital in the Central region of Ghana. A total of 1322 beds from these three hospitals serve the entire country and therefore suffers evident pressure and stress on its resources and staff. Out of these three major hospitals, only one has a children's department with about 15 beds (Roberts et al., 2014). These three major hospitals are directly connected with the Mental Health Authority of Ghana, established in November 2013 under the Ministry of Health. The focus of this Authority is to implement the Mental Health Act (846), which was passed in 2012 to refocus the way mental health services are provided within the country (Roberts et al., 2014). However, it is necessary to note that various hospitals in the country have psychiatric and or psychology departments as the first points of contact when mental issues are considered in the hospitals. Critical cases are then referred for further treatment at Accra's two leading mental health establishments. Due to very few mental health establishments in the city, practitioners such as Pastors, Imams, Traditional priests, herbalists and mental health organisations also support mental health issues.

The choice to use Greater Accra region for this study was greatly influenced by the fact that the researcher is particularly familiar with the region's local culture. the researcher is also familiar with how social work practice is done in this region, having worked with children and adolescents. Accessibility to participants, especially social workers and faith-based healers, formed part of the researcher's motivation for choosing Greater Accra. However, the other regions subsequently added share boundaries with the Greater Accra region, as the map reveals, with little or no cultural differences.

A map showing the regions of the Federal Republic of Ghana

Source: http://www.nationsonline.org/maps/ghana-administrative-map

4.3 Target Population

The target population for this study comprised of all metal health workers and mental health service providers within Ghana including faith-based organisations and traditional/herbal healers. These categories of mental health service providers were explored for their in-depth experiences to enrich this study.

4.3.1 Study Population

Specifically, the population targeted for this study are social workers, faith-based organisations and traditional/herbal healers who practice within the greater Accra region, Eastern region, Central region and the Volta region. Participants from these regions were sampled to inform this study.

4.4 Sampling

According to Cohen and Holiday (1996), there are generally two methods of sample selection. The first, common to quantitative research, is based on probability of inclusion, and the second, common to qualitative research, is based on non-probability of inclusion. For this study, the researcher employed the non-probability sampling technique. According to (Bryman, 2012)this technique uses non-randomized methods for sample selection, and it is a valuable and convenient method for sample selection. The non-probability sampling the research employed for this study is purposive sampling, also known as 'judgement sampling', and snowball sampling. According to (J. Green & Thorogood, 2004), these techniques allow researchers to target information-rich sources to gain a deeper understanding of the phenomena. Researchers can use their selective judgment to select sample units that represent the study population (Frankfort-Nachmias & Nachmias, 2008, p.168). This sampling method is well suited for this study as it accorded the researcher the opportunity to select sampling units' representative of the population under study. For example, Bryman suggests that the "purposive sampling approach is that the sampling is conducted regarding the research goals so that units of analysis are selected in terms of criteria that will allow the research questions to be answered" (Bryman, 2012, p.418). Sampling was done, bearing in mind the research goals. Purposive sampling enabled the researcher to select participants due to their relevance to the research questions. Snowball sampling, also known as 'chain referral sampling', is well suited for this research as some of the study populations are hard to locate. Snowball sampling enables the researcher to make initial contact with few people relevant to their study and then use them as a stepping-stone to others (Bryman, 2012, p.202). Although snowball sampling does not lead to representative sampling, Showkat and Parveen (2017) explain that this method is considered appropriate when the study population is challenging to locate. Social workers were found through the Department of Social Welfare (DSW) and other organizations that work with children with a mental disorder. religious healers were found through their organizations and word of mouth recommendation by other practitioners

4.5 Description of Participants

Participants were selected depending on their experience working with children and adolescents with mental health problems. Seventeen participants were interviewed for this study, five Social Workers, four Traditional Healers, four Pastors and four Imams. All social workers, pastors, and Imams were from the Greater Accra region, but it was difficult to find a traditional priest with experience working with children and adolescents with mental health issues; hence, all traditional priests were from regions outside Greater Accra. Precisely Eastern, Central and Volta regions. Fifteen males and only two females (a social worker and a traditional priestess) participated in this study. Social workers were more due to their availability. Although many pastors and Imams were contacted, only a few had experience working with children and adolescents with mental health problems. In the case of the traditional healers, a telephone interview was a barrier as they preferred face-to-face interview in their shrine as a mark of respect for "the gods", as one priest who declined a telephone interview puts it. Another priest could not participate because there was no internet connection in his community. Participants were aged between 28 and 72 and have had over two-year experience working with children and adolescents with mental health problems**.**

4.6 Inclusion Criteria

Certain criteria were employed in the recruitment of participants since the focus of the study is on practitioners involved in CAMH in Ghana. To be eligible to participate in this study, participants must meet the following criteria.

- Participants must be working or have worked with persons with mental health problems in Ghana. If a person has worked in the field of mental health for a period longer than two years in Ghana but has moved to another country, he/she qualifies to be recruited as a participant because he/she has experience working in the field of study, also, because of the limited number of people that work in this field in Ghana.
- Social worker must be attached to a mental health institution or working with an organisation that supports persons with mental health problems. In Ghana, the Psychiatric hospitals have no separate unit for children and adolescents, so the social workers assigned to the psychiatric hospitals work with both children and adults.
- Pastors and Imams must be from a recognised church/mosque.
- Traditional priests/priestesses must be recognised in the communities where they work or belong to an organised association.

4.7 Source of Data

The source of data for this study is primarily from the In-depth interviews conducted with participants. The nature of this study does not warrant the use of secondary data, as the experiences of practitioners is necessary to inform this study. As they share their experiences in dealing with CAMH, the researcher can glean from these discussions the necessary details to inform this study.

4.8 Recruitment and Data Collection

This study relies on primary data collected virtually using qualitative interview. A semi-structured in-depth interview with open-ended questions was used. The primary function of an interview is to solicit information (Kvale 1996, p. 124). Semi-structured interviews enable the researcher to gather in-depth information from the participants. Bryman (2012, p.472) suggests that questions not included in the question guide may be asked as the researcher picks up on things said by the participants.

The researcher recruited social workers through the DSW and organisations that support persons with mental health issues. An appointment to the DSW was made through a telephone call, and the researcher was asked to submit an introduction letter from her university, her interview guide and consent form. The documents were physically submitted at DSW with strict adherence to Covid-19 social distancing rules. One social worker was from an organisation that works with abused children and adolescents with mental health problems. This social worker recommended another social worker from the same organisation who has worked with children and adolescents with mental health problems. Due to Covid-19, the Christian Council in Accra was not working, and every effort to contact them through telephone was fruitless. Hence Pastors were recruited on a recommendation.

The first pastor is known to the researcher and very popular in his church and the community to deliver persons "bound by spiritual and evil manipulation" and have worked with several children and adolescents. He recommended other pastors. The Imams were mainly recruited by word-of-mouth recommendation. Since each Mosque was autonomous in specific issues, the Chief Imam of one of the mosques in Accra was contacted by telephone and the researcher sent supporting documents electronically upon request and approval was granted. The traditional healers were the most difficult to reach group. Their scarcity is mainly because most of these traditional healers are located outside the Greater Accra Region, and most of them do not work with children and adolescents with mental health problems. However, all traditional priests were found through recommendation by another traditional priest even though they were all in different regions. One of the traditional healers' interview was not with one participant but with a group. This group of traditional priests belongs to a traditional priests' association. Upon submitting the researcher's document, they decided to have all the members with experience working with children and adolescents participate. Interview with this group was conducted via WhatsApp audio call, an online communication app. All the interview questions were answered. Some of the interview questions got multiple responses; some got very few responses. The group leader answered most of the questions, and he also decided who answered specific questions. Even if the researcher could not see them, the researcher sensed a high level of organisation, respect and commitment within the group.

A language translator conversant in English and the local Twi language, and well known to the researcher, was contracted mainly for translation since most of the traditional healers preferred to speak in the local Twi dialect, of which the researcher is not conversant. The research assistant helped translate from English to the local language and vice versa and transcribing documents in the local Twi dialect into English.

Once contacted, participants were informed about the nature and purpose of the study, and determination was made as to whether they fit the criteria. Those who fit the criteria were invited to participate. The researcher had face-to-face interviews with one traditional priest, two imams, two social workers, two pastors, and social distancing was observed in adherence to Covid-19 protocols. The rest of the interviews were done online through WhatsApp audio call. Interviews lasted between 28 to 45 minutes. Interviews were recorded using a tape recorder. The researcher's mobile phone was also used as a backup recorder. Participants were informed adequately on the reasons for recording and their consent sought before recording the interview. Bryman (2012, p.482) submits that recording an interview is vital as qualitative researchers are interested in what their participants say and how they say it and avoid any form of distraction that would lead to missing out on vital details.

4.9 Data Analysis

This study employed thematic analysis in analysing data collected from the interviews. Thematic analysis helps identify, analyse, and report themes found within data (Braun & Clarke, 2006). According to Bryman (2012), Thematic analysis is a common and flexible approach to qualitative data analysis, which involves themes. Transcription is the first step in thematic analysis; then, the researcher reads and re-reads the transcriptions to identify critical points, codes these points, and categorises the code to generate themes. Below is a detailed description of the various stages inspired by Braun & Clarke (2006).

Stage one involves familiarising oneself with the data. The researcher familiarised herself first with the data by first transcribing and then reading and re-reading the transcript and listening to the audio interviews.

Stage two requires working through the entire dataset to generate codes. After familiarising herself with the data, the researcher used a computer software programme, ATLAS.ti 9.0 to generate code in order to identify themes. ATLAS.it is an essential tool developed to analyse extensive data from qualitative research (Muhr, 2004). The researcher also created an analysis table to enable her to identify themes. The third stage is the generation of themes. The researcher generated themes from the codes created using ATLAS.ti. The researcher looked over the codes to identify patterns then generated themes. The researcher also identified repetitions that suggested relevant themes. Bryman (2012) suggests that repetitions are not sufficient for something to be a theme; hence I referred to my research questions in generating themes.

Reviewing and naming themes is the last stage. At this stage refining, the themes became necessary. The researcher collapsed or merged themes with other themes to form broader themes, whereas other themes will break up to form sub or minor themes. Braun and Clark suggest that two levels of review are required at this stage. The first level requires reading through the coded extracts to establish coherence within the patterns. The second level requires considering how valid each theme is, especially concerning the entire data set. After generating and reviewing themes, the researcher extracted relevant quotes used to create codes that explained the different themes and subthemes generated. Finally, the researcher presents an

analytic discussion with the extracted quotations from participants' reports for each identified theme.

Table 1- Thematic Analysis Table

CODE	SUBTHEMES	THEMES	QUOTATION
Exhibiting strange behaviours	Devil influenced, demonic attack, taken over by a spirit	Spiritual cause of mental disorder	"We would say they are just under demonic influence; the devil or certain spirit has taken over them, that makes them behave in a way. They exhibit some strange behaviour. They manifest certain things ermm, aggressiveness"
Rituals to cast out demon	Praying for people, laying of hands, using anointing oil	Performing deliverance/exorcism	"In deliverance, the simplest definition is praying to cast out demons and setting the person free… pray for the person and put anointing oil on the person and then you cast out the demon"
Sitting all alone, giving up on life	Isolating oneself, not seeking help	Consequences of stigma	"you know it can deter people from seeking help. They are sitting quietly…it can push them to do other things. Probably commit suicide"

4.10 Ethical Considerations

Every form of human activity, including social research, is surrounded by ethical issues (Hammersley & Atkinson, 2007, p.222); thus, these issues emerge at various stages in social research (Bryman, 2012, p.130). Banks (2015) submits that ethics is about how human beings treat each other and their ecosystem and involves matters of rights, responsibilities and well-being. Social workers are mandated to respect, promote the well-being, and ensure social justice, dignity, and worth of individuals and groups and are guided by codes of ethics. For example:

Social workers treat each person in a caring and respectful fashion, mindful of individual differences and cultural and ethnic diversity. Social workers promote clients' socially

responsible self-determination. Social workers seek to enhance clients' capacity and opportunity to change and address their own needs. Social workers are cognizant of their dual responsibility to clients and the broader society. They seek to resolve conflicts between clients' interests and the broader society's interests in a socially responsible manner consistent with the profession's values, ethical principles, and ethical standards (National Association of Social Workers, 2017).

This research was conducted in line with the International Federation of Social Workers (IFSW).

Informed consent is essential to protect research participants. Bryman (2012, p.138) stipulates that the principle of informed consent means that research participants should be given the much-needed information to enable them to make an informed decision to be part of the study or not. Kvale (1996, p. 112) suggests that informed consent is to inform the research participants about the study's overall purpose and possible risks or benefits and that they have a right to withdraw from the study at any time without repercussion. Participants were given research details and informed of their right to withdraw from participating at any time during the study. The consent form was sent to participants via email and WhatsApp, and the researcher received a hard copy of signed consent or word of mouth consent recorded before the interview.

To protect participants' dignity and worth, the researcher ensured that the study does not cause actual or potential harm to participants. Bryman (2012, p.136) describes harm as physical harm, harm to participant's development; loss of self-esteem; stress. The researcher took steps to ensure that the study does not affect participant work or relationship with clients. All information that presents as causing harm to participants is avoided. Also, if the participants feel stressed during the interview, the researcher was happy to end the interview or take a break, as the participant wishes.

Another ethical issue is confidentiality. The right to privacy is a right that people cherish and breaching that right due to research is unacceptable (Bryman, 2012, p. 142). The anonymity and privacy of participants should be respected (Bryman, 2012, p.143). The researcher assigned pseudonyms to all participants in order to uphold confidentiality. Storage tapes, contact details, recording devices and transcripts were secured and erased and destroyed after use (Kvale, 1996, p.172; Bryman, 2012, p.143). The researcher ensured that every detail that would lead to the identification of participant(s) was written so that only the researcher could identify the participant(s).

Bryman (2012, p.143) suggests that deception occurs when researchers misrepresent their work. Several authors have reported the observation of widespread deception in social research. To avoid deception and exploitation of participants, the researcher provided adequate information on the purpose of the study. Information on what and how data will be used was adequately communicated to participants before soliciting their consent.

4.10.1 Trustworthiness

Trustworthiness consists of four criteria: credibility, transferability, dependability and confirmability (Bryman, 2012). Different strategies were employed to ensure Trustworthiness based on the above criteria. Transparency, standardised methodology, and bias conscious.

To ensure credibility, the researcher did not accord any participant any form of preferential treatment. Participants were not her friends. All participants were recruited under strict criteria, and participation was voluntary. Incentives were not given to motivate participation in the study. Respondents' validation was also employed to ensure the credibility of the findings. Interviews transcribed from local language were shared with participants for confirmation that the researcher has adequately represented their perspectives.

Transferability addresses the application of findings to other contexts. The rich accounts of research participants and the context allow for comparing research contexts where transfer may be considered. Her intent was not to report social issues that are replicable in other contexts but to give a detailed description of Ghanaian religious practices related to children's and adolescents' mental health. However, similar responses could emanate from studies conducted in other contexts. The number of participants might affect the transferability of findings, but it also contributes to the body of knowledge in CAMH and can trigger more research in this field.

Dependability is concerned with ensuring that record for all research phases is kept (Bryman, 2012). Bryman referred to this criterion as the 'audit approach'. It shows that findings are consistent and repeatable. Dependability refers to the consistency and reliability of research findings and the degree to which the research process is documented. (Moon, Brewer, Januchowski-Hartley, Adams, & Blackman, 2016). The methods and processes employed in this study are clearly articulated and may show similar findings in the same context. However, social phenomena are not static but dynamic; the participants' perspectives may vary at different time and context.

Moon et al. (2016) suggest that to ensure confirmability, the study results should link to the conclusion in a manner that can be followed and replicated. A detailed methodological description can do this. To ensure confirmability, the researcher provided a detailed description of her methodology and discussed every step of her study with her supervisor, providing details of the interview and accounts of ethical dilemmas.
Reflections and Limitation of studies

4. 11 Limitations of Study

The number of participants reflects a small sample of the population under study, and the results may not be generalizable to the entire population. The effect of the restrictions on movement and social distancing due to the Coronavirus disease 2019 (Covid-19) also impacted the research's original data collection method. The Covi9-19 restrictions prevented the researcher from observing non-verbal cues that come with face-to-face interviews. Though some interviews were conducted face to face, the use of a face mask prevented the observation of facial expressions. Challenges in network connections such as poor or weak internet strength affected participant size as some participants could not participate due to lack of internet connections at their locations. There is a potential loss of data through the translation and

transcription processes of the interviews. Hence, the back-and-forth approach was incorporated. Also, the help of a professional transcriber was sought. For interviews conducted in the local language, data was transcribed in the local language (Twi) and was translated into English with the help of a professional. Another professional was then asked to translate the English transcript back into the local language to ensure some level of accuracy. Though this method proved successful as transcription was confirmed to be correct, data may have been lost as some local word have no English translations.

CHAPTER FIVE
FINDINGS AND DISCUSSIONS

5. 1 Introduction

The purpose of this study was to explore and describe the intervention of social workers and religious healers in CAMH care in Ghana. In order to fully understand CAMH care delivery by social workers and religious healers in Ghana, it is important to understand their perceptions of the causes of CAMHD, types of mental disorder children and adolescents face, practitioners' role in treatment of CAMHD, stigma and discriminations associated with mental disorders and suggested ways to end stigma and discriminations. The study adopted the interpretivist approach which allowed the researcher make interpretations of the distinct perspectives of social workers and religious healers in Ghana.

The results below are organised by first presenting the themes and subthemes through exemplifying informant citations, then at the end of each section, discussing this in relation to relevant theoretical concepts and earlier literature.

The outcomes of the analysis are presented according to the research objectives in the introductory chapter. Demographics of the participants are outlined below.

Table 2: Demographic background of professionals working with children and adolescents with mental disorders in Ghana.

Name	Age	Sex	Religion	Profession	Education	Number of years working with children and adolescents with mental disorders
Social worker 1	32	M	Christian	Social worker	Bachelor's Degree	8 years
Social worker 2	40	F	Christian	Social worker	Bachelor's Degree	12 years
Social worker 3	42	M	Christian	Social worker	Master's Degree	9 years
Social worker 4	42	M	Christian	Social worker	Bachelor's Degree	10 years
Social worker 5	35	M	Christian	Social worker	Doctorate Degree (on-going)	8 years
TH 1	69	M	ATR	Traditional priest	Vocational Training	30 years

TH 2	28	M	ATR	Traditional priest	Junior High School	8 years
TH 3	31-72	M	ATR	Traditional priest	Not Stated	4 – 40 years
TH 4	60	F	ATR	Traditional priestess	No Education	34 years
Pastor 1	43	M	Christian	Pastor	Bachelor's Degree	8 years
Pastor 2	40	M	Christian	Pastor	Bachelor's Degree	14 years
Pastor 3	33	M	Christian	Pastor	Bachelor's Degree	8 years
Pastor 4	29	M	Christian	Pastor	Bachelor's Degree	6 years
Imam 1	48	M	Muslim	Imam	Secondary Education	20 years
Imam 2	34	M	Muslim	Imam	Secondary Education	6 years
Imam 3	38	M	Muslim	Imam	Bachelor's Degree	15 years
Imam 4	45	M	Muslim	Imam	Junior High School	15 years

A total of 17 participants, all Ghanaians, took part in the study: five social workers, four traditional healers, four pastors, and four Imams. The participants' age ranged between 28 -72. All participants have some level of formal education except the traditional priestess who had no formal education and the traditional priests' group, which did not mention their educational level. All other participants were either self-employed, employed by an organisation or a public institution. Their years of experience working with children with mental health disorders ranging from 4 years to 34 years.

Table 3: Themes and Subthemes

Objective	Main Themes	Subthemes
Social workers and religious healers' perspectives on the Causes of CAMHD in Ghana	Perceived causes of CAMHD in Ghana	Biological causes of CAMHD
		Psychosocial causes of CAMHD
		Supernatural causes of CAMHD
Intervention of social workers and religious healers in the treatment and management of CAMHD in Ghana	Mental disorders children and adolescents face	
	Role of social workers in the treatment of CAMHD	Diagnostic role
		Treatment role
		Referral and collaboration

	Success and challenges in working with children and adolescents with mental disorders	Successes in treatment
		Challenges in treatment
View of social workers and religious healers about Stigma and discrimination pertaining to mental disorder.	Stigma and discriminations pertaining to mental disorders	Barrier to help-seeking
		Labelling
		Barrier to social inter action
		Parental abandonment
		Barrier to marriage
		Discrimination
	Suggested ways to curb stigma and discrimination towards children and adolescents with mental disorders	

5.2 Perceived Causes of Mental Disorder

From the study, it was evident that participants had different perceptions on the causes of mental disorder. Three subthemes emerged from their perceptions. Biological causes, psychological causes and supernatural causes.

5.2.1 Biological causes of mental disorder

All participants reported that biological factors such as genetic and hereditary and drug and alcohol use contribute to the mental health of children and adolescents. The participants report that some mental disorder can be passed from parents to children. For example, the following subthemes emerged: genetics/hereditary and drug and alcohol use.

Genetics/Hereditary

Most of the participants indicated that several biological factors such as genetics/hereditary cause children and adolescents to develop mental disorders. Some families have history of mental disorder which are likely to be passed on to children from parents. As one participant puts it:

> *"There is a hereditary aspect of it… you find that for some of the children, their parents may have suffered from mental health disorders and due to lack of awareness and the lack of knowledge on how to seek help, the children also find themselves picking up certain things that would make them also slip, you know. So that's on*e" **(Social worker 1)**

Another participant also said:

> *"you'll find out that it's not only happening to that child, but it has happened to maybe somebody who is related to the family, their children. So, you could see that it's a generational issue. And generational issues most of the time are termed…genetic"* **(Pastor 2)**

Another participant explained further that parents age can also affect a child's mental health. This is reflected in the extract below:

> *"The genetic is also there. The genetic makeup can also cause mental health… and even as we know the age difference can be an incompatibility (biological makeup)"* **(Social worker 3)**

Drug/Alcohol Use

The extracts above suggest that some participants perceive mental disorder to be a result of genetics/hereditary factors which can be transmitted from parents to their offspring. Some others perceived alcohol and drug use as a biological factor that can cause mental disorder. This is demonstrated below:

> *"Probably when it comes to drugs, most people go into drugs because of associations…when you do it, this would happen, you'll have a sharp brain"* **(Pastor 2)**

Another participant also adds that women who use drug to terminate pregnancy causing harm to the foetus and when the child is born, it presents with several mental disorders:

> *"What the parents engage in when they are pregnant or the intake of drugs and some others too when they are pregnant the thought around as to whether to abort or not abort the pregnancy"* **(Social worker 3).**

Another participant said:

> *"…sometimes when they want to poison the child like they are doing abortion or all those stuffs it sometimes brings all those stresses because when you drink medicine trying to destroy the child, trying to abort the child or something like that sometimes it causes that"* **(TH 2)**

5.2.2 Psychosocial Cause of Mental Disorder

Psychosocial factors such as such as abuse, environmental, behaviour modelling, family structure, poverty and peer pressure have been identified by participants as causes of mental disorder in children and adolescents.

Child Abuse

Severe emotional, physical, or sexual abuse, the loss of a parent or neglect (both emotional and physical) were identified by some participants to cause mental disorders. This is demonstrated below:

> *"The same way some children usually receive knocks on the head from their parents, it damages the child's brain. If the child is not receiving a good treatment for instance, knocking the child's head or slapping continuously can cause such illness"* **(TH 3)**

> *"When parents maltreat or beat a child, it sometimes affects the mental health of the child. There is no need to maltreat or beat the child as punishment"* **(Imam 4)**

Another respondent added that negligence can affect the mental stability of a child or adolescent:

> *"I'll say negligence…sometimes most of it comes from the home, that's the parents because the child can start with some kind of attitude, the parents see it they try to cover it"* **(Imam 3)**

Environmental factors

The study participants also added that the environment where the child is brought up can also contribute to their mental health status. Further, participants described how childhood mental illness may be a reaction to environmental stresses. One participant informed:

> *"The kind of environment they find themselves in is also one of the causes. If they find themselves in an environment which does not encourage openness, fairness, love for one another but it's just violence, you know, that child obviously may end up having a low self-esteem"* **(Social worker 1)**

Another participant added that children and adolescents who suffer negligence end up adapting behaviours in their environment that affect their mental health:

> *"you see, the environment where you are brought up with different kinds of people with different backgrounds and how some of them were brought up, you will end up adapting somethings from them with time… the child's mind would be oriented in that way as if that is the normal way of living and if the parents are not smart to check those things, with time the child's mind will be formed to live that kind of life and before you know behaviour becomes different"* **(Pastor 2)**

Other participants reported that children learn from their environment, stating that a toxic environment leads to a toxic attitude which affects mental health:

"The environment the child grows in. So, if the mindset is toxic, then the child that would be produced in that environment would definitely be toxic" **(Pastor 3)**

"The environment in which the child is can influence him or her in one way or another… the place can make him learn things that can make him have mental problems" **(Imam 4)**

One participant added that cultural practices in a child's environment can also cause the child to develop mental disorder. This is illustrated below:

"Cultural practices can be a cause of this mental illness because of the concoctions and the things that they drink whiles they are pregnant or during festivities and all that. This can have effect on the foetus" **(Social worker 3)**

Family Structure/Socioeconomic situation

Participants also identified family structure and family socioeconomic situation as risk factors for child and adolescent mental disorders. Participants viewed polygamy as a risk factor for child and adolescent mental disorder as indicated below:

"Maybe the father has two wives, polygamy, he has two wives. So, the other woman sees that maybe this boy has a future so let me destroy him. So, most of them that's the cause…from what I encountered" **(Imam 1)**

Another participant added:

"Someone who is married to 4 wives, 3 wives. You know when that happens, there is some kind of competition between the wives. Everybody wants her child to do better" **(Imam 3)**

While some of the participants perceive family structure as a contributing factor to children's mental problems, some attributed family economic situation to the cause of mental health problem in children and adolescents as indicated below:

"Poverty, economic hardship…poverty can lead to many things. you know, depression and other bad habits" **(Pastor 1)**

Another participant elaborated as follows:

"I believe that the issue with anxiety with students and depression… few of such cases are as a result of poor parental support ok. Both financial and other factors contribute to children getting to that level of the effect of mental health" **(Social worker 4)**

Peer Pressure

Some Participants suggested that children and adolescent learn behaviours from their peers. Peer pressure as perceived by some of the participants can cause mental disorder in children and adolescents. The extracts below indicate this:

> *"In some cases, the children of school going age these days are easily influenced by their friends. When they see their friends doing something, they will also do the same and falls victim of such illness"* **(TH 3)**

> *"Peer pressure, at times because of the pressure outside, when children begin to, you know, absorb certain things from their friends, the enemy uses it as a platform to minister to them, bring them into a form of depression"* **(Pastor 1)**

Another participant suggested that peer pressure force children and adolescents into drug and use:

> *"The causes are first, let's go to the drug abuse. Which they emulate it from their friends"* **(Pastor 4)**

Another participant added that peer pressure and an underlying mental illness can further affect a child's mental health:

> *"So, their friends and school socialization with their friends and mates and anxiety forces them also to getting into those vices, I mean the drugs that would later results into the mental conditions that ends them up in the hospital"* **(Social worker 4)**

Behaviour Modelling

Other Participants reported that children copy what they see their parents do and this in turn affect their mental health especially if it is a behaviour that relates to mental disorder. This is demonstrated in the comments below:

> *"When the child is kept in the custody of a mentally unstable mother, you know at that infant stage, the brain is blank, so whatever the mentally unstable mother does, the child copies it and thinks that's the appropriate thing"* **(Social worker 5)**

> *"Children learn from the actions of their parents so sometimes I think some homes certain activity that causes these children to develop these mental…parental upbringing in the home and sometimes in the environment"* **(Pastor 4)**

Another participant further elaborated that, children and adolescents feel that when they can act out behaviours copied from a parent, it shows they is a true child of their parent. This is demonstrated in the extract below:

"So, I'll say that the causes are behavioural…they think that if I'm able to express these behaviours, it means that yes, I'm my father's son or my mother's daughter and they think that its normal. So, it's both behavioural, environmental or generic. People learn from others. For instance, for a child who regularly witness abuse may feel that it is ok to also abuse, not necessarily counting it as an abuse because they think that that's the normal way of life" **(Social worker 2)**

The findings above suggest that participants in this study perceive various psychosocial factors as contributing to the onset of mental problems in children and adolescents. These findings correspond with previous researchers who suggest that psychosocial factors such as environmental, family structure and family socioeconomic situation, peer pressure and child abuse affect children and adolescent mental health (Ogundele, 2018; Walker, 2003; WHO, 2016). For example, Ogundele (2018) notes that a child's environment shapes the child's thoughts and behaviour. Children and adolescents' environment and their genetic make-up impact their emotions and behaviours. (Ogundele, 2018). Poverty and family socioeconomic situation can lead to exclusion, disempowerment, and marginalisation, giving rise to drug and alcohol abuse and streetism, contributing to further alienation in adolescents (Sheehan, 2017; Walker, 2003). Findings also reveal that external and internal family stressors such as domestic violence and child abuse are placed on modern family life and can affect the mental health of children and adolescents (Walker, 2003). Psychosocial factors include a mother's mental health state, poor stimulating environment, and harmful traditional practices (WHO, 2016).
The next section presents findings on the supernatural cause of CAMHD in Ghana.

5.2.3 Supernatural Causes

All participants except the social worker believe that mental disorders are caused by supernatural influences such as spiritual and demonic attack, witchcraft, curses, taboos, angry deity, jinn, and evil spirit. Here we see a clear demarcation between the folk arena and the professional arena. Kleinman (1978) argues that healers' construction of illness is socially learn and sanctioned by experience. Tirodkar et al. (2011) argues that professionals' (in this case social workers) explanatory models (EMs) are mostly biomedical as they emphasise biological and psychosocial factors as causes of illness.

Spiritual and Demonic attack

Participants reported spiritual and demonic attacks and influences as a cause of mental disorder in children and adolescents. One participant said:

"With what we see, for some people, errm…we would say that they are just under demonic influence that is a generic term we would give it. So, they are being influenced by the devil or certain spirit has taken over them and that makes them behave in a way that we would say they are not normal" **(Pastor 1)**

Another participant added:

> *"With the spiritual attack, it's a lot. You might offend someone, and the person might say something hurtful to you which might also hurt you and bring you such kid"* (TH 2)

Another participant indicated that the way a person dresses also exposes her to spiritual attack, which in turn causes a mental disorder:

> *"The spiritual one, sometimes, especially women, it's their dressing. They get it from their bad dressing. So Islamically, a woman is not allowed to just be walking without covering her body. It's not allowed because that where it is easy for them to enter you, yeah"* **(Imam 1)**

Another participant further explained that certain habitat exposes one to spiritual attack. In his words:

> *"Some people live near water bodies but do what the water does not like. When this happens, the water spirit can deliberately give you some of its offspring just to worry you and cause you a lot of harm financially due to the money that will be spend in catering for such a child. Such child cannot be normal like other children"* **(TH 4)**

The above assertions by the participants indicate that participants perceive that mental disorders are caused by spiritual and demonic attack. Kleinman (1978) explains that people hold different EMs. Here we see an explanatory model that builds upon the idea of illness as existing as a result of spiritual and demonic influences.

One of the participants mentioned (above) that when a lady does not wear something that covers her entire body, a spirit can possess her through the exposed part. Another participant explained(above) that a spirit can give people offspring with mental disorder to worry them because of their behaviour toward their habitat. However, one of the practitioners was not convinced that the cause of mental illness can be spiritual. In his words:

"To be honest I don't think its spiritual because when you say spiritual, I mean how does a child or somebody get depressed as a result of the person's either lack of spirituality… Even pastors suffer from mental health, so you can't tell me that a spirit or somebody's lack of spirituality or too much of spirituality may have caused that because even pastors also suffer that" **(Pastor 4)**

Witchcraft and Jinn

Some participants reported witchcraft and Jinn possession as perceived causes of children's and adolescents' mental disorder as indicated below:

> *"I will say yes! Some of these mental illnesses are spiritual warfare. Some are caused by witchcraft. When this happens, we cure it spiritually"* **(TH 3)**

"There are some people who say they do not possess witchcraft, yet they are the ones causing harm to their child. They claim not to be responsible for the illness of the child. I normally ask such people to excuse us so that I can perform my work and save the life of the child. Some of such parents sometimes threaten me when they realise that I will be able to save the child" **(TH 1)**

Another participant reported that evil jinn possession can cause a child or an adolescent to develop mental problems. This is reflected in the extract below:

"There are evil jinn. When jinn possess a person, Sometimes, it's too serious that you need people to help you hold the person because some of the jinn are very stubborn. You will see the person struggling and if the jinn become stubborn… you see the person shouting so with that, when we see that is it getting to that point we get some people to hold them because sometimes the person at that particular moment don't know what he or she is doing" **(Imam 2)**

The perspective above was held by a few of the practitioners. The idea that family members possess witchcraft that can cause mental illness to a child. For example, **TH 1** (stated above) indicated that he sometime handles situations where a parent's witchcraft is the cause of the child's mental disorder. Here we see a cultural construction of illness.

Curses

Curses were also identified by some participants to cause mental disorder in children and adolescents. Some participants indicated that when a child or adolescent takes something that does not belong to them, they are likely to be cursed by the owner. This is illustrated in the extracts below:

"They go and take somebody's thing; somebody have to go ahead and curse them, and we normally get those problem" **(Imam 2)**

"*For the curse, maybe I put something down, I put my things, so when I left you took it. And when I came, and I asked you said you didn't take it. And I said ok, I leave you with maybe thunder or something…it's a curse"* **(Imam 1)**

Another participant added:

*"I could say somebody has cursed you with it. Yeah, so it still comes back to it been spiritual. "**Obi dia bo ne dua**" the local **Twi** (a major Ghanaian dialect) expression meaning somebody has cursed you with it"* **(Pastor 1)**

Taboos as a Cause of Mental Disorder

Defying taboos is an offence that is taken seriously in specific cultures in Ghana and is believed to have negative consequences for offenders (White, 2015). Some participants reported that

some young people developed mental illness as a result of defying taboos. This is illustrated below:

> *"Some of our sisters…who go mad, it is because of the way they live their lives. When there's a taboo in a home and you marry into that family…you may not know what your father in-law has planted in the house, when you go out of your way to sleep with another man and you return to your husbands' house step on the herbs your father-in-law has planted in the house, you will start laughing. Your madness has begun"* **(TH 3)**

Another participant added:

> *"Sometimes the parents go to shrines to ask for child, they are going through a lot of pains finding child, so they normally go to shrines and big rivers to ask for help and most of the times when the gods or when the spirits help they don't go back to thank them. It is forbidden. You must return to say thank you if not it can affect all your family. With that, it causes them harm by giving them this child which they can't take care of"* **(TH 2)**

The findings suggest that participants perceive biological factors such as genetics/hereditary and alcohol and drug use to cause mental disorder in children and adolescents and these findings are consistent with several studies (Ogundele, 2018; Rector et al., 2016; Tonge, 1998; WHO, 2016). For example, WHO (2016) submit that biological factors such as drug use during pregnancy may increase children's risk of developmental delays. Similarly, Tonge (1998) agrees that biological factors such as parental mental health history are a risk factor for children's mental health. The author explains that parents with major depression are likely to pass this disorder to their offspring as major depression has been identified as a familial disorder caused by the interaction of genetic elements. Issues relating to brain chemistry and brain activity, genetic and substance abuse are all biological factors that have been identified to increase anxiety in children and adolescents (Rector et al., 2016).

Findings of present study also suggest that participants in this study perceive various psychosocial factors as contributing to the onset of mental problems in children and adolescents. These findings correspond with previous researchers who suggest that psychosocial factors such as environmental, family structure and family socioeconomic situation, peer pressure and child abuse affect children and adolescent mental health (Ogundele, 2018; Walker, 2003; WHO, 2016). For example, Ogundele (2018) notes that a child's environment shapes the child's thoughts and behaviour. Children and adolescents' environment and their genetic make-up impact their emotions and behaviours. (Ogundele, 2018). Poverty and family socioeconomic situation can lead to exclusion, disempowerment, and marginalisation, giving rise to drug and alcohol abuse and streetism, contributing to further alienation in adolescents (Sheehan, 2017; Walker, 2003). Findings also reveal that external and internal family stressors such as domestic violence and child abuse are placed on modern family life and can affect the mental health of children and adolescents (Walker, 2003).

Psychosocial factors include a mother's mental health state, poor stimulating environment, and harmful traditional practices (WHO, 2016).

The present study findings that participants believe that some taboos can cause mental disorder to a particular gender. For example, the use of taboo (for example, planted in a house) to check (for example, a woman's fidelity) suggests that young girls and women are vulnerable to violence and abuse due to cultural practice that promotes gender inequality. Some of the traditional healers (above) reported that when a deity blesses a woman (for example, with a child) and the woman does not return to show gratitude to the deity; the child will be inflicted with a mental illness. This report suggests that children are vulnerable to violence and distress due to offences committed by their parents and, particularly, mothers.

The finding that participants in this study attributed supernatural and evil forces as the cause of mental illness is consistent with previous studies (Asamoah et al., 2014; Ovuga et al., 1999). For example, Ovuga et al. (1999), from their study with 29 traditional healers in Uganda, report that traditional healers believe that witchcraft, curses and spiritual manipulations result in mental disorder. The authors argue that their findings correspond to several studies from Africa on the causes of mental illness. They further argue that all the traditional healers involved in their study reported that evil spirits, witchcraft and curses caused mental illness. Similarly, Asamoah et al. (2014) report that in Ghana, Pentecostal pastors believe that mental illness results from the diabolical manipulation of the soul of a victim. They argue that supernatural explanations on the causes of mental disorder supersede biomedical explanation in Ghana as most Ghanaians are more inclined to religious explanations on the causes of mental disorders. White (2015) argues that people with evil power and those who possess witchcraft could decide to punish others whom they consider enemies or disrespectful with an illness. The author further explains that in some Ghanaian communities, someone can become mentally ill by being cursed in the name of Antoa, a river deity, as a means of seeking divine justice. White further argues that taboo violation is another cause of mental illness even when violated secretly.

The current study findings that participants perceive biomedical factors, psychological factors and spiritual factors to cause mental disorders corresponds with previous researches (Kleinman, 1980; Walker, 2003; WHO, 2016). For example, WHO (2016) submits that multiple factors such as biological, psychosocial and harmful traditional practices lead to developing mental disorders in children and adolescents. According to the WHO, biological causes include alcohol and drug use during pregnancy, birth complications, nutritional deficiencies, and psychosocial factors include mother's depression, poor stimulating environment and harmful traditional practices. In her explanatory model, Kleinman explains that people hold varying views on illness causation (Kleinman, 1980). According to Kleinman, In summary, participants indicated that supernatural factors negatively affect the mental health of children and adolescents. Identified supernatural factors include spiritual and demonic attacks, witchcraft and jinn, curses and taboo violations.

In the next section, I present findings and discuss the different roles that practitioners play in the treatment and management of CAMHD. First, I present findings on the types of mental disorders children and adolescents face.

5.3 Roles of Practitioners in the Treatment of CAMHD

The second research objective sought to investigate the role of social workers and religious healers in the treatment and management of CAMHD in Ghana. Concerning this objective, the findings of this objective are presented and discussed under three main themes: types of mental disorders that children and adolescents face, the role of social workers and religious healers in treating CAMHD and the successes and challenges of treating children and adolescents with mental disorders.

5.3.1 Types of Mental Disorders Children and Adolescents Face

Children and adolescents face several disorders which affect their behaviour, development, and social interaction. All the participants in this study identified several disorders that children face. Some of the participants identified the types of mental disorder by name. This is reflected in the statements below:

> *"Often, you'll hear some of the children who undergo some form of abuse, and you can sense that it has caused some level of anxiety in their lives and some sort of fear, you know. For some of the children also you'll find a bit of depression, you could also, especially when you talk to them. I've met a child who had OCD"* **(Social worker 1)**

> *You'll see them depressed…depression, you know, the bible talks about anxiety and that's where those things come from"* **(Pastor 1**)

Similarly, two participants added:

> *"Let me say mild form of bipolar that is the situation of few of them on mental conditions"* **(Social worker 3**)

> *"Some have cognitive challenges that appear to be something they were born with. Aside that, the normal psychiatric conditions, we talk about schizophrenia, mild ones."* **(social worker 4)**

From the extracts above, it can be suggested that the social workers understand the different types of mental disorders. Some participants however used symptoms to describe types of mental disorder. This is illustrated below:

> *"When you see them, they have this different looks, they say nonsense sometimes they act strange Sometimes it's like stroke mixed epilepsy. You see them shaking one side with one side not working and water coming out of their mouth."* **(TH2)**

> *"Some of them are unable to sit because they are weak. Others also have big heads which is heavy and makes movement difficult for them… others have undeveloped minds or are unable to think or behave in accordance with their age. Such children are old but always behave like kids"* **(TH 4**)

Some of the participants reported types of mental disorders using the behaviour of the child or adolescent. This is represented below:

> "*Addiction to all kinds of things like drugs to sexual activities, to incest, to a lot of stuff. Some people cannot stay up to study, some are having issues with things they see, they have conflicts within themselves"* **(Pastor 3)**

> *"Some of them we witnessed stubbornness, others too with time, they go into smoking. There are some too from smoking now… if you look at the attitude, they exhibit is almost close to madness. So, we've been seeing some of these"* **(Imam 3)**

> *"I've dealt with two; children who are unusually truant. They don't like going to school, they don't like coming to church. The second group of people I have worked with are hyper, too hyper. They are not able to stay at one place"* **(Pastor 4)**

The extracts above suggest that some participants recognise the existence of mental disorder from the symptoms or the children's behaviour. Here we see participants using labels. This finding confirms Goffman (1963) conceptualisation of stigma as an attribute that is deeply discrediting. The use of labels in identifying a person is a clear demarcation of 'Us' from 'Them' (Link & Phelan, 2001)

The findings from this study correspond to earlier literature on the types of mental disorder children and adolescents suffer (WHO, 2011a; Patel et al., 2015). As opined by Patel et al. (2015), childhood mental and developmental disorders encompass neurodevelopmental, emotional, and behavioural disorders that have broad and severe adverse impacts on children and adolescents psychological and social well-being. These problems are distressing to children and disrupt their ability to function well at home, school, or other social situations (WHO, 2011a). Mental health disorders in children and adolescents may include childhood anxiety disorders, intellectual disability (intellectual developmental disorder), attention-deficit hyperactivity disorder (ADHD), conduct disorder and autism (Patel et al., 2015). Depression and other mood disorders, post-traumatic stress disorder (PTSD) and schizophrenia are also identified by WHO (2011a). Also, the findings that religious healers identified mental illness with symptoms and patients' behaviours correspond to earlier research (Crawford & Lipsedge, 2004; Kpobi et al., 2019; Mufamadi, 2001). For example, Crawford &Lipsedge (2004) submits that healers observe behaviours such as aggressiveness, incomprehensible speech, confusion, isolation and strange behaviours to determine mental disorder.

In the next section, I present and discuss findings on the role of social workers and religious healers in treating CAMHD,

5.3.2. Diagnostic Role

According to the practitioners interviewed, there are several procedures involved in diagnosing mental disorder. For example, some of the social workers reported that they do assessment, listening and observation before they decide on the treatment or to refer to other professional.

> *"Yes, the mandate is to support the kids, we start with psychosocial assessment"* **(Social worker 4)**

> *"One way or the other you try to do assessment, talk to them, listen to them, watch their behaviour, then you'll realize that there may be or there is some aspect of mental illness and it's kind of challenging especially when you are working with minor children who can't really tell that they are going through such ordeal"* **(social worker 2)**

From the findings of this study social workers interviewed submitted that in diagnosing mental disorder they do an assessment to determine the type of disorder the children and adolescents have. Here we see the professional arena. Kleinman (1980) identifies this arena as comprised of those involved in biomedical approach of health care.

The religious healers reported that they diagnose by observation in behaviour, prayer and consultation with gods and ancestors. This is reflected in the extract below:

> *"When a child is brought here by his or her mother and father, I observe their behaviour and then I can tell what their problem is. Sometimes I have to use the drink they brought to consult the gods to reveal the illness. Sometimes too, I ask them, I mean the parents"* **(TH 1)**

> *"When you sit physical with the person you will know that this person is not that way, or this person is this way. When you see them, they have this different looks, they say nonsense, sometimes they act strange"* **(TH 2)**

The above statements indicate that traditional healers can detect mental illness through the unusual behaviour of the person. TH 3 further pointed out that through foretelling, the cause of the mental illness is also revealed. This is illustrated below:

> "*When the gods are consulted through foretelling and it was revealed that the person's illness has been caused by smoking of marijuana that has caused him brain damage, the brain will not function as it used to be"* **(TH 3)**

Some of the religious healers pointed out in the extract below that they can detect a mental illness by prayer, listening and observation

"When some parents bring their children that they are not doing well in school, they are very dull and by the time you go deeper, and pray you will see that it's the problem of the mind" **(Pastor 2)**

"We listen, you have to listen a lot, you have to pay attention because you could miss it, you could miss where the turning point was, so you have to listen attentively to the person so that you can find the answer" **(Pastor 3)**

Some participants indicated that the parents of the children tell them about the children's behaviour before they are brought to them. This is stated below:

"Once their parents tell us about the child, we observe their behaviour and alert the parents as soon as we perceive that there is something wrong. Getting some of them to come for prayer is not easy" **(Imam 2)**

Imam 2 further pointed out that by merely speaking with an individual, he can tell the state of his mind. This is illustrated in the extract below:

"Sometimes we don't wait for the parents to report, I am an Imam, I identify it once I see the child and I alert the parents. Sometimes I speak to the young man and I know that there is something" **(Imam 2)**

Here, we see the popular arena interacting with the folk arena (Kleinman, 1978). Family members (popular arena) involved in care provision by consulting the healers (folk arena) when they noticed changes in their children's behaviour. Kleinman, Eisenberg, & Good (1978) suggest that in all cases of illness, the popular arena and the folk arena provide a considerable amount of health care.

The current study's finding that social workers perform diagnostic role is confirmed by previous research (Allen, 2014; Coogan et al., 2009). For example, Coogan et al. (2009) opines that social worker assess and treat mental health patients. Also, the findings from this present study that social workers have a mandate to support children with a mental problem is in line with the submission of Watkins (1982) that social workers are experts in helping people with mental health problems as they are involved with identifying factors that aggravate or improve mental health problems and focus on building social support and strength.

The study's findings that religious healers play a diagnostic role before deciding on the type of treatment corroborates previous research findings (Adelekan et al., 2001; Adu-Gyamfi & Anderson Eugenia Ama, 2019; Ally & Laher, 2008). For example, Adu-Gyamfi & Anderson Eugenia Ama (2019) assert that traditional healers perform a diagnostic role of consulting their deity to reveal the cause of the illness and the treatment method to follow. The authors assert that traditional healers also examine the patient's socio-cultural background before they start treatment. Similarly, from their study in Nigeria, Adelekan et al. (2001) report that healers recognise particular behaviours to diagnose mental illness. According to the authors, an

individual's conduct, appearance and hygiene are some of the aspects considered to diagnose mental illness. Prayers and scriptural verses are tools used by healers in diagnosing mental illness (Ally & Laher, 2008; Asamoah et al., 2014).

The next section present findings and discuss the views of the practitioners on their methods of treatment

5.3.3 Treatment Role

Participants acknowledged that their intervention include treatment procedures such as psychotherapy, herbal remedies, exorcism, counselling, prayer and several others. From the texts below, it can be suggested that the method of treatment spun out of their understanding of the cause of the disorder. Treatment role will be discussed under two separate headings: social workers and religious healers.

Social Workers

The social workers, however, play different roles from the religious healers as demonstrated below:

> *"We start with psychosocial assessment and support and total rehabilitation and reintegrating patients. So basically, we assist in the admission screening, we support the psychiatrists and so when issues of some social support come up then we pick it up from there"* **(Social worker 4)**

> *"Assessment… then we introduce group therapy for such children who have as a result of abuse are living in shock and for that matter would not want to associate themselves with other people"* **(Social worker 2)**

The above statements suggest that assessment is the first step in the treatment role of social workers. Assessment helps them to understand the next step to take in the intervention process. Providing support and counselling was also identified as the role of social workers as demonstrated in the extracts below:

> *"I was her case manager, initially when I met the child, the child was in a bad state but with counselling and support, as time moved on, the child was improving, the child was being sent to physiotherapy, I have to be with her"* **(Social worker 5)**

Social workers also identified involving parents and families and notifying the children's school:

"If the person is in school prior to presenting the condition, what we do is to keep the school informed then we prepare parents for the support that teenager or the child would require after discharged from the hospital" **(Social worker 4)**

"*For those of them in the residential homes, we see to it that they are given a special care and then they are also mainstreamed with their family when they are treated, discharged or even in the residential homes being inside with their families"* **(Social worker 3)**

Social workers also stated that they help reintegrate children who have recovered back into their communities and follow-up on their progress.

"We also participate in discharge planning for those who are considered for admission and then finally after treatment we help in repatriation and reintegration of the patients" **(Social worker 4)**

"I did a follow-up, erm…I had to check how she was coping at home and in school, we always do that. Yeah, follow-up" **(Social worker 1)**

Interviews with social workers revealed that their role in treating children and adolescent with mental disorders include group therapy, rehabilitation, counselling and support. Here we see healing activities as highlighted in Kleinman's core adaptive tasks of the health care system. According to Kleinman (1978), the health care system's healing activities include all therapeutic interventions such as psychotherapy and supportive care. Social workers also identified working with families in admission and discharge plan and reintegration into their communities as the efficacy of clinical care. One of the six adaptive tasks of Kleinman (1978) is the management of a range of therapeutic outcomes, which includes a cure. Social workers assist in reintegrating children and adolescents who are fully recovered back into society.

The findings that social workers play a role in mental health care confirms previous research. For example, Allen (2014) submits that social workers role in mental health care delivery is vital. The author argues that social workers bring a unique social perspective to mental health by involving service users, their carers and their families. Teicher (1952) classifies the role of social workers into intake role, which suggests that social workers involve patients and their families in the treatment process and Continued service-role where the social worker helps the patients with admission and coping processes and with discharge and reintegration into their communities.

Religious healers on the other hand have a different approach to the treatment process as demonstrated in the extracts below:

Religious Healers

Herbs

When religious healers were asked about how they treat children and adolescents with mental disorders, some of traditional healers and Imams stated the use of medicines prepared from herbs as illustrated in the following extracts:

> *"If we realise the problem is not spiritual, herbal concoction is prepared for the child to drink"* **(Imam 4)**

Another participant added:

> *"We use leaves for herbal medicine for the mad person or the one suffering from the mental disorder and when they use the herbal medicine prepared by the traditional healer, the mad person gets cure"* **(TH 3)**

In the text above, again we see labelling. A tag to show a difference between 'Us' and 'Them'. Participants also identified the use of specific leaves in preparing herbal remedies. This is illustrated below:

> *if the person needs maybe a medicine, we have some leaves, but I don't know how we call it in English, the name is* ***'sidr'****. It's just a leave, so you'll prepare and mix it and be giving it to him. According to the prophet…when somebody is suffering from this type of sickness, it is advisable to prepare this native medicine* ***(sidr)*** *and give it to him"* **(Imam 1)**

> *"When someone becomes mad, it means that there is sore in his brain. So, we first and foremost shave the person bald, and we use* ***Mitsimitsi*** *(it is a common plant found in our homes or in the bush) grind it on a grinding stone and smear it all over the bald head. This herb helps killed the sore in his brain"* **(TH 3)**

in the statement above, we see an explanatory model that suggests shaving of hair and smearing herbs on the scalp to cure a perceived sore in the brain. This suggests that healers treat patients from a culturally constructed understanding of the cause of illness.

> *"I can mention the names of at least 5 trees to you, but I won't. (Laughs)…. I combine these herbs and then use them to cure sicknesses"* **(TH 1)**

> *"There are also leaves that we sometimes do burn in fire, so the smoke enters them with the help of the recitation of some verses of the Quran"* **(Imam 3)**

Based on the extracts above, it could be suggested that herbs are not just prepared for oral intake, they are also smeared on body parts and inhaled as well. Some other healers also suggested that there are cases where the affected child or adolescent must take their bath with the herbal mixtures. This is demonstrated below:

> *"There are herbs around which we normally give to the child. Some of the herbs are also used to bathe the child. Those who are unable to wash are given herbal medicine as well"* **(TH 4)**

> *"Some of the patients bath the herbs, others drink them and when the sickness is severe, I admit some of them here"* **(TH 1)**

Prayer and Counselling

Imams and Pastors reported that they use scriptural verses, prayers and counselling to treat children and adolescents with mental disorder. This is reflected in the extracts below:

> *"First, I recite…there are some verses in the Quran which our prophet Mohammed advise us to recite to a person who is suffering from this wizard or 'Jinn', so that's what I do"* **(Imam1)**

> *"…use scriptures, prayer and counselling… It's something that we do over and over and over until we see changes in them. We also follow-up and not just leaving them after the counselling"* **(Pastor 4)**

> *"What we do is, first of all we counsel them, we bring in the prophetic teachings and the words of the Quran. So that's what we do… we also pray for them"* **(Imam 3)**

> "*Specifically counselling and prayer. We counsel from the word of God. If the person needs health personnel or something, we give them too but when it comes to the spiritual side, we take the counselling side and the prayer because after counselling we pray for the person"* **(Pastor 2)**

The above statements indicate that healers intervene in mental health care from their understanding of the cause. For example, pastor 2 (above) indicates that the cause of a patient's mental disorder determines the treatment course.

In addition to using the scripture, praying and counselling, some of the pastors and Imam also indicated that they use other items like holy/anointing oil, honey, and water.

> *"We would say that pray for the person, lay hand on the person, sometimes put anointing oil on the person, you know, and then you cast out the demon"* **(Pastor 1)**

*"…So, I use **Zaitun**, (holy oil) to cure the person and **Sidr**... So, you will prepare it and then he would be taking some and he would use some to bath for 7 days"* **(Imam 1)**

*"Some of this problem has to do with the brain. I use **'Habbasauda'** (black seed oil) sometimes mix with honey to be given to the child every morning before meal, and there are also verses of the Quran which would be used, either recited or written for the child to recite every morning before speaking to anybody"* **(Imam 2)**

Confession

Two of the traditional healers reported that some of the treatment process involves confessions for the child or adolescent to get a total healing.

"Run back to the gods and confess and they can help to reverse what they are planning for you then we can do the cleansing ritual bath and the child will be healed completely" **(TH 2)**

"Maybe, the condition of a child is a result of the parent's offence in the past. If this happens to be the case, the parent is made to perform the necessary rites like confession for forgiveness before any medicine is given" **(TH 4)**

One of the participants indicated that for medicine to be administered, sometimes the patients must be restrained with rope or chain.

"They will bring someone with force and a lot of struggles, we have to tie him/her with rope or chain and forcefully give him some herbs to drink to calm him/her down. After the herbs has been given to him/her, he will sleep for a long time and when he/she finally wakes up, all that he/she askes for are food. After eating, he goes back to sleep. Sleeping enables sores to die in your brain. That was why we prefer sleeping herbs" **(TH 3)**

The perception presented above suggests that religious healers understand mental disorders as treated using herbal medicines. Kleinman (1978) submits in his adaptive tasks that healing activities include all therapeutic interventions such as diet, drugs and healing rituals. Therapeutic interventions indicated by participants include using herbal medicines for drinking, smearing on body parts, inhaling, bathing with and mixing with other natural products like water, honey and holy oil. These findings confirm previous research (Ovuga et al., 1999; Tabi et al., 2006). For example, Tabi et al. (2006) suggest that there are specific plants and roots that traditional healer in Ghana use to produce herbal medicines for treating mental illness. The submission by Bulbulia & Laher (2013) that Islamic healers use herbal remedies in treating illnesses also corresponds with this study's findings.

Here we see a case of loss of status and a power situation that permits such derogatory and stigmatising treatment.

The findings that religious healers use scriptural verses, prayer, counselling and items like oil in treating mental illness is consistent with the findings of previous research, which report using quotations from the scripture, counselling and prayers as well as natural products such as water, honey and Holy oil as practical means of treating persons with mental illness (K. Ae-Ngibise et al., 2010; Ali & Milstein, 2012; Ally & Laher, 2008). For example, Ally & Laher (2008) report that in treating mental illness, imams recite specific Qur'anic verses into natural products like water, honey, salt and olive oil before administering them to mentally ill persons. The authors argue that reciting the Qur'an regularly and correctly will facilitate recovery and prevent relapse. Similarly, Ali & Milstein (2012) submit that Imams conduct various religious activities such as prayer and counselling and provide religious guidance to their members. Counselling is also confirmed by previous studies (Ae-Ngibise et al., 2010; Mollica et al., 1986)

In this present study, one participant reported using restraining measures when working with mentally ill persons. This finding corresponds with a study by Green (1980), whose study reports that traditional healers use physical restraints for violent patients. Similarly, Adelekan et al. (2001) assert that some traditional healers beat mentally ill patients not as a form of treatment but as a means of getting them to comply with treatment.

Some of the religious healers interviewed in this present study indicated that an offender requires confession to facilitate recovery and ensure permanent healing. Confession is identified as an act to prevent relapse and ensure cure. This finding is consistent with previous studies (Ae-Ngibise et al., 2010; E. C. Green, 1980). For example, Green (1980) reports that where the cause of a mental disorder is due to evil intent or wickedness perpetrated by the patient, confession becomes necessary for complete healing (Ae-Ngibise et al., 2010; Green, 1980).

5.3.4 Referral Role

Some of the social workers work at the Psychiatric facilities and indicated that they work with other mental health practitioners. For example, social workers informed in this regard:

> *"Yes, we work in a team, we work with team comprising of a psychiatrist, a psychologist, occupational therapist, we have the lab techs, we have the pharmacists and the nurses that takes care of the patients in the wards. So, though I'm a social worker at the department of social works, I am considered at the psychiatric hospital practicing psychiatric social work"* **(Social worker 4)**

> *"Yes, I am a psychiatric social worker, psychiatric nurses are there, a doctor and psychologists they are part of the team and I work with them at the facilities"* **(Social worker 3)**

The other social workers interviewed indicated that they refer to other health practitioners as illustrated below:

"Yes, we do because most of the cases I worked on especially the child with the multiple disability like this, we have to collaborate with the health practitioners, especially those who were in charge of the physiotherapy" **(Social worker 5)**

"So, in our case, we do a lot of referrals to the clinicians to continue from where we have assessed or analysed the situation" **(Social worker 2)**

In addition to playing diagnostic and treatment roles, some of the religious healers indicated that they refer patients to other practitioners as demonstrated in the extracts below:

"Do we refer to doctors? I'll say yes. You have to take the person to the hospital for check-ups and see if there's an improvement in his or her body or in the brain. When we cure the person to a point and the person shows signs of normality, you have to take him to the hospital for check-up". **(TH 3**)

"We collaborate with them. Even, they are the first people that we consult before we bring our side because we believe that it's not everything that is spiritual, so we have the physical side and the spiritual side" **(Pastor 2)**

Another participant further elaborated that some patients do not have faith in biomedical treatment and refuse to go to the hospital when they are referred.

"I have referred at least 3 people to hospitals today. When this happens, most of them refuse to go because they don't have faith in western medicine" **(TH 1)**

Another participant a pastor indicated that medical professionals sometimes refer patients to them

"Definitely. We have counsellors in the church, we have people in those intuitions. We have psychiatrists. You just know that this one is somebody that needs a real professional to talk to. Though we pray for the person, but when there is a need for a psychiatrist to speak to the person, we'll definitely do that. But sometimes the psychiatrists refer them to us because they realize that this is not…" (PS 3)

The above statements suggest that some traditional healers and pastors refer patients to biomedical practitioners after they have done their part of the treatment. This shows an interaction between the folk arena and the professional arena. Practitioners in the folk arena understand certain mental illness to be biological and out of their intervention zone hence to refer to those in the professional arena when they encounter such cases.

However, the following extracts indicate that some religious healers do not refer patients to biomedical practitioners.

*"I have people who help me… there are other priests and herbalists just like me***" (TH4)**

"My grandfather gave me what I was supposed to have but I have people I also talk to, I have elders, I ask for help from them…I send some to my senior brother. He is a priest to" **(TH 2)**

"No, no! we don't because some of the imams only provide their support or help. There are some who are spiritual healers who we go to. Me I do it. But most of the imams, it's not their job but when they bring the complaint, they'll say ok fine, we'll also help you in prayers but maybe they'll write something for the child to be taking for some time, but they don't refer to any other mental health practitioners" (Imam 3)

"Personally, I am very good with herbs they work very well so, I don't have a reason to refer people anywhere. I can ask my seniors but not outside my faith" (Imam 2)

Based on the above perspectives, we can suggest that not everyone in the folk arena refer patients to the professional arena. A healer's EM determines his or her line of action. Most practitioners in the folk arena refer to only professionals in the folk arena

Two religious leaders reported that they also get patients referred to them by medical practitioners or invited to the hospital to pray with them. This is demonstrated in the extracts below

"Sometimes too they also recommend that we should come in because they've tried their best and it's like there is more to what they are doing" **(Pastor 2)**

"I'll say that being a pastor, we have been the last call so after they've gone to the psychiatric hospital with all the drugs and the depression and everything and wanting to be suicidal, they come to us and then they find purpose" **(Pastor 3)**

The current study findings reveal that social workers refer children and adolescents with mental disorder to biomedical or mental health professionals. Here we see a case of referral within the professional arena. Biomedical professionals share similar EMs different from EMs of practitioners in the folk arena; hence referral from the professional arena to the folk arena is unlikely.

This finding corresponds to the submission of Teicher (1952) that social workers are found in psychiatric settings where they work collaboratively with other mental health professionals to provide support to persons with mental illness. Aviram (2002) argues that psychiatric social workers provide aftercare to discharged patients through follow-up visits.

Religious healers report on referral indicate that some religious healers refer patients to biomedical professionals. This finding is similar to the findings of Ovuga et al. (1999) that suggest that while some traditional healers referred patients to local hospitals, others refer to other traditional healers. Similarly, Mollica et al. (1986) report that pastoral counsellors referred individuals with mental health problems to mental health professionals, while Frontus

(2015) suggests that clergy make referrals when the mental health issue is very severe and need professional care.

Some participants interviewed reported that they do not refer patients to other healers. This report is consistent with Adelekan et al. (2001) findings that most traditional priests from their study reveal that they refer patients to other traditional healersAlthough social workers in this study did not indicate that they refer patients to practitioners in the folk arena, the above extracts suggest that practitioners in the folk arena receive patients from the professional arena.

5.4 Success and challenges in working with children and adolescents with mental disorders

All participants indicated that they have had positive outcomes and challenges in working with children and adolescents with mental disorder. Below, I present my findings and discuss the results.

5.4.1 Successes chalked in working with children and adolescents with mental disorders

All participants reported that they have recorded positive outcome working with children and adolescents with mental disorder. This is illustrated in the extracts below:

> *"I was her case manager, initially when I met the child the child was in a bad state but with counselling and support, as time moved on, the child was improving, the child was being sent to physiotherapy, I have to be with her. and so, when you see the child, you can see improvement… those are some of the things when you see, gladdens your heart that you did a good work and made the right recommendations"* **(Social Worker 5)**

> *"When it comes to the successes of it, we thank God most of the cases that we've encountered, the Lord has given us testimonies. They come back and give us positive results that now everything is stable"* **(Pastor 2)**

One of the traditional healers elaborated that he had healed young people of mental disorder in a few days of treating them. He informs thus:

> *"I am not bragging I have healed a lot of young people. I always say that when you come to me, when you are a man, I will give you only three days and for a woman it is 4 days. Assuming you have the sickness for a long time at 2 to 3 years, when you are a woman, I'll give you four days and if you're not fully healed, I'll extend the days to 16 days. Within those 4 to 16 days, you will be fully healed or cured and be strong again. The same applies to men"* **(TH 3)**

Another participant added:

> *"I always want to do this work…it has helped a lot of children too. I have been successful in most of the things that I have been doing especially when it comes to the*

spiritual side because we believe there is a solution to every problem in the Qur'an" **(Imam 4)**

Based on the extracts above, it can be suggested that practitioners believed in the potency of their methods of treatment.

5.4.2 Challenges encountered in working with children and adolescents with mental disorders

Although all the participants reported that they have been successful in treating children and adolescents with mental disorders, they all also added that they have encountered challenges working with CAMHD. This is demonstrated in the extracts below:

> *"The challenges have been…it's been tough when you are the only person trying to help the child out, when the parents are not part of the process, when there's no second party, you are the only party in the process, it's very difficult because two witnesses are needed to establish a matter"* **(Pastor 3)**

> *"I'll start with the challenges. You may have children as I earlier mentioned, who may not really understand what is going on. Some still live in denial, so in cases of children, it's kind of difficult"* **(Social worker 2)**

Some of the participants added that they sometime have encounter with the perpetrator. This is outlined below:

> *"Yes, when it is a curse, that one is difficult. Yeah, yeah, it takes me a bit more than two months before they recover. So sometimes, I do go to the person who did that to them"* **(Imam 1)**

> *"The challenges are many. When the person responsible for the ailment of the child is doing it spiritually, I have to go and have a spiritual encounter with him or her. Sometimes too, I have to walk very late in the night to fetch the herbs that will be used to cure the ailment. After all of these, most of the children refuse to take the herbs when given to them"* **(TH 4)**

The findings that participants reported successful treatment outcomes in treating children and adolescents with mental disorders correspond with earlier literature (Ally & Laher, 2008; Mufamadi, 2001). For example, in her study, Mufamadi (2001) found that most traditional healers in her study claim 100% success in treating persons with mental illness. Ally & Laher argues that Muslim faith healers believe that their treatments of spiritual illnesses are successful as they follow the teachings of the Prophet and adhere to the principles of the Qur'an. They submit that with daily prayers and recitation of prescribed Qur'anic verses, a patient can receive total healing.

On the contrary, none of the earlier literature reviewed included challenges faced by practitioners. This could be because these studies focus more on the roles and cause healers attribute to mental disorder than their challenges in treating mental disorder. However, the report by Adelekan et al. (2001) that healers in their study reported that patients who do not comply with treatment are beaten signifies that non-compliant to treatment is a challenge (as indicated above by TH 4), and beating was a measure the traditional healers in that study adapted to fix that challenge.

In the next section, I present findings and discuss results on stigma and discrimination toward children and adolescents with mental disorders

5.5 Stigma and Discrimination of Children and Adolescents due to Mental Disorders

Six subthemes about stigma and discrimination of children and adolescents with mental disorders emerged from the data of this study. They are: 1) stigma as a barrier to help-seeking, 2) stigma as a source of labelling, 3) stigma as a barrier to social interaction, 4) stigma as a source of parental abandonment, 5) stigma as a barrier to marriage, 6) stigma as a source of discrimination. Each of these subthemes are discussed below.

5.5.1 Stigma as a Barrier to Help-Seeking

Participants in the study report that children and adolescents find it difficult to seek help due to stigma associated with mental illnesses. This is demonstrated in the extracts below:

> *"But the kind of society we live in makes it very difficult for them to accept because they know that if they should say that I acknowledge that my head has been aching continuously and I've been talking whilst I'm asleep or I'm awake, then people would brand them. So, they would live in the face of denial. Even if it is clear, they'll tell you that they are not suffering such abuse"* **(Social worker 2)**

> *"And it's so strong that it affects individuals who access mental health services and so most of the people want to be seen privately or visiting the hospital late because they would not want people to know that they have the condition. That's the level of discrimination and the level of stigma we have against mental health in this country*" **(Social worker 4)**

Based on the above statement, we can suggest that persons with mental illness hide their condition for fear of being rejected or discriminated against. Below, another participant indicated that stigma could prevent people from seeking help and push people to commit suicide:

> *"You know it can deter people from seeking help and it can even… you know if I'm not seeking any help and I'm sitting quietly, no problem but it can also make or push me do other things. Probable commit suicide"* **(Pastor 1)**

Based on the above extract, it can be suggested that children and adolescents internalise the stigma and become isolated leading to suicidal thoughts.

5.5.2 Stigma as a Source of Labelling

Participants reported that children and adolescent with mental disorder are sometimes identified by derogatory names or names that is perceived to be their source of illness. This is demonstrated below***:***

> *"One of the ways that they are stigmatized is labelling, you know. They use certain terms on them…so they'll say* ***bɔdam foɔ wei****, (a mad person)* ***abɔdam foɔ****...you know, yes…you know, it's not right even if the person is"* **(Social worker 2)**

> "*Babɔne, (stubborn)…AKOLA bɔne (stubborn child). For people who suffer from conduct disorder or ADHD, often. they use terms like…you are labelling, you're making the person even feel worse off than they already are"* **(Social worker 2)**

> *"I will say a lot of people don't go close to them. Some people say they are spirits child, they are* ***maame*** *water child (mermaid child), they are whatever so with that most people don't go close to them"* **(TH 2)**

> *"It's just like people who have sickle cell. As a nation most of us would say "****yarefoɔ****" I mean "sicklers" (persons with sickle cell anaemia) but we use it to demean the person "****woye yarefoɔ****" 'he is a sickler' and that also affect them"* **(Pastor 1)**

> *"People make fun of them which is very bad. The name calling is also another problem. All of these kill their spirits. When this happens, the child does not feel happy around other children"* **(Imam 4)**

In the above statements we see the use of labels and tags to refer to children and adolescents with mental disorders as identified by participants.

5.5.3 Stigma as a Barrier to Social Interaction

Participants in this study reported that due to stigma associated with mental illness, children and adolescents with mental disorder are largely avoided. This is illustrated in the extracts below:

> *"That's why I said that we have wrong misconception about mental illness to the extent that some adults think that they can be transferred. For instance, if somebody sees a friend's child going through any form of mental illness, if they are not well sensitised, they may refrain or stop their children from having any social contact with such children but then if we understand that it can happen to anyone and it's not transferrable"* **(Social worker 2)**

> *"Society itself, immediately they get to know that people or some individuals have such conditions, kind of shun away from them, do not want to socialize with them, do not want their children to socialize with such people"* **(Social worker 4)**

Based on the extracts above, participants identified instances where demarcations are created due to stigma and discrimination.

Other participants indicated that a child's mental disorder affects his patents as well:

> *"When people discriminate against these children, it mostly affects their mothers too. Some even cry because of that"* **(TH4)**

> *"It is very disheartening to see your child being sacked or prevented from associating with people. Some people even tell their children not to play with such a kid because he or she is a child from a water deity. This really affects the parents of these children"* ***(TH 4)***

5.5.4 Stigma as a source of parental abandonment

In this section, some participants reported that parents go as far as abandoning their children due to the stigma associated with mental illness

> *"The parents are the main cause. No parents would like to have his or her child except those in the same family and even in the same family they sometimes throw them away, they sometimes don't like them coming close to them"* (TH 2)

> *"The level of stigma in our part of the world is so strong that some people when they have children with these conditions will prefer keeping them in an institution and kind of leaving them for the institution to manage, then they'll take their hands off it. Few people brought their children and, in the end, abandoned them and it's a major challenge to the facility"* (Social worker 4)

> *"Most times when they give birth to them when they are young, most parents it's either he or she they are going to plan to kill the child, they are going to throw the child somewhere, they are going to do any harm to the child"* (TH2)

From the statements above, we see loss of status. Children and adolescents with mental illness lose their status even in their homes. Children and adolescents with mental disorders are associated with undesirable characteristics that lead to loss of status in the eyes of their stigmatisers, in this case, family members.

5.5.5 Stigma as a Barrier to Marriage

One participant identified that due to the stigma associated with mental illness, young people with mental illness are unable to find a marriage partner.

> *"Here when you are with those who are old, those who are the elders, the adolescent and can be able to get married, they don't get the chance to even marry because who*

is going close to take them. Everyone is afraid to go. Most people think they can use their spirits against them" **(TH 2)**

5.5.6 Stigma as a Source of Discrimination

Some participants reported that children and adolescents with mental disorders face a lot of discrimination both at home and outside the home as demonstrated below:

> *"As for the discrimination it's for real, it's there. Even parents do discriminate. If it happens to be that the child is even among those who are mentally stable, and one happens to be…you can see it when you even visit the family"* **(Social worker 5)**

> *"Some tribes believe that maybe the child is a child of the devil or something like that. No! as we are living in this life anything can happen. You know sometimes accidents can happen and it can affect the child. This stigma has made a lot of people to neglect so many children. Even in our schools, we see a child that is not performing to maximum, they just neglect the child and say all kinds of things, as for you you'll not amount to anything, you are doing this and that"* **(Pastor 2)**

The findings from this present study that children and adolescents are labelled as a result of their mental disorder corroborate with earlier literature. For example, Corrigan (2004) argues that labelling puts people in harm's way. The author explains that stigma, stereotype, and prejudice can make life difficult for publicly labelled mentally ill people as they may be denied privileges that would enable them to live a fulfilled life. Rüsch et al. (2005) suggest that when people are referred to by their mental illness, it creates a gap between people with mental illness and people without mental illness.

Participants in this study believe that stigma results in various challenges for children and adolescents with a mental disorder. This finding is consistent with previous studies (Avoke, 2002; Baffoe, 2013; Link & Phelan, 2001). For example, Avoke (2002) found several reasons why people suffer stigma. Superstitions, ignorance, lack of knowledge and empathy, old belief system and the tendency to exclude people with the perception that they are different are all factors that lead to stigmatising people. Goffman (1963) argues that stigma is an attribute that is deeply discrediting. A is a mark of shame and degradation that singles a person out from others (Byrne, 2000), leading to loss of status (Link & Phelan, 2001). The stigma and discrimination that children and adolescents face, for example (labelling) resulting from their mental disorder, push them to the edge, causing more damage than the conditions (Thornicroft et al., 2016). According to Baffoe (2013), stigma hinders people from living a productive life due to the stereotype, fear, shame and social exclusion that comes with it. Letamo (2005) argues that stigmatised people suffer discrimination due to the perception that they belong to another group, leading to their exclusion from participating in society.

This current study findings that stigma and discrimination hinder children and adolescents from seeking help for their illness confirms previous studies. For example, Baffoe (2013) argues that people who suffer discrimination due to stigma cannot seek help as they develop feelings of shame and hopelessness. Similar to the findings of this present study, previous studies have demonstrated that parents of children with mental illness also suffer stigma due to their children's illness (Larson & Corrigan, 2008). Parents develop a feeling of shame as a result of their children's illness. The perception that people with mental illness are dangerous (McDaid, 2008) and their illness are transferrable (Dako-Gyeke & Asumang, 2013) are why people stigmatise and discriminate against people with mental illness. Dako-Gyeke & Asumang (2013) found in their study in Ghana that misconception of mental illness robs sufferers of meaningful relationships because they believe that mental illness is contagious or transferrable. Participants from the present study also indicated that stigma causes a separation of 'Us' from 'Them'. That is the separation of those considered 'normal' from the stigmatised group. Link & Phelan (2001) suggest that people with mental illness are perceived as different. When children and adolescents are stigmatised as a result of mental disorder, they are worthless in the eyes of their stigmatisers (Link & Phelan, 2001). Here we see the fear of being tagged as 'Them' as Link & Phelan (2001) identified in their theory of stigma.
Above, I have presented participant's views of how children and adolescents with mental disorders suffer stigma and discrimination. In the next and final section, I present findings and discuss results on how to combat stigma and discriminations related to CAMHD in GHana.

5.6 Ways to manage stigma partaining to CAMHD in Ghana

while all the study participants reported that children and adolescents with mental disorder suffer so much stigmatisation in Ghana, they also indicated that several measure can be adopted to end stigma towards persons with mental disorders. Participants suggested measures like awareness creation and sensitisation through education, encouraging contact with persons with mental disorders, and implementing and enacting laws that discourage stigmatisation.
Some participants informed in this regard:

> *"Well for a family whose child is going through or undergoing any form of mental illness, such families have to be sensitized for them to understand or to know that this is what would usually come out of such abuses. And when it does occur, you do not blame the victim, or you do not brand the victim or isolate them. So, if close family members are educated or sensitized then they'll also serve as agents of change"* **(Social worker 1)**

> *"Awareness raising can be done at so many levels, you can either meet people one on one, you can also engage with groups, you can also engage with traditional leaders, teachers, government, you can also ensure that if there are any laws against stigmatization, advocate for such laws to be enforced"* **(Social worker 2)**

Based on the above extract, we can suggest that participants believe that collaborating with families and different sectors of society can reduce stigma towards children and adolescents with mental disorder. Two other participants added that the enactment of stringent laws towards the discrimination and stigmatisation of persons with mental disorder will help combat stigma and discrimination. They stated thus:

> *"And the eerm… find ways to make laws. Like to say, it's a crime or it's against the law, then the law must be enforced. Punish people who will engage in this discriminating and stigmatizing of people. That would deter others…pastors too should not be above the law"* **(Pastor 1)**

> *"Laws that are punitive enough and ensuring that they enforce it. It shouldn't just be in the books relaxing somewhere on the shelves. We should see it working. It's a different thing enacting a law and not making it or not enforcing it. If you should enact it and ensure that its punitive enough and go to the extent of enforcing it so that it'll be deterrent enough for people not to attempt engaging in such acts"* **(social worker 4)**

Other participants indicated that contact with persons with mental illness on its own is a therapy. This is illustrated in the extracts below:

> *"What I do is that I try to integrate the children with others… I ask them to go and seat with another child. By doing so, they don't have a choice. It helps the children a lot"* **(Imam 3)**

> *"What we do is, someone like me, when I go to a town… there I enjoy being with them. You see me walking with the person we will be talking like I know him more than years and I will be free with the person, and I will let the people know that this person is normal"* **(TH 2)**

> *"Be close to him so that he would feel comfortable, and he would know that at least people are not running away from me…So the person would feel something in his heart. That is, you are putting smile on his face, and you are letting him know that he is somebody"* **(Imam 1)**

> *"You see, welcoming people and giving them that warm kind of reception is healing in itself. When you accept them, you make them to know that they also matter, they are part of society"* **(Pastor 2)**

The current study findings that creating awareness, enforcement of law and having personal contact with children and adolescents with a mental disorder can reduce stigma confirms previous research (P. W. Corrigan & Watson, 2002; Pinfold et al., 2003; Rüsch et al., 2005). For example, Rüsch et al. (2005) suggest that different consumer groups employ several strategies around the globe in their effort to combat stigma against persons with mental disorders. Educating the public can be done through the provision of information to enable the

public to make an informed decision (P. W. Corrigan & Watson, 2002). Information on mental disorders that contradict unprovoked or inexcusable fear can be disseminated to create awareness (Public Health Agency of Sweden, 2019). A study in the UK found that stigma on mentally ill student reduced in UK secondary schools with personal contact and education. Reports of the participants in the current study suggest that if children are placed to do activities with children with a mental disorder, it may reduce stigma. When children cooperate and interact, it offers an opportunity to bridge the 'Us' from 'Them' gap between sufferers and those likely to stigmatise them.

In this chapter, I have presented the demographics of the study participants; I have also presented the study finding and discussed results on interventions of practitioners in CAMH care in Ghana under six themes: perceived causes of CAMHD in Ghana, types of mental disorders children face in Ghana, the role of practitioners in the treatment of CAMHD in Ghana, successes and challenges in working with children and adolescents with mental disorders, stigma and discrimination on mental disorders, and suggested ways to curb stigma and discrimination towards children and adolescents with mental disorders. In all, participants reported their perception of the causes of CAMHD and the methods of treatment they apply in treating CAMHD. Participants also reported their challenges and successes and stigma towards children and adolescents with mental disorders and ways to curb stigma associated with CAMHD. This chapter has thrown light on practitioners' perspectives on causes, treatments and stigma issues in CAMH in Ghana.
In the next chapter, I discuss the conclusion of my findings make

CHAPTER SIX

Conclusion and Recommendation

This chapter concludes the report of the present study. In this chapter, I draw a conclusion from the study and discuss recommendations for future research.

6.1 Conclusion

This study was conducted with an interpretivist approach. The interpretivist position helped the researcher interpret how the different practitioners involved in this study make sense of their experiences working with children and adolescents with mental disorders. The findings of this study reveal that social workers relied on scientific understanding of the causation and treatment of mental disorders in children and adolescents, and the religious healers understanding is based mainly on cultural contexts and their religious beliefs. While all practitioners in this study mentioned biological and psychosocial such as genetic and hereditary, drug use, peer pressure, environment and family structure and socioeconomic background, the religious healers added that supernatural factors are the primary cause of children's and adolescents' mental disorders. Religious healers listed supernatural factors such as spiritual and demonic attack, witchcraft, curses and taboo violations.

With the types of mental disorders encountered in working with children and adolescents, social workers mentioned the names of the disorders that children suffer. Some of the pastors, too, were able to identify some of the disorders by name. However, most of the religious healers considered behaviours such as strange behaviour, stubbornness, truancy, isolation, self-conflict and symptoms such as looks, distorted speech, size of the head, salivary mouth, weakness. Religious healers believe that children with mental illness will manifest various physical and psychological signs and symptoms. With such belief, religious healers may miss out on specific mental disorders that do not present with behavioural manifestations.

The present study also revealed that social workers conducted a psychosocial assessment before diagnosing a child of mental disorder. Social workers also work hand in hand with other mental health professionals to treat children and adolescents with mental illness. Social workers stated that they are involved with mental health care delivery from the admission phase, working with clients and their family, through to the discharge and reintegration phase. Social workers in this study indicated that they continue with follow-up after reintegration to help patient and their family to avoid relapse. On the other hand, religious healers diagnosed using different means such as consulting gods, behaviour observation, listening and revelation from the gods or ancestors. For treatment, religious healers' method is influenced mainly by their religious faith. Traditional healers mostly heal using herbal remedies while performing rituals like bathing, cleansing, inhalation and smearing of herbs on body parts. Pastors and Imams base their treatment on prayers and scriptures; however, the Imams also mentioned the use of herbal remedies in addition to prayers and scriptural verses, and pastors included

counselling and deliverance, which amounts to exorcism in healing children with mental health disorders.

It was also evident that social workers do not refer patients to religious healers. However, religious healers report referring patients to health professionals depending on the cause of the illness. Where they perceive that the cause of the illness is multiple, that is, supernatural and biomedical, religious healer claim to finish with the spiritual healing before they refer the child to a mental health professional.

Although both groups of professionals admit to several challenges in working with CAMHD, they all claim to have massive success with treatment. Most healers claim 100% success with their treatment, but some did not rate their success.

This study finally reveals that stigmatisation and discrimination of persons with mental health disorder are very high in Ghana. Even among the religious healers, there is frequent and high use of derogatory terms in their description, placing a label on persons with mental illness. Healers may use these terms without the intention of stigmatising children and adolescents with a mental disorder; thus, the attention of healers must be drawn to it.

6.2 Implication for Policy and Social Work Practice

The findings of this study carry several implications for social work practice, religious healers and policymakers. Regarding religious healers, healers need to understand that to treat a mental disorder, effective diagnoses of the conditions are crucial. Even with observation and consultations of spirits and gods, the patient's history should be taken, and proper assessment done before diagnosing a mental disorder. Regarding this, most healers have governing bodies and could, through those governing bodies, push for training in the use of the diagnostic manuals like the DSM-V and DCI-10.

Social workers and religious healers form an ally to advocate for the rights of children and adolescents with mental health disorders and their families and use their different platforms or work collaboratively to end the stigma and discrimination of children with mental disorders and their families. This campaign or advocacy can start with the professionals providing training to the religious healers on the effects of labelling.

There is a lot to be done on policy in mental health care in Ghana. First, policymakers should make an effort to raise the status of mental health care in Ghana through the allocation of resources for equipping the already existing mental health facilities, train personnel and increase the priority in matters concerning mental health care. Also, prioritise children and adolescent mental health by allocating resources towards a mental health facility dedicated to children and adolescents to promote easy access and utilisation of services.

Also, policymakers should make an effort to foster collaboration between professional mental health practitioners and religious healers. Collaboration between the practitioners is vital to facilitate training of the alternative care providers, in this case, religious healers. Policymakers in a similar vein should recognise religious healers in Ghana regardless of their location. Registering the healers under one broad umbrella will help regulate their activities and monitor human rights issues.

6.3 Recommendation for Further Research

The present study was undertaken to explore and describe the involvement of social workers and religious healers in CAMH care. However, it lacks the component of accessibility and utilisation of service, which can also impact the wellbeing of children and adolescents with mental disorders and their families. Hence, further studies should be conducted on barriers to accessing child and adolescent mental health care in Ghana to determine the ease or difficulty of accessing mental health care in Ghana. Studies targeting barriers such as socioeconomic background and stigmatisation should be conducted to create further awareness of the needs of children and adolescents with mental disorders and their families.

Further research should also be conducted on caregivers' treatment choice in CAMH among African migrant families in Sweden. The study should aim to understand if context impacts treatment choice and how help is sort for African migrants' children with mental disorders.

In conclusion, although the population studied was small compared to the range of mental disorders that children and adolescents face, the findings of this study, in my opinion, is rich and informative on the availability of diverse medical systems (medical pluralism) in Ghana. The study also reveals that socially and culturally learned experiences shape people's explanation of illness and health, and different practitioners understood and interpreted mental disorders differently but have an overall aim of restoring the wellbeing of children and their families.

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INTERVIEW GUIDE

Interview guide for social workers, religious leaders and indigenous traditional priests

This study set out to explore the involvement of social workers and religious and traditional healers in Child and Adolescent Mental Health (CAMH) in Ghana. I would be grateful if you could respond to the Questions by sparing some minutes of your time.

Your responses will be treated with absolute confidentiality since this study will be used purely for academic purpose only.

A. Background information

- Sex
- Age
- Education
- Religion
- Profession
- Employment Status

B. Explore social workers, and religious leaders' views on the causes of CAMH in Ghana.

1. Having worked in this area, in your opinion what do you think are causes of Child and adolescent mental disorder in Ghana?
2. What are some of the factors that contribute to the cause of child and adolescent mental orders in Ghana?
3. How do you work with children and adolescents to manage these causes?

C. The role of social workers and religious leaders in the treatment and management of CAMH problems in Ghana.

4. How has it been working with children and adolescents with mental health problem?
5. What are some of the disorders children and adolescents face?
6. What specific role do you play in the treatment and management of CAMH disorders?

7. What are your successes and challenges in working with children and adolescents with mental disorders?
8. Is there any collaboration with other child and adolescent mental health practitioners? What is the nature of the collaboration?

D. Perspectives of social workers and religious leaders about stigma and discrimination in relation to CAMH in Ghana.

1. What is your view of stigma and discrimination in relation to child and adolescent mental disorder?
2. What is the best way of dealing with stigma that relates to CAMH in Ghana?

Finally, is there anything you want to add that I have not asked about, that you think is important for me to know on this topic?

Thank you.

CONSENT FORM

GOTHENBURG UNIVERSITY, SWEDEN

DEPARTMENT OF SOCIAL WORK

The researcher (**Queensley Joy Idanwekhai**) is a Master student at the social work department of Gothenburg University, conducting a study on the topic, **"Child and Adolescent Mental Health Intervention: Perspectives of Social Workers and Religious Healers in Ghana"**, as part of her fulfilment of the requirement of the master's Degree.

In the researcher's bid to honour the ethical requirements of the study, participants have been assured of the following ethical issues:

Informed consent

The researcher introduced herself and her intention of conducting the study to participants before they agreed to participate in the study. The researcher has informed the participants that the data is solely for academic purpose, and that the data obtained would not be shared with a third party or used for any other purpose other than academic. The researcher also informed participants that the data collected will enable the international community understanding their roles in child and adolescent mental health intervention in Ghana and pose no risk to them.

Voluntary participation

The researcher has made it known to the participants that they are free to engage in the study on their willingness without any form of coercion. They have also been informed about their freewill to decide at any time to discontinue from the study.

Self-determination of participation

The researcher has reassured participants of their freewill to respond to questions asked during interviews based on their own intellect and experience without being influenced by the researcher's biases. Also, they have been encouraged to share their ideas based on their candour with no coercion from the researcher.

Anonymity and confidentiality

Participants have also been reassured of that their anonymity and confidentiality will be protected in the presentation of findings in the study. This will be ensured by detaching the names and other identifying attributes to information provided by the participants.

Furthermore, participants have been assured that pseudonyms will be used in place of their names in presenting quotations from the information obtained from them.

Voice recording

In order to facilitate the interview section and data collection, the interviews were recorded using a voice recorder, after permission was sought from participants of the study. These would be destroyed after the thesis has been examined.

Thank you.

…….

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..…….

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…….

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