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A Retrospective Studyof Treatment-Seeking Behaviours of Persons Living with Mental Illness and Their Families: A Focus On Rural Ghana

Emmanuel Kobla Kaledzi[1]
Old Town Health Centre, Akim Oda, Ghana

Mustapha Karikari[1+]
Ulster University- Londonderry, United Kingdom

Victor Adeleke[1,2]
Phoenix Care Centre, Dublin- Republic of Ireland

Akunna Jane Okafor[1,3]
Phoenix Care Centre, Dublin- Republic of Ireland

Emmanuel Darko[1,3]
Elysium Health Care, United Kingdom

Lawrence Asamoah[2,3]
Cygnet Health Care, United Kingdom

Emma Sename Baxey[1,2]
South London and Maudsley NHS Foundation Trust, United Kingdom

Ebenezer Asamoah[1,3]
Cygnet Health Care, United Kingdom

ABSTRACT
Background: *The process to seek for support by persons living with mental healthchallenges may determine how and where they receive the needed treatment and be provided with the required level of care and supervision to improve their mental health state and overall quality of life.*
Objective*: The study intends to explore the treatment-seeking behaviors of persons living with mental illness and the factors that inform their preference for specific treatment forms.*

Methods: *A retrospective review of patients' records was conducted to better appreciate their treatment history. A total of 302 patients' records were reviewed and the data was analyzed descriptively. The data for this study was gathered from both primary and secondary sources. The primary data involved conducting a field survey on the perceived causes of mental illnesses in selected communities in the Birirm Municipality in the Eastern region of Ghana. A questionnaire on perceived causes of mental illness and treatment-seeking behaviors was used to solicit information from participants. Additionally, secondarydata on the subject matter, spanning a five-year*

period (2017 to 2021) were retrieved from the Records Departments of the respective health facilities of the selected communities within the Municipality.

Result: *Whilesthe respondents acknowledged that mental illness may be familial, the study identified 'witchcraft and evil people' as the perceived cause(s) of mental illness by respondents and this informs their treatment preferences. Religious centers such as prayer camps, churches, and shrines as well as traditional healers, pastors and witch doctors were their first point of call for the treatment of their ailments. Interestingly, these decisions to seek support from these areas are mostly initiated by family members and further reinforced by the people they seek support from as indicated above. In furtherance, demographic variables such as gender, age, educational level, marital status, occupation, and monthly income were factors that informed treatment- seeking behaviours by persons living with mental illness in these communities.*

Conclusion: *Public sensitization, awareness creation as well as intensive public mental health education will be required to demystify the causes and treatment forms of mental illnesses and encourage the public to seek treatment from mental health professionals.*

Keywords: *Mental illness, Psychiatric treatment, Perceived causes of mental illness, Medication non-compliance, Relapse, Misconceptions, Behavior change.*

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I. INTRODUCTION

Background

The World Health Organization (2017) underscores that mental health should not be reduced to the mere existence of any symptom or sign of a disease. However, mental health issues are stigmatized and frequently kept secret in many developing nations, including Ghana (Ahmad et al., 2015).Over the past few decades, developed nations like Europe and America have felt pressure to increase access to and utilization of mental health care (MHC) services as a means of promoting good health (Naslund et al., 2016). Increasing public awareness of the nature, dynamics, and treatments of mental disorders was one of many ways to do this (Angermeyer et al., 2013). The reason is that people's decisions to use MHC for family members who are suffering from mental health issues are influenced by their knowledge, perceptions, and beliefs about the causes and treatments of such illnesses. This is especially true of primary caregivers, who are typically family members (Dresler et al., 2019).The World Health Organization estimates that 25% of people globally may at some point in their lives encounter mental, behavioral, and neurological problems such schizophrenia, mental retardation, alcohol and drug abuse, dementias, stress-related disorders, and epilepsy (Javadi, Feldhaus, Mancuso & Ghaffar, 2017).

It is significant to recognize that people with mental illness and their families confront a variety of difficulties, including stigma, human rights abuses, social exclusion and isolation, and discrimination, to name a few (Jakobsen et al., 2020). When caring for mentally ill family members, caregivers can face physical, emotional, and financial difficulties. In other cases, they are troubled by the lack of support from other family members, friends, and society at large, and they feel anxious and guilty about the state of their relatives (Adu-Gyamfi, 2017). Roberts et al (2014), the knowledge and interpretation of the causes (etiology) and treatments of relatives' diseases are social constructs, and they differ depending on the society (Choudhry et al., 2016). The causes of mental diseases were attributed to social factors including drug and alcohol abuse and other traumatic experiences in Canada and among Hispanic immigrants in the USA (Arias et al., 2016; Jones et al.,2011).People's perceptions of what caused their relatives' ailments always have an impact on how aggressively they seek therapy (Girma &Tesafe, 2011; Okello & Neema, 2007). Conventional medicine is thought to be used to treat stress-related mental health issues (Naem et al.,2012). Hospitalization for medical treatment was shown to be the best treatment option for patients with mental health disorders (Kolstad and Gjesvik2014; Van der Ham et al.,2011).

In developing nations, mostly in Africa understanding about the origins of mental illness that are heavily influenced by superstitious beliefs. For instance, mental diseases were linked to supernatural causes in Malawi and Uganda (Crabb et al., 2012; Modie-Moroka, 2016). These include curses brought on by resentment or wrongs committed against someone, as well as punishment from God or other deities. Additionally, some Ethiopian community members believed that mental diseases were mostly caused by extraterrestrial influences, such as the possession of bad spirits (such as witchcraft) (Teferra &Shibre, 2012). In addition, some Nigerians attribute mental diseases to spiritual problems like witchcraft and other demonic spirits (Adewuya&Makanjuola, 2008; Read & Doku, 2012).Like other African nations, Ghana has a general understanding of mental illness and the factors

that contribute to it. Due to its underlying foundations in prevailing cultural ideas, traditions, and behaviors, its explanation and interpretation points to supernatural influences (Dixon, 2012).

Therefore, mental illness has typically been linked to witchcraft (Ofori Atta et al.,2010; Read, Adiibokah, & Nyame, 2009). Cultural beliefs that dictate the kind of treatment pattern to be used, whether official (medical) or informal (non-medical), are a big part of how mental illness is explained in the African culture (Muga & Jenkins, 2008). Most caregivers in Ghana respond to mental illness using prevailing cultural customs (Read, Adiibokah, & Nyame, 2009). Informal forms of treatment were used in regions and locales where supernatural causes of mental disease were believed to exist. That allowed people to consult religious and spiritual healers for treatments (Choudhry &Bokharey, 2013; Fellmeth et al., 2015). The best methods used in the healing process were prayers, the recitation of sacred scriptures, and the use of holy water (Hailemariam, 2015).According to Anderson (1995), in addition to enabling factors (resources available) and need factors (why a person uses available health services), what a person is predisposed to (such as social structure, socio-demographic characteristics, and health beliefs) can also influence a person's decision to seek health care both before and during the illness. This has prompted the need for a study to investigate the people's perceptions of the causes of mental diseases and how these inform their navigation attitudes of various health care options for treatment in the Brim Central Municipality of Eastern Region, Ghana.

OBJECTIVES

The main aim of the study was to investigate perceptions of the causes of mental disorders, and how the resultant classifications inform attitudes toward mental health treatment seeking behaviors. Explore the implications of such etiology and attitudes towards health care remedies for mental health disorders and demographic predictors of mental illness treatment seeking behaviors. Additionally, the study intends to explore the trend of previous health seeking behaviors of mentally ill patients who contact the psychiatric hospital/units for treatment.

LITERATURE REVIEW

INTRODUCTION.

Investigating the causes of mental illnesses and the use of mental healthcare services in the Brim Central Municipality is the primary goal of the current study. The relevant literature includes conceptual, empirical, and theoretical reviews. The review of related studies focuses on four key topics: mental illness issues, mental illness and treatment seeking behavior, perceived causes and treatments of mental illness, perception of mental illness and socio-demographic factors as predictors of mental illness and treatment seeking behavior. The conceptual framework of the study as well as the sickness perception and health care usage models are included in the theoretical review.

MENTAL ILLNESS AND TREATMENT SEEKING BEHAVIORS

Multiple factors influence how people with mental illness seek treatment. For instance, a study conducted by Awuye-Kpobi (2018) on 1,290 mental patients in Ghana found that over 80% discontinued or interrupted psychotropic medication because to side effects (fatigue and drowsiness), a preference for spiritual churches

as a source of healing and feeling better.Similar findings were found in research conducted in Nigeria on 81 patients with schizophrenia who had received psychotropic therapy, showing that only about half of them followed up and that even those who did well with treatment had poor antipsychotic adherence (DePetro, 2020; Fadipe et al., 2020). Feeling well was the most frequent cause for default, followed by money problems, side effects, being far from psychiatric care, and feeling ashamed of the disease.

When it comes to mental illness, seeking assistance might be official (i.e., seeking professional aid) or informal (help from other sources other than professional). People frequently look for either one or the other type of assistance, or perhaps both. People might look for informal assistance when an issue first arises and then turn to professionals as needed. Avanzo et al. (2012) conducted a survey of 710 Italian students to determine which type of assistance for mental health issues they preferred—informal or formal—and why. Only a small percentage of the sample, according to the findings, said they would not seek any kind of support at all (9 percent). Friends were the most favored source of assistance, followed by parents. The clergy was the least desired type of assistance for these people. Many participants (55%) stated they would seek both formal and informal treatment; a small proportion claimed they would solely seek formal care (5 percent). There were gender disparities in the preferences for aid from friends and psychologists, with more women than men favoring these types of support.

The study mentioned above shows that the sample tested does not necessarily distinguish between official and informal help seeking because the majority claimed they would seek both types of assistance. Instead, it suggests that seeking assistance is a generic attitude, thus the source of the assistance is immaterial; rather, what may be crucial is the belief that the assistance will be beneficial when it comes from a particular source. It comes as no surprise that friends are the most sought-after source of assistance. Friendships are significant in the lives of these teenagers because they are still young. This raises the question of whether a person's age affects their propensity to seek care for mental health issues. The pathway to aid seeking, or which source was called first before the next, is not obvious from this study, though. It's probable that close family members will be contacted first, and depending on the results of the advice given, a person may next seek professional assistance.

The beliefs of adolescent girls on treatment and treatment seeking for bulimia nervosa were examined by Mond et al. in a related study of 522 Australian secondary school students on mental health literacy and eating disordered behavior (2007). The findings revealed that the top potential sources of assistance were primary care physicians, mothers, and close female friends. Participants had mixed feelings about the advantages of using anti-depressant medication and were less enthusiastic about the use of mental health professionals. Self-help interventions, such as the use of vitamins and minerals, were also highly regarded. Most participants thought that even with the right treatment, relapse was likely because the problem described would be challenging to treat. Another interesting finding was that participants with high levels of eating disorder symptoms had poorer awareness of their eating disorder.

The researchers concluded that adolescent females may hold attitudes that are likely to encourage low and/or improper treatment-seeking for eating issues. According to this study, there are several psychological issues for which people tend to feel that a mental health expert cannot provide any form of support. Eating disorders are a case in point here. Because of this, they would look for assistance elsewhere in addition to from mental health professionals because they don't think it would be of any use to them. From this premise, it is not incorrect to infer that the sort of sickness would likely predict not only whether a person would seek help or not, but also the kind of care or therapy they would seek. As a result, choosing the type of treatment to seek often depends heavily on assumptions about the efficacy of a certain approach.
In a related study, Mond et al. (2007) discovered that young adult women generally indicated they would go to a general practitioner for assistance first. However, there was an age effect, with younger participants (18-32) more frequently choosing a family member or close friend while older participants (33-45 years) preferred to approach the general practitioner first. This supports a previous claim that age may affect treatment seeking behavior, particularly the kind of assistance sought.De Carlo et al. (2019) investigated the impact of coping style, health locus of control, and past health help-seeking behavior on the duration of untreated psychosis to examine psychological processes that influence the decision-making process to contact primary care in people with emerging psychosis. Patients from two metropolitan mental health facilities who met the criteria for the diagnosis of schizophrenia and were receiving initial treatment were used by the researchers. A total of 42 people took part in the study. According to the findings, persons who have had untreated psychosis for a long time are more likely to use avoidance as a coping mechanism when facing a health concern and are less likely to have seen a general practitioner in the six years before to the commencement of their condition.

The result suggests that psychological variables affect behavior related to seeking assistance. People who are generally less sensitive to health risks are therefore less likely to seek medical attention when they are ill. Since those who visited their general practitioners in the six years prior to developing psychosis also experienced a brief period of untreated psychosis before getting help, the duration of untreated psychosis is subsequently prolonged. Thus, it is now pertinent to investigate people's motivation of not seeking prompt medical attention for their mental health challenges from the appropriate quarters.

PERCEIVED CAUSES AND TREATMENTS OF MENTAL ILLNESS

Until 500 AD, mystical theories predominated in the explanations of the world's social and natural phenomena. The causes of diseases were not well understood. Religion, magic, and healthcare were all interconnected. According to Perez (2016), mental disorders such as "madness," "craziness," abnormal behavior, witches, evildoers, lunatics, and so forth are thought to be brought on by paranormal occurrences like demonic or spiritual possession, sorcery, the evil eye, and an enraged deity (God or gods) because of the person's wrongdoing. Similarly, the treatments were occult and occasionally cruel and included trepanning, exorcisms, spells performed by shamans, and incantations (Andreasen, 2015; Foerschner, 2010; Hussung, 2016; Cunningham et al., 2015). If these remedies failed to heal the patient, it was thought that the person had lost favor with the gods and deserved to die (Colangelo,

2021).Little progress had been made in theory or practice into the causes and cures of mental disease in antiquity.
To explain the causes of mental disease, two main hypotheses have evolved. Despite not having names like these, these were the supernatural theory and the natural theory. The natural theory contends that all illnesses, including mental illness, have natural causes, while the supernatural theory views mental disease because of demon possession and a divine (supernatural) curse (Colangelo, 2021).The use of oils, balms, ointments, "hyoscyamus," a potent psychedelic substance similar to LSD at the time, and music that may have contributed to the therapy or amelioration of depression were also advances in treatment (Colangelo, 2021). In the Holy Bible, for instance, it is stated that King Saul suffered a protracted, agonizing depression and David helped him by encouraging him to keep playing on his harp until the king's sadness subsided (Holy Bible, 1 Samuel 16:14–23) (Carlson, 2022). According to Hegde (2017), music therapy is still practiced today to treat depression and may have its origins in antiquity.As mental disease was thought to be caused by demonic possession in ancient Mesopotamia, priests who were also recognized as physicians treated patients with mental illness using magic and religious rituals (Amedome& Bedi, 2019). Exorcisms, incantations, prayer, atonement, and other varied mystical rituals were among the magico-religious practices employed to expel bad spirits. Threats, punishment, and occasionally submissions that hoped to be an effective treatment were the other methods they tried to use more human devices to appeal to the spirit (Amedome& Bedi, 2019; Hussung, 2016).

The other ancient, civilized people were the Hebrews, who held the view that all illnesses were brought on by God as retribution for sin and that even demons, who were thought to be the source of some illnesses, were responsible for God's wrath. The individual was thought to be responsible for his/her mental illness. The good example of this argument is King Saul's suffering from depression as punishment because he makes God angry by his wrong thought and acts. God made him "mad" and took his coronation as torment to his misbehaving (Holy Bible, 1962, 1samuel 16:14-16; Carlson, 2022). Hence, according to Hebrews, the ultimate and the only healer to these illnesses were God. In the Hebrew tradition, God thought to offer heal through priests –physicians, which they were considered having had special ways of appealing to the higher power to cure sickness.

The ancient Persians believed that taking the right precautions to prevent and protect oneself from diseases could help one achieve good health, which they attributed to demons. The Ancient Persians believed that maintaining good hygiene and the purity of one's mind, which is attained through good deeds and thoughts, are the best ways to prevent and protect oneself from diseases (Amedome& Bedi, 2019). The most innovative approach to treating mental illness was taken by the Ancient Egyptians. They recommended that a person with a mental illness partake in leisure pursuits like dancing, concerts, and painting to ease symptoms and regain a sense of normalcy.
In terms of medicine, surgery, and human anatomy knowledge, the Egyptians were also far ahead of other civilizations. They had creative ideas about illness, magic, and incantations that were employed to treat ailments of unknown origin, frequently believed to be brought on by paranormal forces like demons or irate divine beings (Butcher et al., 2017). Additionally, they shared the early Greek theory that hysteria

in women, now known as Conversion Disorder, was brought on by a "wandering uterus," and so they employed vaginal fumigation to entice the organ back into its proper position. The pharaonic period papyri reveal that Soma and Psyche were not distinguished, and mental illnesses were referred to as heart and uterus symptoms. Mental disorders were treated on a somatic basis, despite the mystical nature of the theories of causation (Okasha, 2005).

In ancient Greece and Rome, early thinkers like Hippocrates (460 BCE), Plato (400BCE) and Aristotle (384–322 BC) changed the beliefs about mental illness and its proper treatments. They arrived with a fairly developed and obviously non-divine viewpoint (Carlson, 2022; Townsend & Morgan, 2017). They investigated the biological, psychological, and social aspects of illness, looking beyond supernatural factors (Plante, 2010). They disproved the long-held notion that mental illness was brought on by supernatural forces and instead proposed that it originated from biological processes that occur naturally in humans, which is known as a "somatic" etiology. However, they did not see the brain as the primary cause. In accordance with this, Hippocrates introduced the idea of the four essential bodily fluids, which included blood, phlegm, yellow bile, and black bile. Galen, a Roman physician, subsequently developed this idea. Humoral theory is the name for this idea or hypothesis. They held that diverse ailments (referred to as "humoral pathology") resulted from altered body fluid balance (Butcher et al., 2017; Hoff, 2009; Plante, 2010; Gold, 2010). Hence, according to them the medicine for the illness was restoring the body's balance. Accordingly, the treatments they suggested for illness were phlebotomies, bloodletting, purging, rest, bathing, exercise, and dieting. The other treatment Hippocrates advocated was changing the occupation and/or environment of the patient (Foerschner, 2010).
Hippocrates, for instance, claimed that melancholia is brought on by an excess of black bile, a very toxic material produced in the spleen or intestines that affects the brain and causes melancholy condition (Carlson, 2022). Aristotle felt that genetic heredity played a larger influence in shaping adult behavior than did Plato, who proposed this theory about 400 BCE. In sum, although there were some advancements in thought in the ancient time, persons with mental illnesses had been chained in a filthy cell for the remainder of their life. People came to entertain themselves by observing them as if they were an animal in a zoo. The treatments of mental disorders are also dominantly tied on supernatural powers or mystics and with little lifestyles treatments.

PERCEIVED CAUSES AND TREATMENTS OF MENTAL ILLNESS

The Middle age (500AD-1500AD) did not bring positive developments regarding the understanding of mental illness and its treatments. In ancient times, there was no science and/or reason, only religion explains phenomena. All illness including mental illness was ascribed to the works of devils, witches, and possession by demons as a curse from God or other supernatural powers (Kroll & Bachrach, 1984; Shuttleworth, 2018). People with mental illness who were described as 'possessed' or 'witches' were facing discrimination and even killed.Priests were the first practitioners of medicine in antiquity. To expel demons, they subjected patients to abhorrent, unimaginable torture and lashings. Exorcisms, prayers, charms, amulets, and other mystical therapies were among the additional treatments available (Craig, 2014). Although the Middle Ages are known for such setbacks, there were some successes

of the era, such as the establishment of mass asylums and the beginning of hospitals admitting mentally ill people as patients (for example, in Valencia, Spain, in 1409). (Hoff, 2009). Before the widespread construction of asylums, humanistic doctors, medical astrologers, apothecaries, and folk or traditional healers provided treatments for people with mental illness (MacDonald, 1989).

In modern times, new ideas about treating the mentally ill were introduced. In the 18th century, two theories of mental illness emerged in explaining “madness”, the current version of the mental illness. These were biological theory and psychosocial theory although they were not named or phrased as such. According to Benjamin Rush, the "biological theory" claims that the cause of mental illness (also known as "madness") is seated in the brain's blood vessels and is a component of the disease pattern, particularly of fever, of which madness is a chronic form and affects the area of the brain that is the seat of the mind. According to him, mental illness is a disease of the mind rather than a demon's possession (Carlson & Simpson, 1964; Szasz, 2001). The alternative view focused more on psychosocial-environmental aspects and attributed anxiousness, or passions associated to life's events to mental health. It contended that diseases could result from poor or unhygienic living. On the other hand, a person would be less likely to develop a mental disease if they lived a morally upright life.

Pinel and Rush held that biological and psychosocial factors, the latter of which most likely originated in childhood, were the root causes of mental illness. They were the forerunners of Sigmund Freud's theories of childhood neurosis, which played a significant role in patients' complaints, with their psychosocial perspectives on the causes of mental illness. When Rush and Pinel started observing depressed patients, they started to notice something intriguing. When they were recording the histories of the depressed patients, they discovered that the patients' ancestors had depression as well. For the first time, they began to think that genetics (heredity) might be involved in the onset of depression because of this. "Heredity is the most predisposing cause of madness," he said. As a result, doctors started to consider mental illness from both a biological and psychosocial perspective in the 18th century. The biological explanation, however, continued to command attention at this time. Before Sigmund Freund relegated biological psychiatry to the shadows, it took more than a century (Spurgas, 2020).

In the 18th century, psychiatry started to take shape by establishing itself as a branch of medicine. The field, which is devoted to the treatment of people with mental illness, is grounded in scientific research and discussion (Beveridge, 2014; Spurgas, 2020). During this period, psychiatric hospitals proliferated throughout Europe, and efforts were made to release particularly severely psychotic individuals from the numerous and frequently brutal mechanical and other constraints that had previously been routinely imposed upon them (Pichot, 2012). The 19th century saw some impressive asylum construction (hospitalization). Modern times have changed the causes of mental illness from environmental to hereditary (genetic) and psychosocial factors, at least according to scholars (Spurgas, 2020). Psychotherapy, asylums, a healthy diet, purges, bleeding, baths and showers, horticulture, emetic for vomiting, gyrators, tranquilizing chairs, Dover's powder, modern medicine, and other contemporary treatments were introduced. Nowadays, people with mental illnesses

are typically treated in specialized facilities, but there are still differences in attitudes, levels of knowledge, service delivery, and other factors across nations.

In conclusion, Mental health, despite its importance, is the most forgotten and neglected aspect of health, especially when compared with physical health. Regarding this, Stavropoulou and Samuels (2015) disclosed that mental illness is given low emphasis than communicable diseases and NCDs such as cancer, cardiovascular diseases. According to Whiteford et al. (2010) and Whiteford et al. (2013), services for mental and substance use disorders have frequently been neglected and separated from mainstream health care, which results in resources not being allocated in a manner that is proportionate to their burden. Along with population aging, worsening social issues, and conflict, this neglect and treatment gap was contributing to the rising burden of mental illness in most of the world. It has also been excluded from the Sustainable Development Goals (MDGs) and other development-related health agendas in developing nations like Ethiopia (Samman & Rodriguez-Takeuchi, 2013). It is also recognized that WHO and other responsible organizations did not give much attention to mental health until 2001 (Stavropoulou & Samuels, 2015).
We draw the conclusion that ideas regarding the origins and treatments of mental illness are dynamic with time, place, and people based on the evidence. Comparatively, there has been a relative shift in attitudes regarding the causes and treatments of mental disease, although it still receives the least attention. Currently, many persons with mental illness across the world are facing stigma, discrimination, exclusion, violations of human and political rights, and other much more psychosocial challenges.

Perception of Mental Illness and Treatment Seeking Behaviors
Numerous studies support the idea that Ghanaians have a very varied range of causal knowledge about mental illness. However, it cannot be said that any belief or impression is inherently good or negative. For instance, the prevalent notion that drug abuse leads to mental illness may be seen as positive considering its potential to curtail the use of illegal or psychoactive substances. However, given that this only applies to a small number of mental problems and since substance abuse is frequently seen as a moral failing by the general population, this concept may lead one to believe that mental illness is something that one causes for themselves. Such a viewpoint is more likely to elicit condemnation than sympathy or understanding. Beliefs regarding mental illness are essential for both seeking treatment and adhering to that treatment (Ahmed et al., 2015; Ae-Ngibise et al., 2010).
Vanheusden et al. (2009) investigated how attitudes toward mental health issues affect young Dutch adults' decisions to seek treatment. They examined people's perceptions of the causes, effects, controllability, and timeline of mental health issues and the need for treatment. In a cross-sectional study, 2,258 young adults were involved. The findings showed that higher levels of personal control were associated with a lower likelihood of using mental health services, while belief in intrapsychic causes, negative consequences, and treatment control were all associated with an increased likelihood of doing so. Treatment control and negative consequences were also found to be very strong predictors of mental health service use.

This means that people are more likely to seek professional mental health treatment when they believe that the causes of mental health problems are intrapsychic, that there are negative consequences to mental illness, and that treatment would help them, whereas when the person believes that he or she could help themselves, they are less likely to seek treatment. This demonstrates unequivocally how important it is to have awareness of mental illness to seek therapy. It was noted that there was an interaction impact between sex and personal control, which is an intriguing finding. Personal control was not significantly associated with decreased service use in females, while it was in males.In a study by Adewuya and Makanjuola (2008), the most common perceptions about the causes of mental illness were those involving the misuse of psychoactive substances and supernatural factors. As a result, many people want to use traditional healers to treat mental illness. Additionally, beliefs about causation have a strong relationship with stigmatizing behaviors toward mental illness (Haghighat, 2001). It is common for people to feel ashamed of and fear those who have mental illnesses because of traditional beliefs that link psychiatric disorders to moral transgression and characterize patients as dangerous. Such societal values and beliefs affect how people seek treatment, how well they respond to treatment, and even how mental health is provided for people (Taylor et al., 2020). Both natural and supernatural explanations can be held for the causes of mental diseases. These opinions differ according on one's socioeconomic status and level of education. There are also spiritual explanations for mental illness that are prevalent in less educated rural communities, such as spirit possession, black magic, or astrological misalignment (Gater et al., 2005).

It was discovered that the communities had local names for mania, schizophrenia, and psychotic depression in Abbo's (2011) study, which used a mixed methods design to investigate profiles and outcomes of traditional healing practices for severe mental illness in two districts in eastern Uganda. Additionally, they sought treatment from numerous sources and had various justifications for the mental illnesses. More than 80% of psychosis patients used both biomedical and conventional healing methods, with those who combined the two experiencing better treatment outcomes.According to Azeem's (2014) research in Haiti, this community may view mental illness, difficulties coping with daily life, and scholastic attainment issues as the results of a spell, hex, or curse cast by a jealous person. People in these situations typically do not blame themselves for their disease or perceive themselves as being flawed. Instead, based on this theory of causation, there is a sense that a curse is frequently directed against someone who is thought to be attractive, smart, and successful. Sometimes failing to appease spirits, including those of deceased family members, is linked to mental illness (Azeem, 2014). This external attribution may have an impact on recovery since people can ask the "lwa-s" (spirits) to step in and help them heal. As a result, many people turn to their inner spiritual and religious resources for help in solving their difficulties.

The use of evidence-based treatments is generally hindered by the public's knowledge and beliefs about mental disorders, according to research done elsewhere in the world within the framework of mental health literacy (Jorm, 2000). For instance, Jorm (2000) noted that the general public preferred the use of self-help interventions and alternative therapies and was found to be dubious about the advantages of specialist treatment for mental disorders. Another misconception is

that long-term treatment is challenging and ineffective. People's beliefs about the causes of illness and its treatment are influenced by a wide range of factors, some of which may be related to culture and religion. The attitudes of British Asians toward seeking help were found to be significantly predicted by these causal beliefs about mental distress (Jorm, 2000).
Along with the previous examples given, this evidence shows that a person's ideas or perceptions about mental illness have a significant impact on the kind of care they would seek. A person is more likely to seek treatment from mental health services that approach mental disease from a supernatural or spiritual perspective if they believe that mental illness is spiritual or stems from a supernatural source. In contrast, if the individual thinks that mental illness is a medical problem, they would first seek medical attention.For instance, the phrase "3nye hospital yade3" is frequently heard in Ghana and refers to the fact that some illnesses, particularly physical ones, are ones that should be treated at a hospital while others are not. A sickness that persisted raised questions about "something behind it," such as witchcraft, demonic possession, or a curse, which would be beyond the control of the hospital doctor and his medications, no matter how strong (Read, 2017). Because chronic illness is incurable by medical science, "spiritual sickness" is defined in opposition to "hospital sickness." The fact that psychiatry has been unable to provide a long-lasting solution supports this.

According to Jegede et al. (2021), culture affects how the Yoruba people of Nigeria perceive illness, which in turn affects how they seek treatment. Yoruba people believe that bad luck ("*ayanmoburuku")* leads to bad health, while good luck ("*ayanmoburuku*") leads to good health ("*ayanmorere*"). When someone is sick, they typically turn to the traditional medical system before going to the hospital, and they only do so if all other measures have failed.However, not all patients may be affected by the claim that attitudes of the causation of illness affect treatment decisions. A study carried out in Ethiopia by Girma and Tesafe revealed this (2011). The results of this survey revealed a dichotomy between the sort of treatment sought and beliefs about the etiology of mental diseases, as many respondents believed that mental illness was brought on by supernatural forces but also thought that biomedical treatment could cure it. Like in many other developing nations, the bulk of the population in Ethiopia lacks access to modern psychiatric services and they are prohibitively expensive. As a result, patients typically use modern mental health services only after traditional treatments have failed to help them feel better. In Ethiopia, it is also typical for family members to support and care for those who are suffering from mental illness at home.

This demonstrates unequivocally that treatment seeking behavior among this population is more likely to be influenced by access to and availability of treatment options than by beliefs about the etiology of illness. Since most mental health professionals reside in and around the largest cities in many low-income and middle-income countries, rural populations, for example, have insufficient access to care. Many patients in Ghana travel considerable distances to the three psychiatric hospitals, Accra Psychiatric Hospital, Ankaful Hospital, and Pantang Hospital, which are all situated in the southern region of the nation. As a result, there is a disparity in the country's coverage of mental health issues.Therefore, it has become vital to look at other factors that may influence help seeking among people with mental illness in

addition to perceptions or beliefs about mental disease and its impact on it. Due to this, there is an increasing interest in how patients portray their sickness to better understand it and the psychological effects of illness (Benyamini & Leventhal, 2019). There has also been an increase in interest in analyzing reactions to psychological interventions, particularly those with a cognitive-behavioral focus and in explaining patterns of care seeking and adherence to treatment guidance (Benyamini & Leventhal, 2019; Thomadakis, 2020; Azeem, 2014).In a study using a Ugandan sample, Nsereko et al. (2011) found that beliefs about the causes of mental illness, the way services are provided, accessibility, stigma, and cost all have an impact on how people behave while seeking help.

Indeed, attitudes toward stigma can affect the type of assistance sought. In their study of Hispanic young women in the United States, Rew et al. (1997) found that because sexual and psychological needs were viewed as particularly delicate, these women tended to seek out informal assistance. As a result, people will be less likely to seek formal treatment in communities where there is a high perception of stigma associated with mental health issues because doing so would mean accepting "madness."

SOCIO-DEMOGRAPHIC VARIABLES PREDICTORS OF MENTAL ILLNESS TREATMENT SEEKING BEHAVIORS

Research has suggested that a few sociodemographic variables can predict treatment seeking behavior. One such factor mentioned in the literature is ethnicity. Angermeyer et al(2017).'s study, for instance, used the national co-morbidity survey replication among non-Hispanic whites, African Americans, and Hispanics to examine how race and ethnicity, as well as some socio-demographic factors, affect attitudes and beliefs about treatment. Based on earlier research, the researchers hypothesized that ethnic minorities would be more likely to view mental health treatment negatively. Results suggest that, in contrast to expectations, non-Hispanic whites and Hispanics (minority) may have more positive attitudes toward seeking mental health treatment.Gale et al. (2014) note that racial and ethnic minority groups report lower rates of accessing mental health care when it comes to the use of these services. This has been linked to unfavorable perceptions of mental health treatment. The findings of the large sample Abuse (2013) study point to the possibility that ethnic minorities use mental health services at lower rates than whites, maybe due to factors other than prejudice. This suggests that while ethnicity may not be a direct predictor of treatment seeking behavior, it may be a mediator along with other characteristics.

According to a 2009 South African study by Sorsdahl et al., about 13% of respondents sought the help of traditional and religious healers for common mental health issues, compared to 21% who only sought Western medicine and 7% who sought both western and alternative therapies. Some sociodemographic factors, including older age, black race, unemployment, lower educational background, having experienced a traumatic event, and having an anxiety or substance-related disorder, were found to predict treatment seeking from a traditional healer.Participants over the age of 50 were more likely than those between the ages of 18 and 29 to seek the advice of a traditional healer, even after accounting for the impact of other variables in the model. Compared to white, colored, and Asian

respondents, black respondents were 9.1 times more likely to seek traditional healers. High school graduation reduced the likelihood of seeking out a traditional healer. Additionally, going to a traditional healer for emotional and mental health issues was linked to having a job, having a substance use disorder, or having an anxiety disorder. This specific study highlights the significance of socio-demographic factors in treatment seeking.

Studies on the impact of sociodemographic factors on the decision to seek medical care have been done in the context of physical illness. In a manner, this can aid in understanding why people seek therapy for mental health issues. Approximately 67 percent of participants in Grover, Kumar, and Jindal's (2006) investigation of the socio-demographic factors influencing treatment-seeking behavior among chest patients in Northern India revealed that they had taken some self-initiated step to seek assistance. The first initiative, however, varied depending on sociodemographic factors. Urban residents were substantially more likely than rural residents (93.9%) to take self-initiated action at home (93.8 percent).Additionally, a higher percentage of men, individuals from higher socioeconomic backgrounds, and older adults (aged 46 to 65) began self-treatment, but these differences were not statistically significant. As people aged, the percentage of people who contacted a health agency for assistance increased to about 66%. 33 percent of participants who sought assistance from a health agency went to a government health agency, while 34.4 percent went to a private allopathic doctor. Male patients of private allopathic doctors outnumbered female patients. Overall, more rural than urban respondents suffered from symptoms for longer before getting help.

Azeem (2014) examined clinical records that were already in existence for patient characteristics based on sex and the role of gender in postponing cataract surgery to investigate gender variations in delayed treatment seeking behavior. After adjusting for hypertension, diabetes, the side of the eye with the cataract, and age over 65, the results revealed that women were more likely than men to undergo surgery at a later stage (i.e., after VA fell below 6/60) (adjusted odds ratio = 1.19) than males. Because women are less likely than men to seek early treatment, gender may play a factor in treatment seeking behavior. However, the study was conducted in Bangladesh, a patriarchal and more traditional social system where women's mobility and independence are constrained (Azeem, 2014). In their situation, the woman's parents or husband may also play a role in making healthcare decisions. Therefore, women won't seek treatment unless their significant others think it's necessary. Therefore, this finding might not hold true in more liberal societies where women are given the freedom to assume significant roles and responsibilities.

In contrast to Azeem's (2014) study, Mackenzie, Gekoski, and Knox's (2006) investigation looked at the influence of help-seeking attitudes on age, gender differences, and underutilization of mental health services. Their research showed that attitudes toward asking for help were more positively correlated with older age and female gender. In addition to interacting with marital status and education, age and gender also had varying effects on various attitude components. Additionally, gender and age had an impact on intentions to seek out professional psychological assistance. While older adults showed more favorable intentions toward seeking help from primary care physicians than younger adults, women showed more

favorable intentions toward seeking help from mental health professionals than men did. This demonstrates that research on how gender and age relate to treatment seeking behavior is inconsistent.Chandra and Minkovitz (2006) showed that there are gender differences in treatment seeking because girls were more likely than boys to report being willing to access mental health services, indicating that there are gender differences in treatment seeking. Furthermore, it was discovered that boys sense stigma more strongly than females do and have less awareness of and experience with mental health. Parental control had an impact on utilization because children who resorted to their parents were more likely to seek out official assistance. This suggests that girls experience greater parental authority than boys.

THEORETICAL FRAMEWORK

The Health Care Utilization Model and the Illness Perception Model were both used in the study. These theories were selected because they provide significant insights for the investigation. The health care utilization model covers the elements that affect people's decisions to use the available health care, whereas the illness perception model explains how people create rational ideas about their illnesses to comprehend and manage health concerns.

LLNESS PERCEPTION MODEL

According to the illness perception model, people develop rational beliefs about their illness to betterappreciate and manage health risks (Bjorgaas, Elgen &Hysing, 2021). People are perceived as actively attempting to comprehend their symptoms and illness. The patient's coping mechanisms and emotional reactions to the illness or threat to their health are driven by this understanding process. Reevaluating one's perceptions of the illness is a continuous process that may be prompted by new information about the illness or changes in symptoms. This may then result in a change in the patient's coping strategies, need for assistance, or emotional reaction.
The disease perception model has demonstrated its usefulness in predicting behavior in people who are physically unwell or injured. The emphasis currently is on how mental health issues may be affected by sickness perception. According to research, patients typically base their impressions of their condition on five primary factors. These factors have a strong track record when it comes to physical sickness, but it's possible that patients with mental problems may have some variations. Patients' causal views regarding their condition make up the first of these components.

After a diagnosis of an illness, causal beliefs frequently come into play as the person tries to understand how they came to have the condition. These beliefs are frequently based on widespread cultural perceptions of a particular illness (Ringer, 2021). The type of care patients seeks for their condition and the kinds of lifestyle adjustments they make to try and control or get rid of their illness may also be influenced by causal attributions. Research has shown, for instance, that organic disorders like genetic issues or brain disorders are perceived as the most likely causes of schizophrenia, whereas psychosocial factors are frequently believed by the public to be the likely cause of depression (Schomerus&Angermeyer, 2021). These causal assumptions lead to the conclusion that psychotherapy is typically favored to medicine in the treatment of depression, but medication is thought to be

more suitable for diseases with biological origins, such as schizophrenia (O'Connor & Yanos, 2021).
Other aspects of illness perception include identity (i.e., the symptoms that patients think are associated with their condition and the classification of their illness), timeline or duration (acute or chronic), control or cure (i.e., how the condition is managed and the efficacy of available treatments), and consequence, which is the perceived impact of the illness on the patient's life.

Health Care Utilization Model
This paradigm, also known as the Andersen or socio-behavioral model, postulates that three elements—predisposing factors, enabling factors, and need factors—influence health behavior. The usage of biomedical health services was the specific focus of the model's development. The concept has been expanded in later versions to cover other healthcare industries, conventional medicine, and home remedies (Kafle, Pant & Dhakal, 2021). Age, gender, religion, prior disease, education, general attitudes toward health care, and understanding of illness are only a few of the predisposing factors. The accessibility of services, the ability to pay for services, and social support are all enabling factors. The final need factors in this model are perceived severity, total days spent in bed, days missed from school or work, and outside help for caregiving. A treatment strategy resulting from the interaction of these variables may include self-treatment, traditional healers, or primary caregivers, among other options.

Through a thorough review of the literature, Kroeger (1983) revised Andersen's model and concluded that there are several interrelated explanatory models that affect health behavior. Like the Andersen model, these factors are divided into three categories. The first category is an individual's traits or predisposing factors, which include age, sex, marital status, status within the household, household size, ethnic group, degree of cultural adaptation, formal education, occupation, assets (land, livestock, cash, income), and social network interactions. Second, the characteristics of the disorder and how they are perceived, such as whether it is chronic, acute, severe, or trivial, its etiology, the benefits of expected treatments (modern versus conventional), and whether it is psychosomatic versus somatic.

The characteristics of the service (health service system and enabling factors) also include acceptability, quality, communication, cost, accessibility, appeal (opinions and attitudes toward traditional and modern healers), and acceptability. The Kroeger (1983) model is extremely pertinent to the current study because it predicted that treatment seeking behavior would be influenced by patients' perceptions of mental illness, attitudes toward professional mental health services, illness type, and some socio-demographic factors. The model proposes that individual characteristics or predisposing factors are socio-demographic variables. While attitudes toward professional mental health services represent characteristics of the service or health service system and enabling factors, illness perception and type represent the characteristics of the disorder and their perception. These factors will interact to predict treatment seeking behavior.The health care utilization model was suitable to explain the treatment/health-seeking behavior of caregivers due to the predisposing factors. According to the framework, it was found that some socio-demographic factors, including age, sex, education, religion, and culture, are likely to have an

impact on a person's beliefs, perceptions, and knowledge about the causes and treatments of mental illness. This further impacted their decisions and attitudes regarding getting help for their mentally ill relatives.

Conclusively, the review presented above demonstrates that there were various viewpoints on the cause and management of mental illness. The cause and treatment of mental illness were the subjects of the empirical literature review because these ideas have an impact on how MHC is used. It is important to note that the literature in this field is limited to a few recent studies. The empirical studies showed that due to preexisting perceptions and beliefs about the illness, caregivers are constrained in their decision to use MHC for their mentally ill relatives. Although the review demonstrates that some family caregivers used a particular type of treatment based on beliefs about its cause, the goal of this study was to determine whether some of these claims hold true in the Ghanaian context.

METHODOLOGY

RESEARCH DESIGN

The study employed a descriptive survey research design in addition to patients' chart reviews. A quantitative descriptive approach was employed to make meaning of the information that was gathered from both respondents and respondents' records. Data for this study was thus solicited from two data sources. The primary source involved a field survey on the perceived causes and treatment-seeking behaviors of persons living with mental illnesses while the secondary source of data was retrieved from the patients' records.

STUDY POPULATION AND SAMPLING

The respondents included persons living with mental illnesses within the Birim Municipality in the Eastern region of Ghana and their families. A convenience sampling approach was used as it allows one to readily accessible respondents. Additionally, persons living with mental disorders were selected purposively from respective treatment centers such as hospitals, health centers, prayer camps and herbal centers. Again, two respondents were chosen as key informants for interviews which included a medical professional and herbalist or spiritual healer. The Krejcie and Morgan (1970) sample size determination table, which is based on the.05 confidence level, was used to determine the approximate sample size. After considering the availability of samples and the goal of the study, the 302-sample size was deemed appropriate. 265 members of the community, 35 caregivers or individuals with mental illness, and 2 key informants.

DATA ANALYSIS

The Statistical Package for Social Sciences (SPSS) version 28 was used to analyze the data. To ascertain the association or relationship between the independent variable or predictor (truancy) and the dependent variable or outcome variable, the researcher also used SPSS to run a linear regression model (academic performance). This was carried out at a significance level of 0.05 and a 95% confidence interval (C.I). The results of the t-test and chi-square analysis were interpreted, allowing for the drawing of the proper conclusions. In furtherance, interviews conducted were audio-taped and the content transcribed and analyzed thematically.

ETHICAL CONSIDERATIONS

Ethical approval was sought from the Birim Municipal Health Directorate. An informed consent was obtained from the study participants. The participants were informed that the outcome of the study will be published for a wider readership and consent for same was sought from the participants.

Confidentiality: The respondents were assured of protecting any personal information that they may provide in accordance with data protection regulation policy of the hospital. The consent form was anonymously filled out without respondents' names.

FUNDING: Not Applicable

DATA ANALYSES AND DISCUSSION OF RESULTS

Response Rate

The data was obtained from the questionnaires administered to community members and people with mental illness in the Birim Central Municipality. In all, three hundred and two (302) participants in the municipality took part in the study. However, due to non-response to some questions in the questionnaire, 295 questionnaires were answered correctly and returned, representing a 97.6% response rate. The response rate can be described as good as it is more than half, of the total number of participants and enough to generate meaningful results.

Demographics Variables

This part examines the respondents' biographical information, which includes their gender, age, educational background, marital status, religious affiliation, occupation, and current financial status. The outcomes are shown in Table 1

Table 1: Summary statistics of Demographic variables of respondents

Variable	Category	Community members		Mentally ill person/caregiver	
		N	%	N	%
Gender	Male	138	53.9	22	59.5
	Female	118	46.1	15	40.5
Age (in years)	18-24	26	10.2	11	29.7
	25-34	69	27.0	12	32.4
	35-44	67	26.2	3	8.1
	45-54	41	16.0	8	21.6
	55-64	35	13.7	3	8.1
	65 and Above	18	7.0	0	0.0
Highest level of education	No formal education	16	6.3	13	35.1
	Basic (Primary-JHS)	114	44.5	19	51.4
	Secondary	77	30.1	4	10.8
	Tertiary	49	19.1	1	2.7
Marital status	Single	77	30.1	22	59.5
	Married	158	51.7	11	29.7
	Widowed	11	4.3	0	0.0
	Divorced	10	3.9	4	108

Occupation	Government	95	37.1	5	13.5
	Formal private	43	16.8	0	0.0
	Informal private	75	29.3	9	24.3
	Unemployed	43	16.8	23	62.2
Religious affiliation	Christian	206	80.5	29	78.4
	Muslim	42	16.4	8	21.6
	Traditional	2	0.8	0	0.0
	Other	6	2.3	0	0.0
Household monthly income (GH₵)	<1,000.00	-	-	29	78.4
	1,000-3,000.00	-	-	7	18.9
	3,000-5,000.00	-	-	0	0.0
	>5,000.00	-	-	1	2.7
Total		**256**	**100.0**	**37**	**100.0**

Source: Field survey (2023)

From Table 1, in terms of community members, 138, representing 53.9%, were males, while 118, representing 46.1%, were females. With respect to persons with mental illness or caregivers, 22 respondents, representing 59.5%, were males, whereas 15 (40.5%) were females. This implies that the male respondents outnumbered their female counterparts. With the age distribution, the single largest proportion (67) of respondents were between the ages of 25–34 years, representing 27.0%, and respondents between 18–24 years recorded the least, with 26 (10.2%) of community member participants. In the same vein, 12 respondents indicating 32.4% were between the ages of 25–34 years, and 3 respondents each for ages between 35–44 years and above 55 years, respectively for people with mental illness or caregivers.

In relation to educational level, the community member respondents had basic education (primary to JHS). This was evident after 114 (44.5%) of the responses were recorded. However, only 16 community member respondents, representing 6.3%, indicated that they had no formal education. This was the least recorded. With participants living with mental illness/caregiver, 19 respondents representing 51.4% had basic education, while 13 (35.1%) had no formal education. From the results, more than half of the respondents had some education. Table 2 shows that the majority of 158 (51.1%) of community member respondents were married, while the majority of 22 (59.5%) of people with mental illness or caregivers were single.

Most mentally ill people were unemployed. This accounts for 23 (62.23%) of respondents, whereas 95 (37.1%) of community member respondents were employed as government workers. The higher number recorded in relation to unemployment among mentally challenged people justifies the fact that their condition does not allow the m to work. The results showed that most respondents (both community members and people with mental illness) where Christians are evident by 206 (80.5%) and 29 (78.4%) respectively. This indicates how Christianity as a religious affiliation is predominant in Ghanaian society.For households that earned some income, most people with mental illness or caregivers had a monthly average income of less than GH₵ 1,000.00. This constituted 29 respondents, indicating 78.4%. Seven (18.9%) of respondents received an average monthly income of between GH₵1,000 and 3,000.00, while only 1 (2.7%) of respondents indicated receiving more than GH₵5,000.00. It was clear that the greater portion of

the participants for the mentally ill had a monthly income of less than GH₵ 1,000.00. This is not a surprise to the researcher since most of these individuals were unemployed, as stated earlier. They are not engaged in any income-earning activities due to their health status.

Research Question 1: What is the trend of mental illness cases for the five (5) year (2017-2021) period in the Brim Central Municipality?

The research question sought to analyze the trend in mental illness cases in the Brim Central Municipality using a five-year secondary data sample from the District Medical Health Information Systems (DHIMS). The results are presented in Figures 2 and 3 respectively.

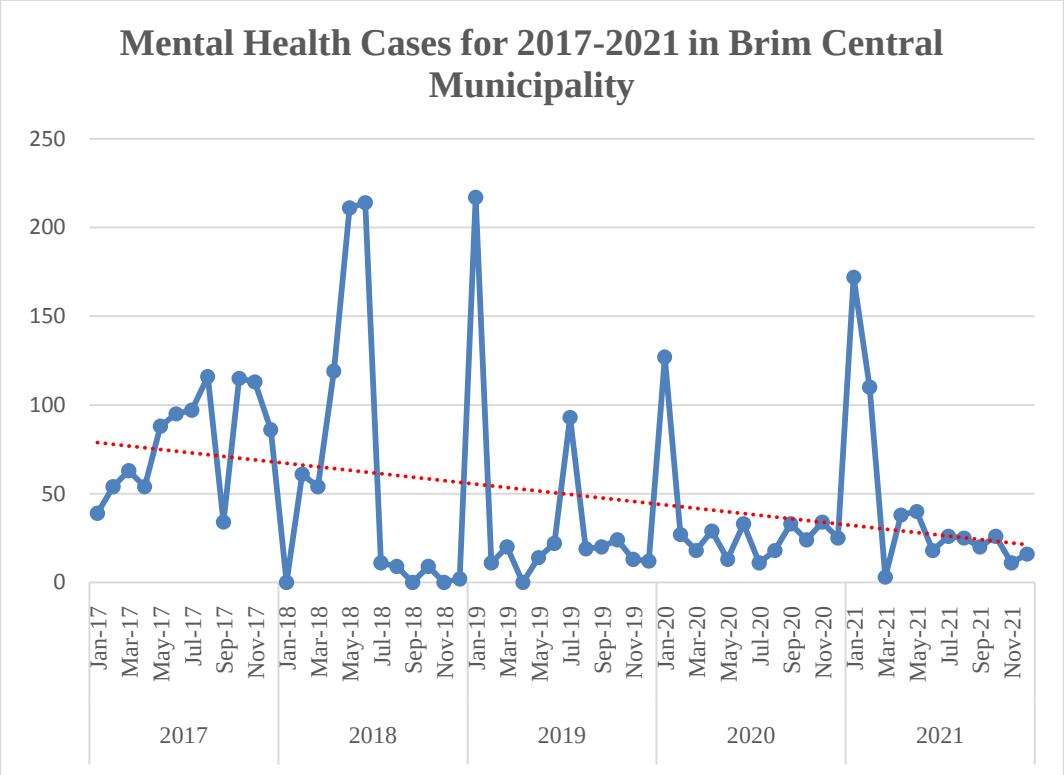

Figure 2: Mental health cases (2017-2021) in Birim Central Municipality
Source: Birim Central Municipal Health Directorate (2023)

Figure 2 depicts the trend in the number of mental health cases reported in the Birim Central Municipality over the past five years. From the chart, the month of January in the year 2019 had the highest number of cases recorded. This accounts for 217 cases, followed by 214 cases recorded in June, and 211 in May, 2018 respectively. However, in 2018, no cases were recorded for January, September, and November, respectively. The highest number of cases was recorded in 2021, with 505 cases. This constituted 29.3% of the total cases recorded for the five-year period. It is further estimated that an average of 601 cases are reported every year and 50.1 every month. From the linear equation, it can be observed that the cases keep declining from 2019 to 2021 after increasing cases were recorded in the previous years (2017 and 2018) correspondingly. From the analysis, there were up and downstream trends in terms of the cases recorded over the stipulated period. There is no stationary between the cases reported over the stipulated time under study.

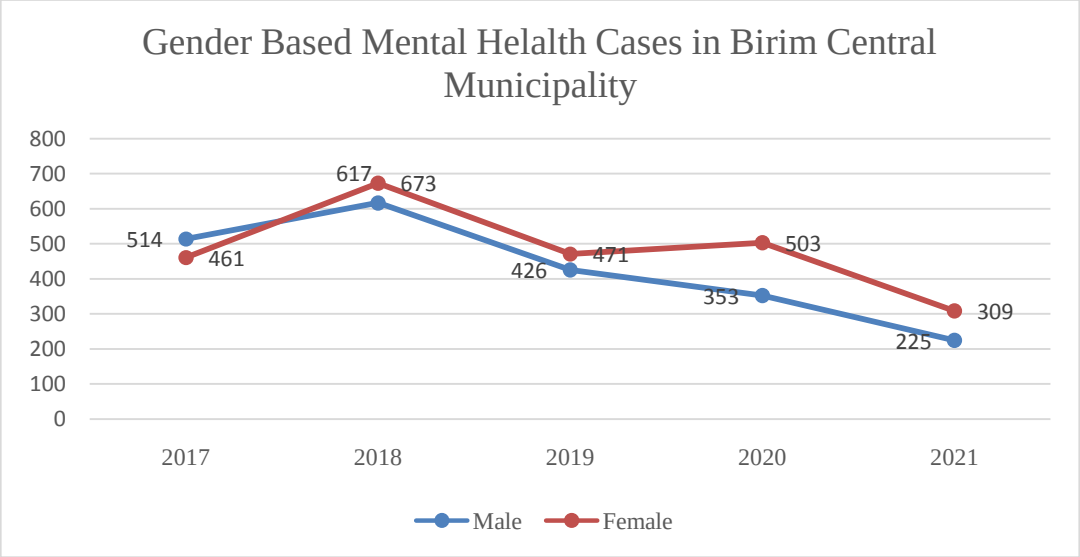

Figure 3: Mental health cases for 2017-2021 based on gender.
Source: Birim Central Municipal Health Directorate (2023)

The figure illustrates that the number of new cases reported for mental health in 2017 was 514 males and 461 females. In 2018, the cases increased to 617 for males and 673 for females. However, these figures declined in the subsequent years. In 2019, mental health cases included 426 males and 471 females, followed by 353 males and an uplift in female cases with 503 in 2020. A drastic decline of mental health cases was recorded in 2021, constituting 534 out of which 225 were male cases and 309 were female cases. From the analysis, an average of 427 males and 483 female cases were reported each year. However, mental illness among females in the municipality was high as compared to their male counterparts. This might be because of the population, which is mostly dominated by females in the country.

Research Question 2: What are the perceptions and etiology people ascribing to mental disorders in the Brim Central Municipality?

The research questions sought to examine the perceptions and etiology of mental disorders in the municipality. To obtain the above, the researcher sought the opinions of both community members and people living with mental illness or caregivers through a questionnaire. On a scale of one (1) to five (5), respondents were asked to rate their levels of agreement with the potential causes of mental illness (5). Strongly disagreeing with something is represented by the lowest rank on a scale of 1 to 5, and strongly agreeing with something is represented by the highest rank of 5. The study used a mean value of 3.00 as the standard by which to compare results.

Reliability Analysis

Table 2.: Perception on causes of mental illness (reliability analysis)

Constructs	Number of items	Cronbach's Alpha
Mental illness etiology	15	0.864

Source: Field Data (2022) N=180

To ascertain the reliability of dissimilar variables, Cronbach's alpha coefficient values are employed. Cronbach's alpha was used to examine the reliability of the important questionnaire variables (perception of mental illness aetiology). We evaluated the variables perceived to be the causes or aetiology of mental illness. The premise underlying this calculation states that a coefficient of construct reliability greater than or equal to 0.7 is reasonable and is a favourable sign (Nunnally, 1978). The lower limit of acceptability for exploratory inquiry, according to Hair, Anderson, Tatham, and Black (1998), is a cut-off point of 0.6. The Cronbach alpha coefficient value for perceived causes of mental illness in this study was 0.864. The findings from Table 2 suggest that the concept measures have a high level of internal consistency. Based on the research tools employed, this supports the validity and acceptability of the study.

Descriptive Statistical Results

Table 3: Perceptions and etiology of mental illness (community members)

Statements	SD %	D %	U %	A %	SA %	Mean	Std. dev.
A germ or virus causes mental illness.	33.6	7.4	6.6	35.2	17.2	2.95	1.570
Diet is largely a result of mental illness.	39.5	16.8	14.8	17.2	11.7	2.45	1.446
This illness is brought on by environmental pollution.	48.8	20.7	15.2	4.3	10.9	2.08	1.341
The family is predisposed to having mental illness.	5.1	3.5	5.1	30.1	56.3	4.29	1.064
An individual only develops a mental illness by accident.	34.0	27.0	19.9	5.5	13.7	2.38	1.361
One of the main causes of mental illness is stress.	2.7	2.0	10.2	44.5	40.6	4.18	0.895
One's behavior is largely to blame for mental illness.	3.1	5.5	12.5	48.8	30.1	3.97	0.964
Mental illness can be a result of subpar care in the past.	24.2	25.0	18.0	18.8	14.1	2.73	1.380
The illness is significantly influenced by the patient's mental state.	1.6	3.5	8.6	46.5	39.5	4.39	3.288
Witches and evil people are the cause of mental illness.	23.4	7.8	24.2	16.8	27.7	3.18	1.507
A person who has been offended may curse them with mental illness.	51.2	7.0	12.1	29.3	0.4	2.27	1.818
Mental illness is treatable.	18.4	0.4	1.6	16.4	63.3	4.06	1.524
It's more likely that mental illness will be chronic than temporary.	5.9	1.6	8.2	43.4	41.0	4.12	1.035
Insanity can persist for a very long time.	1.6	1.6	3.5	43.0	50.4	4.39	0.769
This illness's prognosis is largely determined by luck or	7.4	6.6	23.4	25.8	36.7	3.78	1.221

fate.							

Source: Field survey (2023)

With a mean score of 4.36 and (SD = 0.769) for each, the results in Table 4.3 showed that most respondents felt that mental illness can last for a longer period of time and that their mental state has a significant impact on the illness. These perceptions were ranked highest among others. Next to this was respondents' agreeing to the statement that mental illness is hereditary and therefore runs through one's family (M = 4.29, SD = 1.064). Respondents also agreed that stress is a major factor in causing mental illness (M = 4.18, SD = 0.865). The results also revealed that most respondents (M = 4.12, SD = 1.035) believed that mental illness is more likely to be permanent than temporary, followed by those who thought it was curable (M = 4.06, SD = 1.524). Once more, respondents concurred that mental illness is primarily caused by one's own behaviour (M = 3.97, SD = 0.964), recovery from mental disorders is primarily determined by luck or fate (M = 3.78, SD = 1.221), and that witches and evil people are to blame for mental illness (M = 3.18, SD = 1.507).

However, most respondents disagreed with the statement that mental illness is caused by germs or viruses (M = 2.95, SD = 1.570), followed by the statement that poor care in the past contributed to mental illness (M = 2.73, SD = 1.380). Respondents also disagreed that diet played a major role in causing mental disorders (M = 2.45, SD = 1.446). The statement that "it is by chance that one gets mental disorders" was also disagreed upon (M = 2.38, SD = 1.361). Most respondents further disagreed that mental illness can be caused by a curse invoked by an offended person as well as pollution of the environment causes mental disorders (M = 2.27, SD = 1.818) and (M = 2.08, SD = 1.341) respectively. From the results, there is a clear indication that most community member respondents perceived mental illness could last for a long period if not treated or that the state of mind plays a crucial role in causing mental illness and mental disorders to be acquired through hereditary means. It is believed that people with mental disorders are or can be acquired through hereditary if the illness runs through the family. This was confirmed in an interview with key informants who oversee the care of individuals with mental illnesses.For instance, a senior psychiatric nurse indicated that there are several causes, and the first one is genetics or heredity. Mostly, someone coming from a family where there is mental illness may one way or the other also get mental illness, maybe now or when the person is at the adult stage of his/her life. She further indicated that any person who is unable to accept certain issues at a particular point in time is likely to be exposed to mental illness. These issues may be triggered by relationships, divorce, unemployment, and failure in life situations.She also mentioned that social factors play a role in the aetiology and causes of mental illness. In a scenario whereby the person adapts him or herself to various situations or conditions that may lead the person to get mental illness, such as drinking, smoking, and certain lifestyles that may lead the person to get mental illness, she's of the view that mental illness can be cured when it's in an acute form or chronic form. It can be managed with medications, psychotherapies, recreational therapies, and other things. However, she stated clearly that conditions like dementia, schizophrenia, Alzheimer's, and others cannot be cured. An interview with the spiritual healer indicated that mental illness is curable. He stated emphatically that ever since he held his position as a man of God, he has healed a lot of people living with mental illness without the application of medication.

Nevertheless, both interviewees (health professional and spiritual healer) indicated clearly that germs or viruses are not the cause of mental disorders. Similarly, respondents asserted that mental illness is not caused by poor care in the past or diet not playing a role in mental illness. Respondents also stated emphatically that pollution of the environs does not have any connection with the causes of mental illness in any way.

Table 3: Perceptions and etiology of mental illness (Persons with mental illness)

Statements	SD %	D %	U %	A %	SA %	Mean	Std. dev.
My illness was caused by a virus or germ.	18.9	5.4	5.4	2.7	67.6	3.95	1.649
My illness was largely brought on by my diet.	27.0	0.0	0.0	2.7	70.3	3.89	1.415
My illness was brought on by environmental pollution.	13.5	0.0	5.4	2.7	78.9	4.32	1.415
My condition is inherited; it runs in my family.	54.1	2.7	2.7	2.7	37.8	2.68	1.930
It was pure coincidence that I got sick.	2.7	0.0	0.0	2.7	94.6	4.86	0.673
My illness was largely brought on by stress.	8.1	5.4	5.4	2.7	78.4	4.38	1.299
My own actions are largely to blame for my illness.	48.6	2.7	5.4	2.	40.5	2.84	1.922
Poor care in the past led to my mental illness.	2.7	0.0	0.0	2.7	94.6	4.86	0.673
My illness is largely brought on by my mental state.	45.9	5.4	8.1	0.0	40.5	2.84	1.893
Witches and evil people are the cause of my mental illness.	24.3	8.1	2.7	0.0	64.9	3.73	1.790
My mental illness can be a curse invoked by person I offended	10.8	0.0	0.0	86.5	0.4	4.54	1.260

Source: Field survey (2023)

According to the data, the most believed causes of mental illness were that the person's condition was brought on by subpar treatment in the past and that it happened by accident. This was evident after most respondents agreed to the statement, with a mean score of 4.86 and SD of 0.673, respectively. In the same vein, respondents agreed that their mental disorders were because of a curse invoked by someone they offended (M = 4.54, SD = 1.260). This was followed by respondents agreeing to the following statements: stress played a major factor in causing their illness (M = 4.38, SD = 1.299); that pollution of the environment significantly played a role in their mental illness (M = 4.32, SD = 1.415); that their mental illness was caused by a germ or virus (M = 3.95, SD = 1.649); that diet played a major role in causing their illness and that their illness is caused by witches and evil people (M = 3.73, SD = 1.790).Conversely, the results in Table 3 showed that respondents disagreed with the fact that their state of mind played a role in

causing their illness (M = 2.84, SD = 1.893). Most respondents disagreed that their illness is largely due to their own behaviour (M = 2.84, SD = 1.922). Also, respondents disagreed that their illness is hereditary and, therefore, mental illness does not run in their family. Based on the analysis, it is evident that people with mental illness or caregivers perceive that their mental disorders were because of poor care provided to them in the past, or that it was by chance that they became mentally ill. When comparing these with those of the community respondents, there is a contradiction in the responses provided by the groups of respondents selected for the survey. They both have very different perspectives on the aetiology and causes of mental illness in the municipality.

People with mental illnesses or those who care for them indicated that inadequate healthcare in the past may have contributed to mental illness when asked about the causes and aetiology of mental illness. This supported by a senior psychiatric nurse through interview as she indicated that head injuries from accidents, if not properly taken care of or treated, may lead to mental illness. On the hand, the spiritual healer all asserted that some of these mental illnesses are not physical as one may perceive but rather spiritual.

Research Question 3: What are the implications of such aetiology and attitudes towards health care remedies for mental health disorders and demographic predictors of mental illness treatment seeking behaviour?The purpose of this research question was to examine the implications of such aetiology, attitudes toward mental illness treatment options, and demographic indicators of treatment seeking behaviour. The analysis's findings are presented in Table 4

Table 4: Implications and attitudes toward healthcare remedies (Community members)

Statements	SD %	D %	U %	A %	SA %	Mean	Std. dev.
Professional mental health services can effectively cure mental health problems.	10.9	3.9	5.9	14.8	64.5	4.18	1.349
Mental health professionals are well trained to handle mental health issues.	0.8	5.1	11.7	12.5	69.9	4.46	0.940
I do not fully trust mental health professionals.	27.0	17.6	26.2	7.4	21.9	2.80	1.473
It is a last resort to seek professional mental health services.	26.2	14.5	23.0	8.6	27.7	2.97	1.548
Mental illness needs the intervention of spiritualists.	25.0	13.3	16.0	13.3	32.4	3.15	1.597
It’s only prayers that can heal mental illness.	32.4	30.1	16.8	7.4	13.3	2.39	1.356
This illness's prognosis is largely determined by luck or fate.	7.4	6.6	23.4	25.8	36.7	3.78	1.221
Herbalist are the best persons to treat mental illness.	45.3	27.3	17.2	5.1	5.1	1.97	1.136

For mental illness, you require a mix of hospital care, herbalist care, and spiritual care.	39.5	21.1	19.1	7.8	12.5	2.33	1.387
You need a combination of spiritual care and hospital care for mental illness	13.3	5.9	16.8	28.9	35.2	3.67	1.359
You need a combination of spiritual care and herbalists for mental illness	43.8	23.4	18.8	7.8	6.3	2.09	1.224
You need a combination of herbalists and hospital care for mental illness	34.4	29.7	15.2	12.5	8.2	2.30	1.284

Source: Field survey (2023)

Table 4 shows community member respondents' opinions on the implications of the causes and attitudes toward healthcare remedies for mental health disorders. The results showed that most respondents (M = 4.46, SD = 0.940) agreed that mental health professionals are well-trained to handle mental health issues and offer treatments to people with mental illness. The respondents gave this the top rating. Most respondents (M = 4.18, SD = 1.349) then agreed with the statement that professional mental health services can successfully treat mental health issues. Instead, they concurred that one needs a combination of spiritual care and hospital care for mental illness (M = 3.67, SD = 1.359), that one needs to seek spiritualist intervention for mental illness (M = 3.15, SD = 1.597), and that recovery from mental illness largely depends on luck or fate (M = 3.78, SD = 1.221).The majority of respondents (M = 2.97, SD = 1.548) disagreed that seeking professional mental health services should only be done as a last resort. Respondents also disagreed with the statement that they do not fully trust mental health professionals (M = 2.80, SD = 1.473). This means that most of the respondents fully trust mental health professionals when it comes to the handling of mental health disorders. Again, respondents disagreed with the statement that it is only prayers that can heal mental illness (M = 2.39, SD = 1.356). Statements on one needing a combination of spiritual care, herbalists, and hospital care for mental illness (M = 2.33, SD = 1.387), one needing a combination of herbalists and hospital care for mental illness (M = 2.30, SD = 1.284), one needing a combination of spiritual care and herbalists for mental illness (M = 2.09, SD = 1.224), and herbalists are the best people for treating mental illness (M = 1.97, SD = 1.136) were all disagreed by respondents. This implies that a larger proportion of respondents perceived mental health professionals and psychiatric hospitals as the best places to seek help for mental health disorders rather than seeking help from spiritualists and herbalists. Consistent the above, the researcher engaged people with mental illness or their caregivers where the implication of the aetiology and attitudes toward treatment seeking for mental illness were assessed. Table 4.6 addresses the results obtained from the analysis.

Table 5: Attitudes toward mental illness treatment among mentally ill persons

Variables	Category	Frequency (N)	Valid percent (%)
Number of years	<1 year	2	5.4

with illness	Between 1-5 years Between 6-10 years > 10 years	16 17 2	43.2 45.9 5.4
Treatment options resorted in the past	Biomedical care Spiritualist Herbal Combination of these	8 8 4 17	21.6 21.6 10.8 45.9
First seen for treatment	Traditional healer Religious healer Medical practitioner/general hospital Psychiatric hospital Spiritual healer	6 14 8 2 7	16.2 37.8 21.6 5.4 18.9
Informed decision	Perceived causes/symptoms Family/friends influence Perceived treatment effects Other	11 10 15 1	29.7 27.0 40.5 2.7
Duration of symptoms before contact	<1month After 1-6 months After 6 months-1 year After 1-3 years >3 years	9 14 11 3 0	24.3 37.8 29.7 8.1 0.0
Total		**37**	**100.0**

Source: Field survey (2023)

In the quest to know how long one has lived with the mental illness, the results in Table 5 indicated that 17 out of 37 respondents, representing 45.9%, have lived with the illness for between 6 and 10 years, followed by 16 (43.2%) of respondents who have lived with the illness for between 1–5 years. The results showed that 2 respondents, each making up 5.4%, have lived with the illness for less than a year and over 10 years, respectively. Based on the results, it could be said that about 95.0% of respondents have lived with the illness for more than a year.Again, respondents were asked to list the types of mental healthcare treatments they had previously used. The results showed that 17 (45.9%) of respondents cited the combinations of biomedical care, spiritualist, and herbal, followed by 8 respondents each representing 21.6% who resorted to biomedical care and spiritualist, with only 4 respondents accounting for 10.8% who portrayed herbal as the kind of treatment option resorted to in the past for mental illness. In affirmation of the above, 14 respondents (37.8%) indicated that a religious healer was the first call for their treatment of mental illness, 8 (21.6%) cited a medical practitioner/general hospital, 7 (18.9%) mentioned a spiritual healer, and 6 (16.2%) said they contacted a traditional

healer, whereas only 2 respondents (5.4%) said the psychiatric hospital was the first seen when they decided to seek treatment.

The results clearly indicated that more than 73.0% of the respondents resorted to treatment for mental illness from religious healers, spiritual healers, and traditional healers rather than medical practitioners or psychiatric professionals. This may be attributed to the fact that most individuals suffering from mental illness perceive such illnesses to be acquired through witchcraft, evil people, or from a curse revoked on them. As a result, they may decide to seek treatment from this group of healers rather than go to a psychiatric hospital.The above was further contradicts that of what the senior psychiatric nurse said in the interview that in community psychiatry, they mostly preferred medication, and then it was backed up with family therapy. They mostly opt for medication when in the facility because they have mostly tried various prayer camps. When they are in their homes, they usually go to prayer camps, traditionalists, herbalists, and so on. She also indicated that mostly after failed attempts in the religious institutions like the prayer camps and the herbalists, mostly when they go to prayer camps, she says the health sector, which includes the hospital, is the most efficient. She says going to the prayer camp would not help.In terms of what informed their decision, 15 respondents representing 40.5% mentioned perceived effectiveness of treatment, followed by 11 (29.7%) of respondents who said their decision was informed by perceived causes and symptoms; 10 (27.0%) said their decision was informed by the influence of family and friends; and the remaining 1 (2.7%) of respondents indicated other reasons.

Regarding waiting period before seeking treatment, 14 respondents representing 37.8% indicated 1-6 months as the duration of symptoms before first contact for treatment; 11 (29.7%) cited 6 months–1 year of symptoms before first contact; 9 (24.3%) of respondents said they had symptoms for a duration of less than 1 month before first contact; and 3 (8.1%) of respondents stated that they had symptoms for 1-3 years before first contact for treatment of mental illness. From the results, approximately 62.0% of respondents waited more than 6 months before making their first contact even though they had symptoms of mental illness, 14 respondents representing 37.8% indicated after 1-6 months as the duration of symptoms before first contact for treatment; 11 (29.7%) cited after 6 months–1 year of symptoms before first contact; 9 (24.3%) of respondents said they had symptoms for a duration of less than 1 month before first contact; and 3 (8.1%) of respondents stated that they had symptoms for 1-3 years before first contact for treatment of mental illness. From the results, approximately 62.0% of respondents waited more than 6 months before making their first contact even though they had symptoms of mental illness.In addition, the researcher used the regression model to predict which demographic variable affects treatment seeking behaviour of mental illness. The results are depicted in Table 7 below.

Table 6: Regression estimates on relationship between demographic variables and treatment seeking behaviour.

Variable	B	β	S.E	t	Prob.
Constant	2.713		0.121	22.502	0.001**
Gender	0.181	0.207	0.104	1.743	0.092
Age	-0.120	-0.372	0.053	-2.255	0.032

Educational level	0.090	0.153	0.076	1.188	0.245
Marital status	-0.128	-0.028	0.058	-2.195	0.036
Occupation	0.010	0.025	0.035	0.298	0.768
Religion	-0.707	-0.679	0.092	-7.664	0.001**
Monthly income	-0.036	-0.050	0.077	-0.465	0.645
S.E of estimate	0.131				
R-Square	0.927			**F-statistic**	52.773
Adj. R-square	0.910			**Prob. (F-stats.)**	0.001**
Note: **significant at p<0.01; * Significant at p<0.05					

Regression analysis assesses the relationship between independent and dependent variables (composite scores) by their influence on one another in a model. Regression analysis, in other words, looks at how much the independent factors affect the dependent variables. Treatment seeking behaviour is the dependent variable, and the independent variables considered by the study are the demographic characteristics influencing the treatment seeking behaviour of mental illness. According to Table 7, there is a strong and favourable correlation between the demographic variables and treatment seeking behaviour (F = 52.773, p 0.01). An R-Square of 92.7% was recorded, indicating the model had a strong goodness of fit. This implies that demographics (gender, age, level of education, level of marriage, profession, religion, and monthly income) jointly contribute about 93% of the variance in treatment seeking behaviour, especially the religious affiliation of the respondents.

From Table 6, gender had a positive coefficient of 0.181 but was statistically insignificant at p 0.01, indicating that there is no relationship between gender and treatment seeking behaviour. In other words, gender as a demographic characteristic is not a predictor of the treatment seeking behaviour of mental illness. Similarly, other variables such as age (-0.120), educational qualification (0.090), marital status (-0.128), profession (0.010), and monthly income (-0.036) were not statistically significant at p 0.01. This suggests that there is no correlation between treatment seeking behaviour among people with mental illness and age, education level, marital status, occupation, and monthly income. However, despite having a negative coefficient of -0.707 and being statistically significant at p0.01, religious affiliation. This suggests that there is a significant association between religious affiliation and the behaviours of mental illness patients who seek treatment. As a result, the behaviour of people with mental illness in seeking treatment was predicted by their religious affiliation.

Research Question 4: What is the trend of previous health seeking behaviours of mentally ill patients who contact the psychiatric hospital/units for treatment?

Table 7: Trend of previous health seeking behaviours of mentally ill patients

Variable	Category	Frequency (N)	Valid percent (%)

First initiated contact	Myself	1	2.7
	Family relative	30	81.1
	Friend/Neighbour	4	10.8
	Employer	2	5.4
Treatment(s) offered	Non-psychotropic medication	6	16.2
	Herbal/traditional medication	9	24.3
	Prayers/fasting	16	43.2
	Psychotropic medication	6	16.2
Treatment(s) currently resorting	Biomedical care	25	67.6
	Spiritualist	1	2.7
	Herbal	1	2.7
	Combination of these	10	27.0
Changed source of care	Yes	9	24.3
	No	28	75.7
Total		**37**	**100.0**
Initial source	General hospital	3	33.3
	Psychiatric hospital	2	22.2
	Spiritual/healing center	4	44.4
Change to what source of care	General hospital	1	11.1
	Psychiatric hospital	3	33.3
	Spiritual/healing center	4	44.4
	Other	1	11.1
Reason for change	Poor service delivery	1	11.1
	High cost of treatment	3	33.3
	Not convinced of the place	1	11.1
	Not responding to treatment	4	44.4
Role played by who?	Myself	6	66.6
	Family relative	1	11.1
	Friend/neighbour	1	11.1
	Employer	1	11.1
Total		**9**	**100.0**

Source: Field survey (2023)

The results on the pattern of prior health-seeking behaviours of mentally ill patients who contact psychiatric hospitals or units for treatment are shown in Table 7. From the results, 30 respondents (81.1%) indicated their family relatives initiated first contact for treatment, 4 (10.8%) cited friends/neighbours, 2 (5.4%) employers, with only 1 (2.7%) respondent indicating that initial first contact was made by him/herself for treatment. This was affirmed through the interview with the senior psychiatric nurse who said that the mind is not sound, so the client cannot make any informed decisions as to what they want to do here or to go there. Therefore, the relatives make most of the decisions.In terms of the treatment offered after the contact, 16 respondents representing 43.2% indicated they were offered with prayer/fasting; 9 (24.3%) of respondents were offered herbal/traditional medication;

and 6 (16.2%) of respondents indicated non-psychotropic medication and psychotropic medication as treatment offered on their first contact. This implies that most people living with mental disorders were offered prayers, fasting, and herbal or traditional medications on the first contact made by their relatives. This indicates that these individuals have been sent to religious homes for prayers or herbal healers as the first point of contact. However, only a few contacted the psychiatric hospital for medication at the initial contact or at an early stage of their illness. The spiritual healer confirmed that herbal remedies and prayers were frequently given to patients who were suffering from mental illnesses. He indicated that people with mental illness are prayed for in the shift system (morning, afternoon and evening) after which herbal medicines are smeared on them.

Respondents further indicated that biomedical care is the current treatment option they are resorting to. This accounts for 25 respondents out of 37, forming 67.6%, followed by 10 respondents, representing 27.0%, who said they are on a combination of biomedical care, spiritualist, and herbal treatment options for now. Only 1 respondent each, indicating 2.7%, portrayed spiritualist and herbal as the current treatment options they are resorting to now for their illness. This showed that almost 70.0% of respondents were currently resorting to biomedical care as a treatment option for mental illness currently.In our quest to know whether respondents have ever changed sources of care while seeking treatment, the result in Table 4. illustrated that 28 respondents, constituting 75.7%, said "no" while 9 (24.3%) indicated "yes". Out of the 9 who indicated yes, 4 respondents (44.4%) mentioned a spiritual/healing centre as their initial source of health care, 3 (33.3%) cited a general hospital, and 2 (22.2%) said a psychiatric hospital was their initial source of health care. Further, the results showed that 5 out of 9 respondents representing 55.5% said that they changed to another spiritual/healing centre, 3 (33.3%) of respondents changed to a psychiatric hospital, and 1 (11.1%) of respondents indicated they changed to a general hospital, and other sources, respectively. Reasons for change of source of care ranged from the inability to respond to treatment (44.4%), high cost incurred in treatment (33.3%), and not being convinced with the source of care (11.1%), respectively.

Table 8 further demonstrated that most of the respondents played a role in the decision to change the source of care. This was evident as 6 respondents, representing 66.6%, cited "myself" as a response to the question posed. However, 1 respondent each (11.1%) respectively cited family relatives, friends, and employers to have played a role in deciding for the change of care. From the above, it is arguable that only a few of the respondents have changed their initial source of care for mental illness from one spiritual centre to another or a psychiatric hospital for effective treatment. This decision was mostly taken by the individual living with the mental illness on most occasions, but sometimes it was influenced by family members. However, most of these individuals decided to change their source of care due to failure to respond to treatment and the high cost of treatment at the particular care centre.

DISCUSSION OF RESULT

THE TREND IN MENTAL ILLNESS CASES

The objective of the analysis was to identify a five-year trend of mental illness cases in the Birim Central Municipality. The study found that in terms of cases, the highest cases were recorded in the months of January 2019, May, and June 2018, while January, September, and November recorded the least, with zero cases. In terms of years, the study revealed that 2018 had the highest mental health disorders, accounting for 28.4% of all recorded over the past five years in the municipality. The study revealed that an average of 601 mental illness cases are reported each year, with 50 cases per month. However, the study disclosed that there were up and downstream trends in terms of the cases recorded over the stipulated period. There was no stationary in terms of cases for the years under study.The study also reported that the number of females suffering from mental illness outweighs that of their male counterparts. The study found that the number of cases increased in the years 2017 and 2018 respectively but declined drastically in the subsequent years. A World Health Organization (WHO) (2007) report found that 2,816,000 of the 21.6 million people in the population had varying degrees of mental disorders (Dako-Gyeke &Asumang, 2013). However, different perspectives on the condition have resulted in different terminologies being used, which has strengthened already-existing socially and culturally constructed myths (Walker, 2006).

PERCEPTIONS AND ETIOLOGY PERSONS ASCRIBE TO MENTAL DISORDERS

Objective two looked at the causes and perceptions that people have of mental illnesses. According to the study's findings, respondents from the community believed that mental illness was inherited or genetic. It might have come from a family history. The conclusion, in line with that of Pinel and Rush, also suggested that biological and psychosocial factors, the latter of which likely originated in childhood, were the causes of mental illness. "Heredity is the most common predisposing cause of madness," they claimed. Similar changes have been made to hereditary (genetic) and psychosocial risk factors for mental illness, at least among scholars (Spurgas, 2020). They also perceived mental illness as being permanent but not temporary since the state of mind plays a major role in causing the illness. The study further revealed that mental health disorders are caused by witchcraft and evil people as perceived by respondents. This was confirmed by the spiritual healer who believed that most of the mental illness cases are more of spiritual than physical.The study found that people living with mental illness or caregivers perceive that poor care in their past caused their illness. They further perceived, in the same direction as the community member respondents, that mental illness is caused by witches, evil people, or a curse invoked by a person they offend. This finding supported the findings of Kroll and Bachrach (1984) and Shuttleworth (2018), who indicated that all illness, including mental illness, was ascribed to the works of devils, witches, and possession by demons as a curse from God or other supernatural powers.

In addition, the study revealed that, contrary to what community member respondents believed, people who live with mental illness believe that germs or viruses are the cause of their illness. In their minds, mental illness is also a result of

chance or fate and can be acquired through poor diet. Most respondents in the study believed that mental illness can be cured. The senior psychiatric nurse and the spiritual healer both agreed with the conclusion and said that mental illness is treatable. Patients would rarely choose options considered to be interventions that deal with germs or viruses, food management, or sanitation when seeking treatment for mental illness because it has been found that the type of treatment sought is influenced by the perceived cause of the illness (Desrosiers &Fluerose, 2002; Vanheusden et al., 2009).

ATTITUDES TOWARDS HEALTH CARE REMEDIES FOR MENTAL HEALTH DISORDERS

The third objective of the study explored implications of such etiology and attitudes towards health care remedies for mental health disorders and demographic predictors of mental illness treatment seeking behavior. The study revealed that respondents view mental health professionals as well trained to handle mental health issues and provide remedies to people with mental illness. The discovery that expert mental health services can successfully treat mental health issues came next. Instead, the study found that recovery from mental illness is largely dependent on luck or fate, that treatment for mental illness requires both spiritual guidance and hospitalization, and that spiritualist intervention is necessary. The informant interviews conducted to support all of this.The study's results are consistent with those of Girma and Tesafe (2011), who discovered that although people in Ethiopia thought mental illness was brought on by supernatural forces, they also thought it could be cured by biomedical treatment, showing that beliefs about the etiology of illness do not always influence treatment seeking behavior. Finding professional mental health services is not a last resort, the study found. As a result, they have limited faith in mental health professionals. Again, the study found that prayers alone cannot heal mental illness. This implies that a larger proportion of respondents perceived mental health professionals and psychiatric hospitals as the best places to seek help for mental health disorders rather than seeking help from spiritualists and herbalists. This was also affirmed by the informants selected for the interview.

The study also revealed that they use combinations of biomedical care, spiritualist, and herbal medicine for the treatment of mental illness, with most of these individuals contacting religious or spiritualists at the first sign of the illness rather than contacting health professionals. The study found that most people with mental illness sought treatment from religious healers, spiritual healers, and traditional healers rather than medical practitioners or psychiatric professionals.This may be attributed to the fact that most individuals suffering from mental illness perceive such illnesses to be acquired through witchcraft, evil people, or from a curse revoked on them. As a result, they may decide to seek treatment from this group of healers rather than go to the psychiatric hospital as first point of treatment. The communities had unique names for mania, schizophrenia, and psychotic depression, according to Abbo's (2011) study. Additionally, they sought treatment from numerous sources and had various justifications for the mental illnesses. More than 80% of psychosis patients used both biomedical and conventional healing methods, with those who combined the two experiencing better treatment outcomes.

Similarly, Jegede et al. (2021) claim that culture affects how the Yoruba people of Nigeria perceive disease, which in turn affects how they seek care. Yoruba people

believe that bad luck leads to bad health, while good luck leads to good health. When someone is sick, they typically turn to the traditional medical system before going to the hospital, and they only do so if all other measures have failed. In a study using a Ugandan sample, Nsereko et al. (2011) found that beliefs about the causes of mental illness, the way services are provided, accessibility, stigma, and cost all have an impact on how people behave while seeking help.

DEMOGRAPHIC VARIABLES AND TREATMENT SEEKING BEHAVIORS

Except for religious background, the study found that demographic factors like age, gender, education level, marital status, occupation, and monthly income did not significantly predict a person's propensity to seek medical treatment. These results corroborate those of Azeem (2014), who studied how people with mental illness sought out medical care at the local psychiatric hospital in Ghana. Her research revealed no link between the treatment-seeking behaviors of people with mental illness and demographic factors.This conclusion is at odds with studies that found these factors to be important predictors of treatment seeking. According to some studies (Sorsdahl et al., 2009; Tanchangya et al., 2012), older age is associated with delaying treatment, while other studies (Sorsdahl et al., 2009; Tanchangya et al., 2012) associate it with increased willingness to seek treatment and a positive attitude toward treatment seeking (Mackenzie, Gekoski& Knox, 2006).

Additionally, research has shown that women are more likely than men to seek treatment (Chandra &Minkovitz, 2006; Mackenzie et al., 2006), though some studies have also shown that women are less likely than men to seek early treatment (Tanchangya et al., 2012). In contrast to the current conclusion, research has also found that treatment seeking behavior can be influenced by marital status, educational attainment, employment status, and income level (Elhai et al., 2014; Sorsdahl et al., 2009).

Religious affiliation was identified to be the only predictor of treatment seeking behavior for mental illness. This means that the religious background of an individual will determine the type of treatment he/she would like to receive. The current research corroborates Wu et al.'s (2014) finding that there is a strong relationship between religious inclinations and help-seeking behaviors.

TREND IN PREVIOUS HEALTH SEEKING BEHAVIORS OF MENTALLY ILL PATIENTS

The final objective was to determine the pattern of prior health-seeking behaviors among mentally ill patients who sought treatment at psychiatric hospitals or units. The study revealed that the first initial contact was mostly made by family members with prayers, fasting, and herbal or traditional medications offered as the initial treatment based on the perception of the illness that is spiritual. However, the study revealed that only a few contacted the psychiatric hospital for medication at the initial contact or at an early stage of their illness.This was affirmed through the interview as the senior psychiatric nurse who said that the mind is not sound, so the client cannot make any better decisions as to what they want to do here or to go there. Therefore, the relatives make most of the decisions.

This was also affirmed by the spiritual healer who indicated that the family give support to their mentally ill person since they are not in good frame of mind. Decisions are mostly taken by these relatives on behalf of the patient.The study

further disclosed that most of these patients are currently resorting to biomedical care haven previously changed care in the past due to the inability to respond to treatment on time, the high cost of treatment incurred and poor service delivery by some treatment centers. The decision for change of care was most often taken by the individuals themselves or sometimes influenced by family members. However, most mentally ill patients sought treatment only after 6 months of symptoms.WHO (2001) says that milder forms of mental disorders are more frequently underdiagnosed than more severe ones. They stated in the same paper that many patients with anxiety and depressive disorders do not receive a diagnosis because they typically do not seek therapy. The current investigation established that the nature of the ailment would influence treatment seeking based on this premise.

SUMMARY AND CONCLUSION

Summary of Findings

The study's main goal was to assess the aetiology of mental disorders and resort to mental healthcare services in Birim Central Municipality, Eastern Region. Community members, people living with mental illness or their caregivers, health professionals, and spiritual healers of mental illness in the municipality participated in the survey. The statistical program SPSS version 28 was used to analyse the data that was obtained. The study's findings were as follows:

In terms of the trend in cases recorded, the study found that there were upward and downward streams for the period under review in the municipality. It was observed that the highest number of mental health disorder cases were recorded in 2018 and 2021, with the latter reporting the least number of mental illness cases in the municipality. Cases of mental illness were on the increase in the years 2017 (975) and 2018 (1290) respectively, but declined in 2019 (897), 2020 (855) and 2021 (534). The study revealed that the most mental illness cases recorded were among females in terms of gender, while male cases accounted for the least in the Birim Central Municipality.

The study found that the most perceived causes and aetiologies of mental disorders were genetics/hereditary, witchcraft, and evil people. The study revealed that most people perceived mental illness as hereditary and therefore ran through one's family. Thus, it could be passed on or the possibility of one suffering from mental disorders is very high when he/she is from a family with a history of mental illness.The study also disclosed that mental illness is curable as perceived by most respondents. The study reported that mental illness is curable when it is at its early stages (acute) but cannot be cured if early treatment is not administered at the early stage. However, the study found that while people with mental illness perceive their condition to be caused by germs and diet, the community members disagreed with that and rather perceive mental illness as happening by chance or fate.

Additionally, the study discovered that mental health professionals are perceived as well trained to handle mental health disorders as indicated by respondents. It was disclosed that even though mental health services can effectively cure mental health problems, religious healers are the first to be contacted for prayers and fasting as treatment for people with mental illness. The study found that these contacts are mostly initiated by family relatives only after 6 months to 1 year of symptomatic

symptoms. Lastly, the study revealed that people with mental illness resorted to a combination of biomedical care, spiritualist, and herbal treatment for their mental ailments.

CONCLUSION

In view of the findings, the study concludes that the aetiology of mental illness cannot be attributed to a specific cause. There are several factors that cause mental disorders, which include genetics or hereditary, environmental factors, and social factors. Mental illness can be acquired through hereditary lineage. For instance, in a family where there is a trace of mental illness, one can also be affected when growing up. Mental illness can be caused by environmental factors when an individual is frequently exposed to certain events in society and become overwhelmed by these events and circumstances. However, mental illness is curable depending on the severity or duration of the symptoms.

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