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Just Desserts, Hexes, and Stigma: No Compassion for the Mentally Ill in Ghana

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ABSTRACT

Although the knowledge of biological, psychological, and social contributions to psychopathology exists in Ghana, most individuals overwhelming ascribe supernatural origins to mental disorders. Under this paradigm, mental disorders are assumed to result from supernatural judgement for wrongs committed or from some sort of lack in an individual who makes them vulnerable to spiritual attacks. In addition, beliefs that individuals with mental disorders are contagious and dangerous lead to the unfortunate consequences of victim blaming and stigmatization. This paper explores the culture's conceptualizations of mental disorders and social defenses used to communicate the culture's anxiety around mental disorder states. Recommendations for addressing the stigma challenge in the culture using a small wins approach are discussed.

Keywords: Stigma; Mental disorders; Supernatural beliefs; Social defenses; Small wins; Wicked problem

INTRODUCTION

Ghana is a stable lower middle income country in West Africa with a population of 31 million and a 2017 estimated prevalence of the following mental health disorders: Schizophrenia 0.2%; bipolar disorder 0.5%; major depressive disorder 2.6%; epilepsy 0.43%; alcohol use disorders 0.5%; and other drug use disorders 0.5%. Estimates of the number of individuals with a mental disorder who receive professional treatment is low at 2.8% and high levels of stigma accompany diagnoses of mental disorders for both individuals and their families in the country. Given that stigma reduces a person from being a whole person to discounted one, individuals with mental disorders in the country are discriminated against and treated as tainted and inferior to others in the society. This paper reviews Ghanaian culture's historical religious beliefs which have shaped the stigmatization of individuals with mental disorders and proposes a culturally informed way of reducing stigma in the society [1-5].

LITERATURE REVIEW

Mental Health Stigma in Ghana: The Cultural Context

The stigmatization of individuals with mental disorders occurs across cultures, however reasons for these stigmatizations are culture specific. Ghanaian culture is highly superstitious, and while the knowledge of biological, psychological, and social contributions to psychopathology exists in the country, the literature shows that the majority of Ghanaians continue to

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believe diseases of the mind originate from the supernatural realm. Although Christianity is at present the largest religion in the country, Ghanaian traditional religion was the only system for understanding and relating to the supernatural prior to Christian missionaries bringing the gospel to the shores of country in the 15th century. Ghanaian traditional religion involves a polytheistic hierarchal system of a supreme being referred to by different names in different tribes (e.g., Nyame by the Akan tribes, and Mawu by the Ewe tribes) who was seen as remote and not directly worshipped; followed by a pantheon of lesser gods who lived in streams, rivers, mountains, and forests; and then finally household gods. These lesser gods acted as intermediaries between the supreme being and the society, and administered justice in their various jurisdictions (e.g., region, village or family) by rewarding obedience with fruitfulness, prosperity, and health and swiftly punishing disobedience with lack, ill health, and even death unless appeased. Mental disorders were understood to result primarily from offenses against a god and secondarily from the actions of malevolent others who consulted a fetish priest or a shrine to afflict their victims with a mental disorder. A mental disorder believed to have occurred through the primary mode of an offense against a god was usually confirmed by consultations at the shrine of the local god and treated by appeasing the affronted god with the necessary sacrifice. A mental disorder believed to have originated from the mechanisms of an evil wisher could be treated by afflicted individuals or their families consulting a fetish priest/shrine of another god with powers assumed to be higher than the afflicting god and offering the required sacrifice.

The introduction of Christianity into Ghanaian society gradually shifted beliefs from a polytheist to a monotheistic worldview although beliefs in animism coexisted. Some individuals/families superficially pledged their allegiance to the Christian God who was viewed as benign while still ascribing to a worldview of a pantheon of lesser gods who inflicted individuals with mental disorders for trespasses. Others fully embraced the Christian God while holding on to beliefs that mental disorders could be caused by malevolent others invoking a curse or hex against them or their loved ones.

Irrespective of whether a mental disorder was assumed to originate from personal or familial sin or a hex from a malevolent other, the end result for individuals with a mental disorder was the same; victim blaming and stigmatization. In the former instance the afflicted individual was perceived to be “guilty” and in the second instance the afflicted individual was perceived to “lack” something or be “spiritually weak” which had allowed the spiritual attack to succeed. Thus, like Hester in the scarlet letter who had to wear a visible scarlet “A” on her chest for the rest of her life as the outward sign of a moral failure, individuals with mental disorders are forced to live in society with an invisible “S” for stigma branded on their foreheads, and suffer doubly from the mental disorder itself as well as the stigma that accompanies having a mental disorder.

Feldman and Crandall state that three dimensions of mental health stigma account for the social rejection of individuals with mental disorders: Personal responsibility for the illness or onset controllability; dangerousness to others; and rarity of the disease. In Ghana, the justification of personal responsibility in perpetrating stigma falls under the ‘just desserts’ and/or ‘hexes’ category. One is getting the mental disorder they deserve because of the actions or inactions of themselves or their close family relations, or their weak spiritual standing which made the hex of mental disorder successful. The dangerousness to others dimension is driven by misperceptions that a person with any kind of mental disorder is dangerous as observed in a minority of a few individuals with severe mental illnesses who exhibit aggressive behaviors which are then generalized to all mental disorder categories.

In addition to these three universal dimensions of mental health stigma, a motivation for the discrimination or ostracism of individuals with mental disorders in Ghana is a fear of contagion. Oral traditions for example note the custom of older family members investigating the family of a potential spouse for a younger family member to rule out the presence of psychopathology in the potential spouse’s family and thereby prevent the introduction of a mental disorder into the investigating family’s bloodline. The contagion associated with mental disorders was assumed to have a mechanism of action similar to the “evil eye” which imparted ill will on any who beheld its gaze, although more vulnerable individuals such as a baby in the womb were at higher risk of contagion. Thus, given traditional beliefs that a pregnant woman who looked upon a person with a specific mental disorder would have that same mental disorder transferred unto her unborn child, individuals with mental disorders and by association their families were shunned by society in the interest of self, familial, and societal preservation. The stigmatization of individuals with a mental disorder usually results in affected individuals facing economic and social discrimination and battling self-loathing due to internalized stigma.

Social Defenses Employed Against Mental Disorders Anxiety

The field of group dynamics provides a group dynamics perspective from which to understand the persistence in the stigmatization of individuals with mental disorders. Hopper refers to the collective unconscious or out of awareness behavior of a society as the ‘social unconscious’. He defines the social unconscious as “the existence and constraints of social, cultural and communicational arrangements of which people are unaware, in so far as these arrangements are not perceived (not "known"), and if perceived, not acknowledged ("denied"), and if acknowledged, not taken as problematic ("given"), and if taken as problematic, not considered with an optimal degree of detachment and objectivity”. Under Hopper’s definition, the attributions of mental disorders to supernatural activity in Ghanaian culture falls in the “given” arena of its social unconscious in so far as the culture’s overreliance on religious explanations to understand and treat

mental disorders is accepted but not seen as problematic even though evidence for alternative causes of mental disorders exist. Irrespective of levels of educational attainment, most families consider it a "given" to consult a spiritual leader as the first response when a family member exhibits signs of mental distress following beliefs that the supernatural rules everything in the natural [6-10].

From a group dynamics perspective, this persistence in ascribing supernatural origins to mental disorders may lie in the defensive function employed by the society's social unconscious. A group, organization, community, or society's social unconscious uses social defenses such as repression of memory, denial and projection to keep its members past actions or inactions in any given sphere out of awareness in order to protect the social group from being overwhelmed by fear or guilt. Although this operates at the out of awareness level, the communications of a group's social unconscious may be inferred by the social defenses it employs to ward off anxiety. Persecutory anxiety, which arises when one has a paranoid and usually irrational fear of being attacked or killed appears to be driving anxiety behind the stigmatization of individuals with mental disorders which is then collectively defended against at the out of awareness level but communicated through its use of projection, rationalization, and denial.

Projection involves locating unacceptable or threatening traits or impulses outside of the self and in another. Societal level projections place threatening impulses from the stronger or less vulnerable in society into the weaker or more vulnerable in the society to allow the stronger people in the society to function unhindered by these threatening impulses. Thus, for the supposed greater good of the society, the weaker group is forced to become containers for projected impulses and take on the tension reliving role on behalf of the stronger group of the society. As a social defense, projection works through otherness, the process whereby individuals define themselves in comparison to other individuals with different demographic variables. In othering, the group that holds the position of privilege in the society is used as the reference group for comparison (e.g., women are the other two men and not vice versa, the uneducated are the other to the uneducated, the sick the other to the healthy, etc.). In the specific case of individuals with mental disorders, projection arises when the majority or the mentally well's phantasies of their behavior if they were to lose control of their minds produce anxiety laden affects (*i.e.*, would they behave bestially and be a menace to themselves or others? would they need to be bathed and fed?) which are then mentally transferred into the minority or mentally unwell in the society, causing them to be unjustifiably perceived as dangerous and violent. Thus, the unacceptable thought of 'I can be dangerous' is projected as 'you are dangerous' into individuals suffering from mental disorders. Once the fear of losing self-control and individual autonomy is located in individuals with mental disorders in the society, the mentally well functions unhindered by this anxiety. Societal level projections lead to the generalization of all individuals with any type of mental disorder as dangerous, irrespective of whether the diagnosis is as mild as an adjustment disorder with depressive symptoms or as severe as a schizophrenia spectrum or other psychotic disorder.

The social defense of rationalization involves giving rational and logical, albeit false reasons for failures or shortcomings. In reality very few individuals with mental disorders are dangerous, with the majority of this population being vulnerable and needing care and compassion rather than ostracism or economic discrimination. By rationalizing however that individuals with mental disorders need to be avoided since they are:

- Unpredictable and dangerous to others.
- Reaping their just deserts for wrongful sinful actions.
- Not having put in the work to strengthen themselves spiritually, the just world paradigm and the attribution of an internal locus of control is unfairly employed against individuals with mental disorders.

This keeps the collective anxiety which would arise from acknowledging a lack of compassion toward a vulnerable group of the society at bay.

A final social defense utilized against the persecutory anxiety aroused by the phenomenon of mental disorders and which continues the stigmatization of this population is denial. Denial takes many forms such as minimizing or negation, and is employed when one refuses to accept or believe an unpleasant reality to protect oneself from that reality. As a social defense, denial works to prevent identification with the mentally ill in the society. Identifying with another arises from the understanding that one is similar to another human due to our shared experiences, and builds empathy towards so called others since they are not so other after all. The anxiety however that would arise from acknowledging our shared experiences as humans, with the possibility that one could also experience a mental disorder and possibly loose one's autonomy prevents the building of empathy towards this vulnerable group in the society and hinders the subsequent de-stigmatization of individuals with mental disorders that this empathy would bring.

DISCUSSION

Tackling the Stigma Status Quo: A Wicked Problem!

Attempts to address mental health stigma are unfortunately largely unsuccessful in most societies because mental health stigma additionally falls in the category of social problems classified as 'wicked problems'. Wicked problems are problems which are ill defined, complex, or intractable and which cannot be tackled using traditional and linear approaches. They are therefore analogous to virus strains which mutate and defy attempts to neutralize them.

In addition to mental health stigma being a wicked problem, a change in relating to individuals with mental disorders at the societal level means giving up a familiar and known way of relating for a relatively unknown way which is anxiety provoking.

One way to address both hurdles could be by following the recommendations from Weick's seminal paper on using "small wins" to make inroads in big problems so as to avoid being overwhelmed by dysfunctional levels of arousal, frustration and helplessness which paralyze action. Small wins also have the advantage of "testing implicit theories about resistance and opportunities, and uncover both resources and barriers that were invisible before the situation was stirred up". A small win then in changing the stigma narrative for individuals with mental disorders in Ghana should therefore begin at the individual treatment level with mental health providers taking the lead in making the inclusion of patients' religious leaders in treatment plans a standard for care. Although low levels of collaboration and distrust between healers who use the religious belief system to guide their interventions and those who use the scientific belief system have been reported, a small win approach will both test implicit theories about resistance from providers who use supernatural interventions such as prayer, fasting, and deliverance and view mental health professionals as "carnal" or "unspiritual"; and providers who use evidence based interventions and view faith healers as "quack" or "ignorant", and implicit theories about opportunities, such as a shift in long held beliefs that mental disorders respond primarily to supernatural interventions when faith healers readily refer their members to the scientific community to coordinate their mental healthcare.

Potts and Henderson have reported that an anti-stigma social marketing campaign time to change global implemented in Ghana using predominantly social media platforms and a core message of "it could be you" reported significant post intervention positive changes in attitudes towards mental health and intent to associate more with individuals with mental disorders. Thus, a concurrent small win approach to tackling the stigmatization of individuals with mental disorders could be in the arena of social activism *via* infotainment designed to counteract stereotypical portrayals of individuals with mental disorders as dangerous that would change the derogatory language used to describe this population in the media. This activism can be achieved under a partnership of representatives from the scientific and religious communities who serve as consultants, media houses who sponsor this social justice project as part of their corporate social responsibility, and social media influencers who advocate for mental health. Analyses of outcomes following the implementation of these small wins could begin with a measurement of changes in the beliefs and behaviors which perpetuate stigma for individuals with mental disorders, and, following feedback of positive outcomes, encourage stakeholders to attempt bigger wins. In addition, the bandwagon effect's mechanism of publicized small wins occurring simultaneously in different places can help bring about transformative changes to the mental disorders' narrative. The work of religious healers for example who destigmatize mental health disorders to their peers and congregations and collaborate with scientific providers in providing holistic mental health treatments, can be featured in various media to help transform negative attitudes towards individuals with mental disorders and their families in their communities. The combination of the modeling effects of behaviors of providers from both the religious and scientific communities who complimentarily and collaboratively treat individuals with mental disorders, and the use of a social justice-oriented infotainment approach to mental disorder stigma reduction which has been proven effective in changing stigmatizing behaviors of the public, e.g., Potts and Henderson would provide a synergistic effect towards reducing stigma in the country.

The challenge to implementing change from the group dynamics level of analysis comes from confronting the structural opposition that works to keep the unfair treatment of the society's vulnerable population of individuals with mental disorders out of awareness. Social defenses employed to deal with anxiety surrounding mental disorders are organized under the principle of utility, where "the needs of the many outweighs the needs of the few". The needs of the mentally well in the society to function unhampered by persecutory anxiety is thus seen to outweigh the needs of the mentally unwell for empathic responses since their mental health affects their ability to contribute economically and socially to the society to the same degree as the mentally well. To address this colossal constraint, the Akan proverb which states that wode ka na wo se te, na wo yere te a, na woawie fere (bringing a thing into the open no longer makes it so fearful), may be the small win that brings about a change in the defensive structure employed against mental disorders on the societal level. Translating this proverb into action could involve the use of social activism to dispel the myths and fears surrounding individuals with mental disorders and also build empathy towards individuals with mental disorders [11-16].

CONCLUSION

In Ghanaian society, the governing role of the supernatural as it pertains to the interpretations and treatments given to individuals with mental disorders in the country has been explored, and the "given" arena under which it operates has been examined. This arena of operation which does not accept the overreliance of supernatural origins and interventions for problems as problematic, needs modification before the stigmatization of individuals with mental disorders can be tackled with any degree of objectivity. Secondly, although the stigmatization of individuals with mental disorders and their families is a big social issue, it is seen as such by the minority of affected individuals and workers in the mental health field. The preceding recommendations have been provided as a way to use small wins to make lasting change and prevent the minority working in this field from being overwhelmed by the magnitude of this systemic reality. Following a series of successfully implemented small wins, bigger wins at the policy level of analysis, such as evidence based guidelines for determining the criteria under which mental disorders should be treated from purely faith based approaches, scientific approaches, or a combination of the two can be adopted as frameworks for treatment [17-20].

CONFLICT OF INTEREST DISCLOSURES AND OTHER ETHICS STATEMENTS

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

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