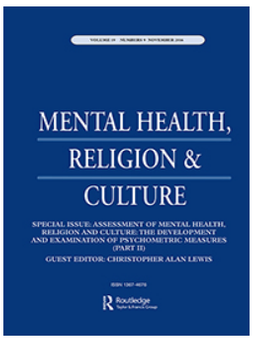

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"It's only 'madness' that I know": analysis of how mental illness is conceptualised by congregants of selected Charismatic churches in Ghana

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ABSTRACT

In Ghana, many individuals employ traditional and faith healing for treating illnesses. Although attitudes and knowledge of laypeople on mental illness have been explored, little is known about Christians' knowledge and how the church influences such knowledge. The present study explored knowledge on definition, types and symptoms of mental illness, church teachings on mental illness and the influence of such teachings on the mental well-being of 86 congregants of six Charismatic churches in Ghana. Through in-depth interviews, focus group discussions and observations, we found that knowledge surrounded psychotic disorders with a few citing other DSM/ICD categories. Regarding church teachings, some churches provided education and spiritual healing, and others emphasised non-existence of, and immunity from, mental illness. Findings showed the "double-edged" role of religion in enhancing and hindering congregants' mental well-being. The paper concludes with an argument for psycho-education on mental illness and collaboration between churches and mental health practitioners.

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Introduction

Mental illnesses form part of the common health conditions that affect individuals' well-being globally (Hugo, Boshoff, Traut, Zungu-Dirwayi, & Stein, 2003). It is estimated to affect about 10% of the adult population at any moment, and at least 25% of all individuals at some time in their lives (World Health Organization [WHO], 2001). Despite the high prevalence and widespread nature of such conditions, mentally ill individuals experience stigmatisation, social rejection and isolation (Lauber, Anthony, Ajdacic-Gross, & Rossler, 2004). These negative attitudes are not only expressed by laypeople (Gur, Sener, Kucuk, Cetindag, & Basar, 2012), but also by mental health professionals (Lauber et al., 2004). There are also poor knowledge and misconceptions of mental illness which can impede early recognition and appropriate help-seeking behaviour (Jorm, 2000).

In Africa, it has been found that about 5% of the total population shows definite psychiatric syndrome and about 20% shows evidence of psychiatric distress (German,

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1987). These findings, although limited, suggest that the prevalence of mental illness in Africa is comparable to that of the global community (Hugo et al., 2003). Despite the high prevalence, there are still ignorance, stigma and misinformation surrounding mental illness (Hugo et al., 2003). The limited knowledge on mental illness has also been cited to underlie numerous consultations at the general practitioners (WHO, 2001).

In Ghana, although different treatments exist, including psychiatry, psychology, herbal and spiritual treatments (Ae-Ngibise et al., 2010), many people (70–80%) resort to traditional treatments for solutions to ill health (WHO, 2007). Traditional treatment options are estimated to comprise 45,000 traditional healers and church facilities throughout the country (WHO, 2007). The high patronage of traditional treatment has been associated with scarcity of mental health resources (Barke, Nyarko, & Klecha, 2011); affordability, availability, accessibility and social support associated with traditional treatment (Ae-Ngibise et al., 2010; Opare-Henaku, 2013; Roberts, 2001). Other factors include limited knowledge about mental illness, stigma surrounding psychiatric treatment and causal attribution of illness to supernatural forces (Roberts, 2001). Of these factors, individuals' causal attribution has been found to directly predict choice of treatment (Lynch & Medin, 2006).

In Ghana, mental illness is largely viewed as a "spiritual illness" (Kyei, Dueck, Indart, & Nyarko, 2014; Opare-Henaku, 2013, p. 5), thus pointing to the significance of spirituality in the conceptualisation of mental illness. The supernatural mechanisms are thought to be the roadmap to understanding agents and sources of health. In this regard, Opare-Henaku (2013) outlines three supernatural models on illness causality, including the human causality (use of sorcery for health or illness), the non-human causality (the role of ancestors or evil spirits in health or illness) and the Supreme Being causality (The Supreme Being as the sole source of health or illness). The above scenarios highlight the strong beliefs held by some Ghanaians on the role of supernatural forces in health or illness.

An extension of this belief can be seen in the dominant role of religion and religious organisations in the treatment of mental illnesses in Ghana. It has been estimated that only 2% of individuals with mental illness seek biomedical treatment (Roberts, Mogan, & Asare, 2014) with a vast majority resorting to traditional and faith healers (who are either Christians or Muslims) (Ae-Ngibise et al., 2010). Of those who seek traditional and faith healing, many resort to prayer camps which are predominantly of the Christian faith and are run by faith healers (Read, Adibokah, & Nyame, 2009). Despite the identified factors already discussed in the preceding paragraphs (Ae-Ngibise et al., 2010; Barke et al., 2011; Opare-Henaku, 2013; Roberts, 2001) that are associated with the high patronage of traditional and faith healers, the religious beliefs of the individuals and the nature of Christian teachings that are advanced in the religious affiliations of Ghanaians might have a significant role.

The literature has shown that people's causal explanations and beliefs of illness have a strong influence on the kind of treatment options they would consider, whether they would believe in the potency of other treatment options that are not in line with their beliefs, and may lead them to perceive other treatments as less satisfactory (Lynch & Medin, 2006). Against this background, it is possible that Ghanaians sought after traditional and faith treatments because of their religious and cultural beliefs in the role of the supernatural in mental illness. Additionally, according to Mbiti (1995), religion permeates all aspects of the lives of Africans. Similarly, Ghanaians have been found to be highly

religious, with 90% of the population identifying with a religious group and 71.2% professing the Christian faith (Ghana Statistical Service, 2012). It is therefore not surprising that Christianity plays an immersed role in the management of ill health in Ghana.

In Ghana, although attempts have been made to understand how Ghanaians conceptualise mental illness (Fiasorgbor & Aniah, 2015; Kyei et al., 2014; Opare-Henaku, 2013), little has been done to explore the role of religion in shaping Ghanaians' knowledge on mental illness. The present paper forms part of a broader study that explored the influence of activities of selected Neo-prophetic/Charismatic churches on the mental health of congregants in Ghana. This paper focuses specifically on exploring congregants' knowledge of definition, types and symptoms of mental illness, as well as church teachings on mental illness and the subsequent impact on the teachings on congregants' mental well-being.

Methodology

Research design

Qualitative research design was used for in-depth exploration of participants' conceptualisation of mental illness (Nunn, 2009) and for rich narratives of participants' perspectives. Precisely, the phenomenological qualitative design was used to guide the study due to the focus on individuals' thoughts on mental illness. In-depth semi-structured interviews, focus group discussions and observations of church activities were used for data gathering.

Research settings and sample

Six churches in Kumasi (three) and Accra (three) were recruited using snowball, convenient and purposive sampling techniques. These settings were used because they are the most cosmopolitan areas and most populated with Pentecostal/Charismatic churches in Ghana. We used only churches that self-identified as Neo-prophetic churches. The participating churches were Favour, Charity, Godliness, Holiness, Endurance and Purity (these are pseudonyms). In total, 86 individuals (38 males, 48 females), aged between 13 and 64 years participated in the study. Of them, 13 (15.12%) were from Favour, 15 (17.44%) from Charity, 28 (32.56%) from Godliness, 6 (6.98%) from Holiness, 14 (16.28%) from Endurance and 10 (11.62%) from Purity. Fourteen were church leaders, made up of pastors, prophetesses, deacons and deaconesses and 72 were congregants.

Trustworthiness of the data

We followed Sheton's (2004) and Maxwell's (2005, 2009) recommendations to ensure trustworthiness. For credibility, triangulation was employed through multiple informants (congregants and leaders) and multiple data collection methods (interviews, focus group and observations). Reliability was ensured through the use of quality tape recorders and detailed transcription of interviews. To augment trustworthiness, we adopted established qualitative research methods suitable for the study (phenomenological design) and familiarised ourselves with the culture of research settings through participating in church

activities before and during data gathering. Furthermore, we frequently debriefed participants and research team, enlisted peer scrutiny of project and member checks.

Ethical considerations

Ethical approval was obtained from the Ethics Committee for Humanities of the University of Ghana. Informed consent was sought from leaders of the participating churches and from participants. Interviews were conducted in English and Twi depending on which language the participants were comfortable with. Voluntary participation, anonymity and confidentiality of the information shared were emphasised. Money was given as a token of appreciation for participants' time and personal experiences shared towards the research.

Procedure

A weeklong observation of church activities was conducted at all churches during which participants were recruited. In-depth semi-structured interviews and focus group discussions which aimed at exploring participants' conceptualisation of mental illness were conducted. All interviews were conducted by the first and third authors and they took place at the church premises after or before church activities. Interviews lasted between 9 and 96 minutes and observations lasted between 1 hour 30 minutes and 6 hours.

Data analyses

Transcribed interviews were analysed using Interpretative Phenomenological Analyses (IPA; Smith, 1996). IPA aided the researchers in the explanation and interpreting of the meaning of participants' accounts of their experiences (Smith & Osborn, 2003). The first and third authors independently coded the transcribed interviewees' responses from each church. During the initial coding, the researchers focused on identifying patterns of participants' understanding of mental illness, in terms of definition, knowledge on symptoms and types, and accounts of church teachings on mental illness. The next level of analysis was focused on interpretation made of participants' explanations and meaning made of their experiences. Codes were compared across interviews for similarities and differences in order to generate clusters of themes. Following this process, the second author compiled all the generated codes, quotes and interpretations made and compared and contrasted codes by the first and third authors. The second author, while compiling, comparing and contrasting the codes and interpretations, identified areas of agreement and disagreement between the two coders and her personal position on all the codes. There was a back-and-forth engagement among the three authors and refinement of codes and generated themes until agreement was reached. We then formulated and interpreted themes in light of the literature and existing theories on conceptualisation of mental illness.

Results and discussion

The results are organised according to the research questions and findings are categorised into themes and sub-themes based on participants' accounts.

Defining mental illness as deviation from normal behaviour

Some of the participants described mental illness in line with acceptable definitions in the field of mental health. Mental illness was defined as a deviation from normal behaviour (Comer, 2004). Abnormal behaviour was described as behaviours that deviate from acceptable behaviours in the Ghanaian culture. Abnormal behaviours included inappropriate nudity, aggressive or harmful behaviour as well as poor expressive language and social interactions:

> What I know is that mental illness is a process whereby one acts abnormally or one behaves out of his sense and does not behave normal … as a human being is supposed to behave. He behaves abnormally … Normal is like we are … but if you see someone outside dressed naked passing by, someone using the head to hit the wall … you will know that person's … sickness is abnormal … . (Participant 45, Godliness)

Deviation from normal behaviour was also believed to be evident through language expression and interaction with others in the society. Once an individual's language and interpersonal relationship do not conform to those acceptable in the society, such behaviours were perceived to be a symptom of mental illness:

> … I know mental illness, they are basically a group of people who one way or the other I would say they are deformed in their language and some of the things they do are not quite pretty or enough like how normal people speak or talk or do other things … . (Participant 19, Male, 22 years, Charity)

Defining mental illness as dysfunction of the brain

Some participants also reported that mental illness is a dysfunction, a disease or a disorder that affects the brain or mind. These perceptions were consistent with the biomedical model (Myers, 2008) that tends to view illness as being caused by biological agents that overtly affect the individual's behaviour and well-being:

> When we talk of mental illness … it's a disorder in the brain, as a human being, there's a disorder in your brain, that's mental illness. (Participant 35, Godliness)

Additionally, it was also perceived that although a disorder of the brain is an internal condition, the physical evidence is the abnormal behaviours exhibited by individuals who suffer from mental illness. The aftermath of the disorder is also perceived to affect all aspects of the individual's life:

> mental illness … has to do with brain disorder … it has to do with stuffs that goes wrong in your brain and then comes out to affect you in general. (Participant 22, Charity)

It is worthy to note that participants who defined mental illness as brain disorder and deviation from normal behaviour were students in tertiary and high schools. This highlights the significance of education in the understanding of mental illness, as these definitions were close to the academic conceptualisation of mental illness.

Lay views: mental illness as madness (Abɔdam)

Mental illness was commonly equated to "madness" an English translation of the local label for mental illness, which is Abɔdam in Twi, meaning an illness of/that affects the

brain or mind. As illustrated in the quotes below, the behaviour associated with "madness" involves poor hygiene and nudity. These are portrayals of people with severe mental illness that walk the streets of Ghana. This finding is consistent with previous research (Opare-Henaku, 2013). Although Opare-Henaku found different labels, the participants in the present study used only "madness" to label mental illness. Judging from the symptoms exhibited by individuals who are considered "mad" in the Ghanaian context, it could be alleged that Abɔdam denotes psychotic disorders. These individuals exhibit signs of hallucinations (e.g., talking to themselves), delusions (e.g., grandiose beliefs), poor hygiene (usually dressed in tattered and dirty clothes), aggression (sometimes attack people without a reason), sometime nude, sometime harmful to self and others and wander across several distance from their home (some migrate from far places on foot):

> … Madness, it's only "Madness" that I know … that is, those who eat on the refuse dumps. They are not normal. They do things as if they are not humans. They do things anyhow. (Participant 73, Endurance)

The quote below also highlights how madness (Abɔdam) is generally equated with mental illness. The belief that Abɔdam is caused through abuse of drugs also corresponds with lay Ghanaian beliefs on the causes of mental illness (Opare-Henaku, 2013):

> Mental illness, … like madness, yes, a madness is a mental illness or let me say like you abuse drugs you always get a mental illness. (Participant 36, Godliness)

Lay views: mental illness as a cause of, or different from, madness

Some participants also perceived that mental illness is different from madness. From the quote below, although the participant reported to have suffered from mental illness, because his symptoms did not conform to the general notion of mental illness (madness), he believed what he suffered was not mental illness:

> … for mental illness, I've experienced some myself but I didn't behave like how a mentally ill person behaves … . (Participant 55, Holiness)

Some participants also erroneously believed that mental illness is a potential cause of madness. This is a misconception given that what is considered "madness" in the Ghanaian context can be classified as psychotic disorders:

> Mental illness can lead to madness. (Participant 36, Godliness)

Types of mental illness: DSM/ICD categories

When asked to cite some types of mental illness, some participants cited examples that are listed in the DSM (APA, 2013) and ICD (WHO, 1993) categorisation of mental illness. Types cited included depression, schizophrenia, mania, obsession, drug addiction, phobia, down syndrome and autism:

> I think any type of phobia is a mental illness. You know we have people who are afraid of … height … is not really a mental illness but it's quite an abnormality when it gets to the extreme, or people that are afraid of a duck or maybe some particular type of noises. (Participant 14, Charity)

> I know of down syndrome … I don't know if autism is supposed to be a mental illness but yea I know of down syndrome that one I'm so sure about. (Participant 21, Charity)

> I think depression is one, that's what we all know … I don't know … I think depression and maybe frustration. Those are the two I can say. I don't know much about it. (Participant 20, Charity)

From the above quotations, it is evident that despite the fact that these participants cited credible examples, there were implicit uncertainties in their response. The repeated use of "I think" and "I don't know" points to the level of doubt in their own knowledge on mental illness and further emphasises the limit of their knowledge. It is also worth noting that participants who cited these categories were tertiary students, thus, highlighting the significance of higher education in aiding understanding of mental illness.

Lay views of types of mental illness: nudity as a predictor of types of "madness"

Besides viewing mental illness as "madness" (Abɔdam), participants also mentioned types of "madness" which could be differentiated by the levels of nudity. In this regard, there seemed to "total or partial madness". Mentally ill individuals who go completely nude were perceived as "totally mad" and those who might be suffering from mental illness but are not nude could be perceived as "partially mad":

> That's the mental illness, even some can remove all their clothes, that one is total madness, but some dress well but their speech doesn't make sense. (Participant 3, Favour)

From participants' accounts, nudity could also be used to judge the severity of "madness". Completely nude people were perceived to be severely mentally ill, whereas dressed people who show other signs of mental illness could be perceived as mildly or moderately mentally ill:

> … there are some people who have burning sensations in their brain, but they don't become naked on the streets and pick things from the refuse dump. But for some people too, they become naked. I know a man … when his madness comes, he dresses well and carries a watch, and when you meet him, you wouldn't even know he is mad. He goes about talking to himself, but at sometimes, the condition goes off. There are times that it goes off and other times that, it come on. So for me, these are the types I can talk about. For some people, they are able to run into the public and get themselves naked. And there are others that are mad but are gentle. (Participant 72, Endurance)

Lay views of types of mental illness: physical illnesses as types of mental illness

When participants were specifically asked to cite examples or types of mental illnesses they knew, some participants cited several physical conditions as types of mental illness, including typhoid fever, pneumococcal meningitis, brain tumour and epilepsy. Given the specificity of the question asked of participants, the outright citation of physical illnesses as types of mental illness suggests that participants really believed that the physical illnesses cited were types of mental illnesses. Additionally, although it can be argued that some physical illnesses can lead to some mental illnesses (such as depression and anxiety), there was no evidence that participants understood the link between physical

and mental illnesses. The outright citation of physical illness in their response further highlights the lack of understanding on the differences between mental and physical illnesses:

> … pneumococcal meningitis, that one they said that it … affects your brain and your spinal cord. (Participant 29, Godliness)

> Hmm, brain tumor and maybe, pneumococcal meningitis. It is also in the nervous system, it also affect [people]. (Participant 30, Godliness)

Symptoms: harm to self and others

Harm and aggression were commonly cited by many participants. These were either self-inflicted harm or harm caused to other people. The self-inflicted harm was perceived as abnormal due to the perceived satisfaction and pleasure obtained by the individual following the self-inflicted injury:

> Whenever [the mental illness] comes, that friend of mine tries using something on the head. Sometimes … hitting her head on the ground very hard and the metallic double bed … she says that's what she feels, sometimes she can hit her head on the class wall … she'll lie on the floor and she'll hit her head on the floor … she says when she uses her head to hit something, she feels okay … . (Participant 39, Godliness)

Harm to others was also perceived to be a symptom of mental illness due to the belief that such behaviour was largely triggered by narcotic drug use which is perceived to be a cause of mental illness in the Ghanaian context (Opare-Henaku, 2013):

> … he smokes weed [marijuana] … and adds alcohol, then he begins to shiver as if something bad has happened to him … and now he is mentally ill … his illness is not severe to the level where he is naked in public, but he has mental issues. When it comes … it made him to steal … he can take your bags and draw out your money. If you don't give him money, he would rape you … . (Participant 70, Endurance)

Aggression

Aggressive behaviour was also one of the prominent themes that emerged from participants' accounts of symptoms. Participants perceived that those with mental illness often become aggressive in their interaction with others:

> Some people's mental illness makes them aggressive. They do everything aggressively … They … pick this, look at it, picks up things and plays with it. Some … become very aggressive when it comes. There are some who get mad and go outside with it … they go around picking food from places. (Participant 65, Purity)

Inappropriate behaviour

A number of inappropriate behaviours were cited as being symptoms of mental illness. These include strange/unexplained behaviour, wondering, drooling, destructive behaviour, nudity, indiscriminate laughter, incoherent speech and catatonic posture. For many participants, the behaviours of individuals with mental illness are strange and cannot be explained:

> … for instance you can see that when someone is sitting there, he or she can behave strangely and display some behaviors that cannot be explained. (Participant 2, Favour)

Incoherent speech, indecent dressing and nudity emerged consistently in participants' accounts of symptoms of mental illness. These findings were also not surprising given that they are common behaviours of mentally ill individuals who can be found on the streets of Ghana:

> when a person starts talking "by heart" [haphazardly] and it's not normal, and the person doesn't even know what he's saying, and also the person doesn't dress well. That's mental illness, even some can remove all their clothes … . (Participant 3, Favour)

For other participants, laughter without an external triggering stimulus was not a behaviour that is expected of "normal" people and therefore was perceived to be a symptom of mental illness:

> Like, I know that someone can just be talking, and then he'll start laughing. (Participant 57, Holiness)

Some participants also reported that prolonged standing posture without responsiveness is a symptom of mental illness. This behaviour was perceived to be particularly unusual given the unfriendly environmental conditions which mentally ill individuals tend to endure when in a catatonic stupor, and was therefore perceived to be a symptom of mental illness:

> Some can also stand at one place from the morning up to the evening. That person can be standing in the sun but nothing will cross his mind to go under shade. So those behaviours will make you see that the person has a mental issue. (Participant 57, Holiness)

Issues of hygiene

Issues of hygiene emerged strongly and were cited by many participants. Particularly significant was sleeping in inappropriate places:

> When someone is mentally ill, the person does things in a messy way. He or she doesn't act as a normal person. A mad person can just go sleeping on the streets but a normal person won't do that. (Participant 11, Favour)

Also significant was the issue of uncleanliness and feeding from refuse dumps. This behaviour was viewed as abnormal because it was perceived to be preferred by the mentally ill individual who seems oblivious of the dirt and continues to engage in unhygienic behaviour. It was also acknowledged that although uncleanliness could be observed in normal people, it is extreme in individuals with mental illness:

> … He would prefer the rubbish dump and places that aren't good … They are not neat at home … the person could take an empty water sachet and stuff it in an empty or partially empty match box with weeds … and the person gets his things dirty and when his things get dirty he doesn't realize it and still wears them … When you enter the room of a neat and normal person, [you] will see … and there are dirty people too. So when I see someone like that [behaving as described above], I feel the person is mad. (Participant 53, Godliness)

Hallucinations

Hallucinations were also cited by some participants as being a symptom of mental illness. These behaviours were considered abnormal due to the absence of observable external triggers:

> … he began to smoke marijuana, cigarette and also sniffs cocaine as well. His body system did not like it, and it made him to dance outside without music at the background, but he would be dancing … when he is there, then he is talking to himself … . (Participant 70, Endurance)

To recapitulate, it would seem that the types and symptoms cited were surrounding psychotic and drug-related disorders. These are the kinds of disorders that are easily identified in the Ghanaian community, those that are often shown in the media and those that Ghanaians have native lexicons for. It was therefore not surprising that such accounts dominated participants' knowledge on mental illness, highlighting the limited knowledge on mental illness.

Views on church teachings: provision of resources

There were some churches that provided education on the causes, treatment and care for mental illness through either professionals or Biblical sermons. It would seem that the aim of these teachings was to instigate abstinence from activities that were perceived to cause mental illness:

> Hmm, they do teach us to be careful from peer influence and taking drugs and not doing what you're not supposed to do especially when we go to school … . (Participant 29, Godliness)

> They teach us about hard drugs and advise the youth especially to abstain from drugs. They even advise us, Christians, to stay away from alcohol since too much alcohol intake can cause mental illness and not even to engage in occasional alcohol intake. (Participant 2, Favour)

It could also be deduced from the quote below that some of the teachings are also geared towards teaching virtues about caring for those with mental illness and reducing stigma surrounding mental illness:

> my church teaches about mental illness … about how to manage or take care of people who face such kind of disease so that … they would become useful also to the society or to the church again. (Participant 17, Charity)

The above teachings illustrate the positive impact religion can have on society through instilling values that could lead to positive attitudes and virtues that can promote individual and collective well-being.

Some churches provided teachings that emphasised the role of spiritual forces in mental illness. This finding is consistent with previous Ghanaians studies (Kyei et al., 2014; Opare-Henaku, 2013). Some of these teachings have the potential to induce fear and paranoia given that some congregants believed that working towards success and progress in life could attract envy and demonic machinations:

> … my church teaches me that sometimes when you're progressing or you are learning too much than someone [else], that person can send you to a traditional priest or any other person to do something bad to you, then it'll cause maybe madness so that you can't move on in life. (Participant 28, Godliness)

Others emphasised the interaction of lifestyle and spiritual factors in determining mental illness. Most of these messages were geared towards conscientising individuals on negative behaviours that are perceived to have the potential to cause mental illnesses. It would also seem that these messages are geared towards teaching moral values to congregants:

> … The teachings about [mental illness] is that, don't try to steal someone's husband, the person might not know the word of God. If you get close to the person's husband the person might curse you and that curse might make you mad. So if I weren't married, and I didn't have the word of God in me and if I go near someone's husband … I might get mad … (Participant 63, Purity)

Some churches also emphasised spiritual healing and the ability of the church to provide spiritual solutions for mental illness. From the quote below, congregants appeared to believe that there is an instant and permanent cure for mental illness, and that the congregants have power to induce cure through prayers. This teaching could encourage optimism, hope and agency by inciting the inward power of the individual to overcome problems. On the other hand, it could restrict individual's help-seeking avenues through engendering an overreliance on spiritual solutions or faith healing. In situations where faith healing fails, it could engender feelings of hopelessness which could in turn cause other mental illnesses such as depression (Brissette, Scheier, & Carver, 2002).

> … prayer is the key to everything because if you have a mental illness we can pray for you and it will vanish at once and it will never come back. Most of them, [...] you normally watch TV [television] "Oh this person is insane" then the pastor will pray for that person and the madness will vanish so, about mental illness, prayer is the key. (Participant 35, Godliness)

Some churches also provide healing schools and deliverance sessions for healing mental illnesses and other diseases. It is perceived that these sessions are meant to teach the Bible and build the individual's faith, which are believed to be the needed mechanisms for spiritual healing to occur. The nature of the healing and deliverance sessions described by participants is similar to that of the Presbyterian Deliverance School in both Akropong and the USA described by Mohr (2013). It would seem that church teachings of the role of supernatural forces in causing mental illness and the potency of religious healing are universal Christian doctrine that can be found in Ghanaian religious communities both in Ghana and in the diaspora:

> … people with mental illness mostly are taken to our healing school. We have a healing school that runs at some point in times of the year and people with such illness are taken there and then they are taught the word of God, their faith is built up and then most of them … are healed. (Participant 23, Charity)

Advancing "invincibility theology"

Some of the teachings tend to emphasise the non-existence of mental illness and how the Christian identity gives congregants the power to abolish thoughts of mental illness from their mind. Of the six churches (i.e., Charity, Endurance, Godliness, Holiness, Favour and Purity) sampled for the present study, the "invincibility theology" was more pronounced in Charity and appeared to be at the core of their teachings. However, traces of this teaching were found in Godliness. Congregants in these churches therefore live in denial of the

existence of mental illness and believe that once they identify with Christianity, they are immune to mental illness:

> mental illness, we've not really had any, those things they are all classified as illnesses, so as a Christian if you know who you are, you are not permitted to ponder such things, they are demonic, so you are to cast it out. (Participant 16, Charity)

Additionally, some churches also teach that membership in a particular church makes congregants invulnerable to mental illness. Although such teachings could promote a sense of hope, it has the potential to induce a false sense of invincibility to mental illness. From the quote below, the potential caveat from such teachings is that, individuals could live in denial of the existence of mental illness and in situations where one has been a member but suffers any form of mental illness, there could be the potential for faith crisis or cognitive dissonance, which in turn can cause mental illness such as depression (Hartog & Gow, 2005):

> … we also believe that no one … is mentally ill in this church, if you are mentally ill, then it means that maybe you are a first timer, you just came to the church or something, because we also teach that … we have a sound mind, we have the mind of God. The mind of God is not an ill mind, yes so we can't be mentally ill. (Participant 13, Charity)

Through other participants' accounts, it appeared that mental illness is equated to death and perceived as the worst experience that could happen to any human. It was thought to develop through one's declarations and admission of negative experiences and thoughts. This finding is consistent with previous research (Stanford, 2007). It was also believed that certain religious declarations by the individual and church leader could cure mental illness. For the individual, such teachings could induce a sense of self-efficacy through encouraging congregants that they have the capacity to effect spiritual healing:

> mental illness is basically death. Most at times we make confessions through all those things so … our bodies too respond to the way we talk and all that stuff, so you have a sound mind like, we have some confessions that we make so those things would not happen to you, so if you are … coming and [you have mental illness] you just preach or your leader or someone cast that thing out and you are cool. (Participant 14, Charity)

The potential for self-efficacy beliefs as well as blind faith is also highlighted by the quote below through placing healings in the hands of the individual as opposed to the medical doctor, for example. However, in situations where the confessions do not yield solution, there is the potential for faith crisis:

> … my church, [we] believe that God didn't intentionally [cause us to be ill], so when it happens that you are mentally ill … we still believe that out of your confessions and your faith, things can change, so in my church for instance when you come and maybe your eye cannot see, what our church teaches us is that, by your confessing and by your faith, that Christ has come to do everything, if you keep on proclaiming all these things, it would come to pass and your eyes would open … . (Participant 19, Charity)

Some churches also espouse the view that prayers and other religious activities are the only means of treating mental illness. This could limit congregants' help-seeking avenues and potentially lead to faith crisis in cases where prayer is not able to cure the mental illness:

> Okay, mental illness, they say that if you have mental illness, there's one thing, I always say that prayer is the key to everything because if you have a mental illness we can pray for you and it will vanish at once and it will never come back … prayer is the key. (Participant 35, Godliness)

> … my church, for my church we believe in miracles so when you are mentally ill I believe you can come and you will be healed. (Participant 21, Charity)

Conclusion and implications for well-being

The results of the study showed a knowledge gap on mental illness with respect to knowledge on definition, types and symptoms. The study shows that participants' knowledge on mental illness seems to surround only psychotic disorders while lacking on other categories. Some participants also hold certain erroneous beliefs about mental illness. This trend is consistent with previous studies (Hugo et al., 2003). These findings highlight the need for psycho-education on mental illness. For example, Ghana could consider adopting the efficacious "mental health first aid training" programme (Kitchener & Jorm, 2002, p. 10) used in Australia to educate the general public on mental health.

The original programme is delivered in the form of 9-hour course training across three sessions in which individuals are trained to identify symptoms of mental health problems including depression, anxiety and psychotic disorders as well as manage crisis situations such as suicidal thoughts and behaviours, acute stress reactions, panic attacks and acute psychotic behaviours. In these training sessions, participants learn symptoms of the above disorders, the potential risk factors as well as the avenues and process of accessing evidence-based effective help. For the Ghanaian population, the aim would be to raise awareness of mental illness, specifically, the types, symptoms, causes and available treatment options. In order to access many people at a time, instead of using the 9-hour over three sessions course-approach and training sessions, we could consider adopting one-session talk shows and presentations at public gatherings such as churches, mosques, schools, market places and through the media. During the session, the educator could deliver the programme in a summarised manner in order to retain attention and incite interest, and then give participants the opportunity to share their thoughts and ask questions. Using this approach would be cost effective as groups of participants could be easily accessed at a time.

As alluded elsewhere (Hugo et al., 2003), the findings also call for the need to broaden knowledge and educate the public about the psychobiological underpinnings of mental illnesses. If congregants of Neo-prophetic/Charismatic churches could be assisted to understand that mental illness has a physiological cause (Kaplan & Sadock, 1998) and that it can be diagnosed and treated with medications and therapy (Taylor & Bentley, 2004), then the journey to health promotion and mental illness stigma reduction could be close to achievement (Hugo et al., 2003).

Education should target the media, church leaders and congregants, students and laypersons. Policy-makers could consider integrating psycho-education on mental illness into the Ghanaian educational curriculum from the basic schools to the senior high schools in order that children and young adults would be well informed of mental illnesses. We also agree with other researchers (Asamoah, Osafo, & Agyapong, 2014; Stanford, 2007) who have called for collaboration between the church and mental health professionals given that the church plays a vital role in the management of mental illness.

The finding of the study also highlights the double-edged role of contemporary churches on mental health. On the negative side, some of the teachings could induce a sense of hopelessness, they may encourage the use of denial as a coping strategy with distress, may limit the avenues for treatments, encourage overdependence on individual's self-declarations and church leaders for solutions to ill health, reinforce erroneous cultural beliefs of causal attributions of mental illness, and potentially create avenues for faith crises. All of these are potential risk factors for mental illness.

On the positive side, the church also functions as a place for promoting positive self-beliefs and providing self-enhancing mechanisms for managing mental illness. This is consistent with previous studies in orphanage children (Salifu Yendork & Somhlaba, 2016). Through teachings of the individual's potential to manage problems, the church places the power to overcome problems in the hands of the individual. Additionally, the church could foster a sense of hope, resilience and self-efficacy beliefs which in turn could promote mental well-being.

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