FAMILY-SYSTEMS AND SUPPORT FOR RECOVERY: EXPERIENCES OF MENTAL HEALTH SERVICE USERS AND THEIR FAMILY CAREGIVERS IN GHANA

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ABSTRACT

Given the limited access to formal mental health services, which are still underdeveloped, coupled with the prevailing influence of traditional and spiritual perceptions of mental illness, Ghanaian families frequently function as the primary support system and assume the responsibility of care for their members experiencing mental illness. This thesis explores the role of family caregiving and support in the recovery journey of individuals experiencing mental illness in Ghana.

Central to this exploration are the lived experiences of Ghanaian mental health service users and their family caregivers, with a specific focus on how supportive or unsupportive family relationships can shape, facilitate, or hinder recovery. Drawing on relevant literature on systemic and socially based recovery frameworks such as Urie Bronfenbrenner's (1979) Ecological Systems Theory/Model, Murray Bowen's (1976) Family Systems Theory, Jerry Tew's (2013) Recovery Capitals, Robert Weiss's (1974) Social Provisions Theory and Leamy *et al*.'s (2011) Recovery Model to examine the social recovery framework in the Ghanaian context, alongside culturally grounded understandings of mental illness, this small-scale research identifies both the enabling and constraining dimensions of family caregiving and relationships towards mental illness recovery.

Employing Creswell's (2014) explanatory mixed-methods participant selection model and Weiss's (1974) social provisions scale, 140 service users were randomly sampled and medically screened to participate in the quantitative phase and subsequently 12 participants comprising six service users and their respective six family caregivers were quota sampled to complete the qualitative phase, examining the social interactions between service users and their family caregivers, underscoring how familial support influences service users' recovery trajectories.

The findings reveal that while supportive family caregiving relationships can enhance social reintegration, attachment, and reassurance of worth (emotional stability), treatment adherence and guidance, and material provisions, they can also reproduce stigma, dependency, interrelation conflicts, negative sociocultural attributions, socioeconomic challenges, and physical burdens when not adequately supported.

Consequently, this thesis argues for enhancing family relationships in the caregiving process and shifting towards a rights-based approach to recovery that recognises the mutual interdependence of caregivers and service users within Ghanaian households. It recommends policy reforms to

formally integrate family caregivers into mental health planning, including collaboration between biomedical, traditional, and faith-based systems of care, developing mental health social work practices to champion culturally sensitive psychoeducation programs, and providing psychosocial and economic support to families. By centring the experiences of both mental health service users and their family caregivers, this thesis ultimately contributes to a more holistic understanding of mental illness recovery as a shared and dynamic process within the realities of Ghanaian family and social life.

Keywords: *Ghanaian family structure, family support provisions, family caregiving, family interpersonal relationships, mental illness recovery, health-seeking behaviours, physical burdens and socioeconomic difficulties.*

PREFACE

"Holding Stories: A Reflexive Account of My PhD Journey"

When I began the PhD, I thought it would be an academic exercise—a structured path leading to expertise in a specific area. I did not realise that the PhD would become a mirror, reflecting not just what I knew, but who I was, how I thought, and what I feared. I thought the most challenging part would be the writing—the theories, the references, the constant push for originality. But I quickly discovered that the deeper challenge lay in holding the weight of the stories I had set out to hear. Researching family caregiving and mental illness recovery in Ghana was not just an academic exercise; it was a profoundly human, often emotional, and at times ethically unsettling journey.

The first year was full of ambition and idealism. I devoured literature, highlighting obsessively, convinced I could 'cover' everything. The more I read, the more I realised how little I actually knew. I remember staring at a wall of books, wondering if I would made a mistake. The question that haunted me in those early days was: *Am I smart enough to do this*? Supervisions were both affirming and terrifying. My supervisor would ask gentle, probing questions that revealed gaps in my thinking. I began to see that the PhD was not about knowing everything—it was about learning to ask better questions and being comfortable sitting in the unknown. I immersed myself in the literature—global mental health frameworks, recovery models, cultural psychiatry, and theories of care. But I was struck by how little these texts said about everyday family life in Ghana. The knowledge I sought did not sit neatly in articles or chapters—it lived in homes, conversations, and unspoken gestures. I realised my research would not just fill a gap in the literature; it had to *listen differently*.

Entering the field, I was welcomed into spaces marked by love, exhaustion, resilience, and silence. Family caregivers shared experiences shaped by obligation, faith, stigma, and unwavering commitment. Service users spoke with courage about navigating systems that often misunderstood them. Sometimes, I left surveys and interviews emotionally overwhelmed, grateful, yet burdened. I remember once sitting quietly in a *trotro* [mini bus] after a particularly intense conversation, trying to hold back tears, not just from what was said, but from what it meant for my role as a researcher. I was not just a researcher anymore—I was an emotional participant in my own research. Participants' stories were not abstract data points; they were lives full of complexity, pain, and courage. I started

to question the ethics of my distance. *Was I taking too much*? *Was I giving enough back*? These questions became central to how I wrote and thought.

Reflexivity became more than a methodological tool—it became a necessity. I constantly asked myself: *Who am I in this space? What am I carrying into these rooms? What am I taking away?* I was aware of the power dynamics between myself as a researcher and those I interviewed, especially given that I shared cultural proximity but not always the same lived experiences. This made me cautious, sometimes anxious about how I represented people's words. *Could I honour their narratives without reducing them to data*?

There were times I wanted to quit. Loneliness crept in, especially during long stretches of writing and developing health issues. Imposter syndrome became a familiar companion, whispering doubts as I typed. But I learned that reaching out—to peers, to mentors, to friends—wasn't weakness. It was survival. There were also moments of doubt—when transcriptions blurred into each other, when analysis felt like a betrayal of the richness of people's lives, and when writing felt impossible. But there were also moments of clarity: when a theme emerged that connected stories across different homes, when a participant said, "Thank you for listening," and when I realised that research, at its best, can be a form of witnessing.

Writing the thesis was the most humbling part of the entire process. Every sentence felt like a negotiation between clarity and complexity. I wrestled with theory, trying to honour both the participants' voices and the academic expectations. At some point, I stopped writing to impress and started writing to express what I honestly thought. That was when my voice emerged. As I write this now, I no longer see the PhD as a destination. It has been a process of deep learning—intellectually, yes, but also ethically and emotionally. I have learned how to sit with discomfort, stay curious in the face of complexity, and tell stories that are not mine, with care. This PhD has not just shaped my thinking. It has shaped who I am: a more reflective scholar, a grounded listener, and a humble human being. Through my reflexive activity, I began penning the poem entitled "**The Hands That Hold**," which is set out on the following page.

POEM

"The Hands That Hold"

In compounds where the morning breaks,
Where hope is found, though the body aches,
A caregiver walks with quiet grace,
With love and strength etched in their face.

They rise before the cock has crowed,
To sweep, to wash, to share the load.
Not just as a duty, but with pride—
Their heart, their hands, are always beside.

In villages and bustling towns,
Through crowded streets and healing grounds,
They guide the weak, uplift the soul,
Restoring lives to make them whole.

The service user—strong and brave,
Fights through each setback, every wave.
With dignity, they rise again,
Their journey marked by inner flame.

Together, under the Ghanaian sun,
Their healing work is never done.
Through heat, through storms, through weary nights,
They hold on strong to human rights.

For care is more than medicine—
It's kin, it's faith, it's drawn from within.
It's family bonds and neighbours near,
It's the elders' wisdom, grounded and clear.

Though few may see, and fewer praise,
These silent heroes of our days—
Their service echoes, deep and wide,
Through every soul they stand beside.

So here's to those who choose to stay,
To walk with others, come what may.
In every act, both brave and small,
They bring us closer, heal us all.

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I would like to express my sincere gratitude to the Department of Social Work and Social Care at the University of Birmingham, United Kingdom, for sponsoring my doctoral degree. I also wish to convey my appreciation to the Commonwealth Scholarship Commission (CSC), UK, for its dedication to educational initiatives supporting developing Commonwealth countries and facilitating my opportunity to pursue studies abroad. Furthermore, I would like to extend my heartfelt thanks to my family and friends for their steadfast support and encouragement throughout my educational journey in the United Kingdom.

I express my sincere appreciation for the valuable contributions of Mr. Eric Antwi (CPA, Canada), Dr. Bisola Grace Joloko, Dr. Edward Cudjoe, Dr. Abdullah Alhassan, Dr. Ishmael Arhin and Mr. Evans Gyan Ntim, Mr Paul Oduro, who exhibited exemplary patience as I frequently communicated my varied health and emotional experiences throughout this doctoral journey.

I appreciate all medical and non-medical mental health professionals, including Ghanaian social work and social care researchers, who played a crucial role in evaluating data collection instruments and assisting prospective mental health service users and their family caregivers in accessing this study. Furthermore, I express my gratitude to all mental health service users and their family caregivers who willingly participated by completing surveys and sharing their recovery experiences during the unprecedented COVID-19 pandemic.

I wish to convey my profound appreciation to Professor Harry Ferguson and Dr Jason Schaub for facilitating financial sponsorship through the Department for my doctoral degree. Your genuine care and selflessness have contributed significantly to my academic development. I also sincerely thank Professor Jerry Tew and Professor Jon Glasby for their supervision and for providing essential resources for my thesis. Your guidance, approachability, expertise, insightful feedback and valuable corrections have been instrumental in shaping this thesis. I sincerely appreciate the time you devoted to supervising my research, reviewing my papers, and offering constructive suggestions for improvement. Your considerable efforts in refining the theoretical framework and reviewing draft versions multiple times, especially during the challenging circumstances presented by the COVID-19 pandemic and hectic work schedules, are truly remarkable.

Lastly, I wish to express my profound gratitude to my Heavenly Father. His unconditional love, blessings, and guidance have been invaluable to my success. I shall carry this inspiration with me always!

TABLE OF CONTENTS

ABSTRACT i
PREFACE iii
"Holding Stories: A Reflexive Account of My PhD Journey" iii
POEM v
"The Hands That Hold" v
ACKNOWLEDGEMENTS vi
TABLE OF CONTENTS vii
ABBREVIATIONS xiv
LIST OF TABLES xv
LIST OF FIGURES xvi
DEFINITION OF TERMS xvii
CHAPTER ONE: OVERVIEW OF THE THESIS 1
1.0. Introduction 1
1.1. Problem Statement 2
1.2. Research Questions 5
1.3. Scope of the Study 5
1.4. Overview of Research Design 8
1.4.1. Overview of the Quantitative Phase 8
1.4.2. Overview of the Qualitative Phases 9
1.5. Significance of the Study 9
1.6. Organisation of the Study 10
CHAPTER TWO: LITERATURE REVIEW-PART ONE 12
WESTERN PERSPECTIVES ON MENTAL ILLNESS AND RECOVERY 12
2.0. Introduction 12
2.1. Western Medical Construction of Mental Illness and Recovery 12
2.2. Social Support for Mental Illness Recovery 15
2.3. Recovery and Social Care Systems 18
2.4. Summary 25
CHAPTER THREE: LITERATURE REVIEW-PART TWO 26
AFRICAN PERSPECTIVES ON FAMILY CAREGIVING AND MENTAL ILLNESS RECOVERY 26

3.0. Introduction 26
3.1. Ghana's Sociocultural Aspects of Caregiving 26
3.2. Family Agency Towards Recovery 30
3.3. Perceptions of Mental Illness and Recovery 34
3.4. Family Practices and Support Provisions in Recovery 39
3.5. Family Interpersonal Relationship in Recovery 42
3.6. Barriers in the Recovery Journey 46
3.7. Summary 48
CHAPTER FOUR: THEORETICAL FRAMEWORK 49
4.0. Introduction 49
4.1. Ecological Systems Theory 50
4.1.1. Tenets of the Ecological Systems Theory/Model 52
4.1.1.1. The Microsystem: Immediate Environment and Interactions 52
4.1.1.2. The Mesosystem: Connecting the Different Microsystems 52
4.1.1.3. The Exosystem: Indirect Influences on Individual Development 53
4.1.1.4. The Macrosystem: Cultural and Societal Forces at Play 54
4.1.1.5. The Chronosystem 55
4.1.2. Ecological Systems Theory Implications on Family Caregiving 56
4.2. Systems Theory- Family as a Microsystem (*Resilience and Sustainability*) 58
4.3. Resources for Recovery in the Ghanaian Context. 61
4.3.1. Forms of Capitals for Social Recovery 62
4.3.1.1. Personal Capital 62
4.3.1.2. Identity Capital 64
4.3.1.3. Social Capital 66
4.3.1.4. Economic Capital 68
4. 3.1.5. Relationship Capital 69
4.3.2. Weiss's (1974) Social Provision Theory 72
4.4. Recovery Model 77
4.4.1. Social *Versus* Medical Approach to Recovery 81
4.4.2. Social Recovery Framework-African/Ghanaian Perspectives 84
4.4.2.1. Healing and Wellness 84
4.4.2.2. Meaning, Purpose and Identity 86

4.4.2.3. Hope, Religion and Spirituality 88
4.4.2.4. Socio-Cultural Context and Stigma 89
4.4.2.5. Socio-Economic Context 92
4.4.2.6. Family Interaction: Coping and Resilience 95
4.4.2.6. Study's Conceptual Framework 97
4.5. Implications of Theoretical Triangulation 99
4.6. Summary 102
CHAPTER FIVE: RESEARCH METHODOLOGY 103
5.0. Introduction 103
5.1. Research Process 103
5.2. Research Philosophy 104
5.2.1. Study's Philosophy: Pragmatic philosophical framework 109
5.3. Methodological Choices 111
5.3.1. Mixed-methods Research Design 112
5.3.1. Mixed-methods techniques and rationale 113
5.4. Data Collection Instruments 117
5.4.1. Quantitative Instrument- (SPS) 117
5.4.1.1. Social Provision Scale-10 Items 118
5.4.1.1.1. Modification of the SPS-10 Items 119
5.4.1.2. New Scaled Items 121
5.4.1.3. Survey Questionnaire Design 122
5.4.2. Qualitative Instruments (Semi-structured interview schedule(s)). 123
5.4.3. Participants' Information Sheets and Consent Forms 124
5.5. Recruitment of Participants 124
5.5.1. Target Population 124
5.5.2. Sampling Techniques 125
5.5.2.1. Quantitative Sampling Technique and Sample Size 125
5.5.2.2. Qualitative Sampling Technique 125
5.5.2.2.1. Quota Sampling Technique 126
5.6. Data Collection 131
5.6.1. Survey and Interviews Process 131
5.6.1.1. Stage 1: Pilot study 131

5.6.1.1.1 Survey Reliability Test of the Pilot Study 132
5.6.1.1.2 Credibility and Trustworthiness Interviews for the Pilot Study 133
5.6.2 Stage 2: Survey/Quantitative Phase I (MHSUs only) 134
5.6.2.1 Eligibility Criteria 134
5.6.2.2 Survey Sample Size 135
5.6.2.3 Procedure for Phase I Data Collection (Surveys) 135
5.6.3 Stage 3: Qualitative Phase II - Participant Selection 138
5.6.3.1 Qualitative Sample Size 139
5.6.3.2. Procedure for Phase II Data Collection/Fieldwork (Interviews) 141
5.7. Ethical Considerations 144
5.8. Data Analytical Approaches 148
5.8.1. Quantitative Data Analysis and Presentations of Results. 148
5.8.2. Qualitative Data Analysis 150
5.9. Summary 153
CHAPTER SIX: FIELDWORK EXPERIENCES 154
6.0. Introduction 154
6.1. Fieldwork Situational Issues and Actions for Recruiting Study Participants 154
6.1.1. Negotiating Access 158
6.1.2. Collecting Data 161
6.1.3. Researcher Positionality 163
6.1.3.1. Dealing with Ethical Dilemmas 167
6.2. Fieldwork Challenges 168
6.2.1. Excessive Bureaucracy 168
6.2.2. *Ayaresabe's* Security/Police Interruption 169
6.2.3. Language/Translation Issues 170
6.3. Exiting the Field 171
6.4. Summary 174
CHAPTER SEVEN: PRESENTATION OF QUANTITATIVE DATA & DISCUSSION OF RESULTS 176
7.0. Introduction 176
7.1. Quantitative Data Results 177
7.1.1. Socio-Demographic Characteristics of MHSUs (Respondents). 177

7.1.1.1. *Gender* 178
7.1.1.2. *Age* 179
7.1.1.3. *Education status* 179
7.1.1.4. *Marital status* 180
7.1.1.5. *Religious status* 180
7.1.1.6. *Employment status* 180
7.1.1.7. *Place of residence* 181
7.2. Chi-square test of Independence or Association and Effect Size. 182
7.2.1. Chi-square test of association of respondents' socio-demographics. 182
7.2.2. Effect Size 183
7.3. Presentation of the Social Provision Scale (SPS-10) Results and Hypothesis Testing 190
7.3.1. Social Provision Scale (SPS-10) Results 190
7.3.2. Reliability Statistics 196
7.3.3. Statistical Tests 198
7.3.3.1. Goodness-of-fit test 198
7.3.3.2. Spearman's rank order correlation test for nonparametric data set. 199
7.3.3.3. Hypothesis Testing 204
7.3.3.4. Pearson Chi-squared Statistical Test by Gender. 206
7.4. Levels of Perceived Family Support 216
7.5. Summary 218
CHAPTER EIGHT: QUALITATIVE DATA ANALYSIS 220
8.0. Introduction 220
8.1. Participant's Sociodemographic (Interview Phases) 221
8.2. Qualitative Theme Development 225
8.3. Discussion of Themes 226
8.3.1. Theme 1: Terminologies for Mental Illness and Recovery 226
8.3.1.1. Understanding Mental Illness and Recovery 227
8.3.1.2. Identifying Mental Illness through Spiritual and Biomedical Definition 228
8.3.1.3. Blaming Others for Mental Illness 230
8.3.1.4. Complexity of Understanding Mental Illness 231
8.3.1.5. Pluristic Approaches to Mental Illness Recovery: Traditional and Medical Services 232
8.3.1.6. Overarching Expectations of MHSUs and FCs 233

8.3.2 Theme 2: Family Identity and Inclusivity Interplay in the Recovery Journey 235
8.3.2.1. Family Ties and Care Provision 235
8.3.2.2. Place, Space and Support for Recovery within Family Relationships 237
8.3.3. Theme 3: Family Agency in the Recovery Process 239
8.3.3.1. Practical Sources of Support from Family 240
8.3.4. Theme 4: Economic Arrangements and Hardship 244
8.3.5. Theme 5: Supportive Family Relationships in the Recovery Journey 247
8.3.6. Theme 6: Expressed And Unexpressed Emotions in the Recovery Journey 250
8.3.6.1. Stigmatisation and Shame within Family Relationships 251
8.3.6.2. Secondary Stigmatisation 254
8.4. Summary 257
CHAPTER NINE: DISCUSSION OF FINDINGS AND IMPLICATIONS 259
9.0. Introduction 259
9.1. Family Support and Inclusivity 260
9.1.1. Symbolic and Emotional Meaning of Family Support 265
9.2. Lay vs Westernised Language 267
9.2.1. Mental Illness Constructs 269
9.2.2. Recovery Constructs 272
9.3. Health-Seeking Behaviours 273
9.4. Complexity of Family Relationships 276
9.4.1. Family Dynamics 278
9.4.2. Family Tensions 281
9.5. Stigmatisation 286
9.6. Family Caregivers' Burdens 290
9.6.1. Economic Hardships 291
9.6.2 Risks, Burdens, and Resilience 293
9.7. Summary 296
CHAPTER TEN: RECOMMENDATIONS, LIMITATIONS AND CONCLUSION 297
10.0. Introduction 297
10.1. Summary of Study's Implications 297
10.2. Recommendations 298
10.3. Limitations of the study 302

10.4. Conclusion 306
LIST OF REFERENCES 312
LIST OF APPENDICES 404
Appendices A 404
Appendices B 412
Appendices C 415
Appendices D 418
Appendices E 420
Appendices F 422
Appendices G 424
Appendices H 428
Appendices I 429
Appendices J 430

ABBREVIATIONS

ADHD: Attention Deficit Hyperactivity Disorder ---------- 15, 211
AIDS: Acquired Immunodeficiency Syndrome ---------- 31, 35, 58, 281
APA: American Psychological Association ---------- 14, 81, 86, 264
BPS: British Psychiatry Society ---------- 14, 15
CMHAP: WHO's Comprehensive Mental Health Action Plan ---------- 34
DSM: Diagnostic and Statistical Manual of Mental Disorders ---------- passim
EML: WHO's Model List of Essential Medicines ---------- 16
EU: European Union ---------- 22, 25
FC: Family Caregiver(s) ---------- passim
GSS: Ghana Statistical Service ---------- 29, 214
HIV: Human Immunodeficiency Virus ---------- passim
ICFDH: International Classification of Functioning, Disability and Health ---------- 36
LEAP: Livelihood Empowerment Programme ---------- 96
LMICs: Low- and Middle-Income Countries ---------- 93
MHSUs; Mental Health Service User(s) ---------- passim
NCPHSBBR: National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research ---------- 144, 298
NGOs: Non-Governmental Organisations ---------- 58, 96
NHIS: National Health Insurance Scheme ---------- 287
NHS: National Health Service ---------- 14, 15
NIST: National Institute of Standards and Technology ---------- 197, 199
OCD: Obsessive-Compulsive Disorder ---------- 211
ODD: Oppositional Defiant Disorder ---------- 211
ONS: Office for National Statistics ---------- 210
SCIE: Social Care Institute for Excellence ---------- 84
SPS: Social Provision Scale ---------- passim
SPSS: Statistical Package for the Social Sciences ---------- 8
UK: United Kingdom ---------- passim
UN DESA: UN Department of Economic and Social Affairs ---------- 258, 387
UOB: University of Birmingham ---------- passim
USA: United States of America ---------- 15, 78, 80
WFMH: World Federation of Mental Health ---------- 14, 25
WHO: World Health Organisation ---------- passim
WMA: World Medical Association ---------- 144, 298, 392

LIST OF TABLES

Table 1: Comparison of Weiss's Social Provisions Components with some Ghanaian Literature on Social Support 76
Table 2: Modified Version of SPS-10 Items Considering the Study's Aims 120
Table 3: New Constructs 122
Table 4: Survey Recruitment of MHSU 138
Table 5: Qualitative Sample Size and Interview Process 140
Table 6: Socio-Demographic Profile of MHSUs (Respondents) 177
Table 7: Chi-Square Statistical Test Matrix on Respondents' Socio-Demographics 183
Table 8: Gender * Employment Crosstabulation 185
Table 9: Gender * Marital Status Crosstabulation 186
Table 10: Age of respondents * Marital Status Crosstabulation 187
Table 11: Age of respondents * Employment status Crosstabulation 188
Table 12: Level of Education * Employment Status Crosstabulation 189
Table 13: Summary of Respondents' Ratings on the Modified SPS 191
Table 14: Summary of Respondents' Ratings for the New Constructs 194
Table 15: Reliability Statistics from SPSS Output 196
Table 16: Test for Normality of Data Set 199
Table 17: Spearman's Correlation Matrix (r_s /rho) 201
Table 18: Bivariate Summary Statistics of Gender Differences in the Quantitative Sample. 206
Table 19: Levels of Perceived Family Support 216
Table 20: Sociodemographic Profile of Qualitative Participants 223
Table 21: Summary of the Study's Recommendations 298

LIST OF FIGURES

Figure 1: Ghana's Major Outpatient Mental Hospitals in Perspective 6
Figure 2: Ecological Model 51
Figure 3: The CHIME Framework for Personal Recovery. 79
Figure 4: Social Recovery in the Ghanaian Context 99
Figure 5: The Research Onion 103
Figure 6: Continuum of Key Philosophical Positions in Human and Social Sciences Research 105
Figure 7: Creswell's (2014) Explanatory Mixed-methods Design 115
Figure 8: Data Collection Processes 143
Figure 9: Illustrates the Study's Thematic Analysis Approach for Developing Themes. 152
Figure 10: MHSUs' Experiences of Stigmatisation within their Families 205
Figure 11: Distribution of Perceived Levels of Family Support Scores (N = 140) 217
Figure 12: Summary of Emergent Themes 225

DEFINITION OF TERMS

- **Caregiving,** in the context of mental illness recovery, represents the network of individuals engaged in the care, support, and recovery processes of individuals experiencing mental health issues. This supportive network can be categorised into formal or institutional care and informal or primary care. Depending on the individual's relationship to the user of mental health services, this network encompasses family members (both close/nuclear and wider/extended family relations), next-of-kin, peers or significant others, mental health professionals (including doctors, psychologists, and nurses), and social workers. The nature and intensity of caregiving can vary depending on the severity and type of mental illness, as well as the cultural and social context in which care is provided.

- **Family agency** refers to the role families play in supporting recovery, influencing treatment outcomes, and making care-related decisions. This role can encompass providing emotional support, assisting with daily living activities, managing medication, and coordinating with healthcare services.

- **Family interpersonal relationships** refer to the emotional, social, and communicative interactions that occur between family members. These relationships are shaped by roles, responsibilities, affection, trust, and patterns of communication within the family unit. They influence how family members relate to, support, and respond to one another in everyday life. Positive family interpersonal relationships are often characterised by mutual respect, empathy, cooperation, and effective conflict resolution, while strained relationships may involve misunderstandings, lack of communication, or emotional distance. These dynamics play a critical role in individual development, wellbeing, and the overall functioning of the family.

- **Ghanaian family caregivers** are individuals responsible for caring for a family member diagnosed with mental illness at home. Traditionally, these individuals are expected to be related to the patient by blood and include members of the patient's immediate (nuclear) and extended family (such as parents, grandparents, siblings, children, and spouses). They often play a central role in monitoring symptoms, encouraging treatment adherence, and fostering a supportive environment that contributes to the person's recovery and wellbeing. This positions family caregivers as the essential support system for home care for individuals diagnosed with mental illnesses.

- **Ghanaian family system/structure** refers to the network of relationships that bind individuals through blood, marriage, or social ties, often extending beyond the nuclear unit to include the extended family. This system is deeply rooted in communal values, kinship structures, and cultural traditions that emphasise collective responsibility, interdependence, and mutual support. In Ghanaian society, the family plays a central role in shaping individual identity, providing emotional, financial, and caregiving support, and serving as a primary unit for socialisation and decision-making. The system is often organised along matrilineal or patrilineal lines, depending on the ethnic group, influencing inheritance, lineage, and social roles. Values of respect, interdependence, and communal support underpin the structure.

- **Health-seeking behaviours** refer to the actions and decisions individuals take to maintain, promote, or restore their health. These behaviours include how people recognise and respond to symptoms, when and where they seek medical advice or treatment, their use of healthcare services, and their adherence to health recommendations. Factors such as cultural beliefs,

socioeconomic status, education, and access to healthcare significantly influence these behaviours.

- **Mental health** encompasses an individual's emotional, psychological, and social state, shaping how they perceive, experience, and respond to life. It affects one's ability to manage stress, maintain healthy relationships, and make informed decisions. Factors, including life experiences and social conditions, shape it. Positive mental health encompasses a sense of inner wellbeing, resilience in the face of adversity, and the ability to engage meaningfully with others and contribute to the broader community.

- **Mental illness (**also called a mental disorder) is a condition that affects a person's thinking, feeling, mood, behaviour, or perception. It often impacts their ability to function in daily life. These disorders can be occasional or long-lasting (chronic) and may significantly interfere with social, occupational, or personal activities. Mental disorders include conditions such as depression, anxiety disorders, schizophrenia, bipolar disorder, and post-traumatic stress disorder (PTSD). They are influenced by a combination of genetic, biological, psychological, and environmental factors, and often require medical, psychological, or psychosocial intervention for effective management and recovery.

- **Mental illness recovery** refers to a personal and unique journey through which individuals living with mental health problems work toward leading meaningful, fulfilling lives. It involves regaining a sense of control, hope, and identity, even while symptoms may persist. Recovery is not just about symptom reduction, but also about achieving personal goals,

building supportive relationships, and actively participating in community life. It emphasises empowerment, resilience, and the capacity to thrive beyond a clinical diagnosis.

- **Social support** refers to the emotional, informational, and practical assistance received from others, including family, friends, colleagues, and broader social networks. Social support is widely recognised as a protective factor in physical and mental health, promoting resilience and wellbeing. It encompasses the sense of being cared for, valued, and part of a supportive community. Social support can take several forms, including emotional support – expressions of empathy, love, trust, and care. Instrumental support – tangible aid and services, such as financial help or caregiving. Informational support – advice, suggestions, or information to solve problems. Appraisal support – feedback and affirmation are helpful for self-evaluation.

- **Wellbeing** is a positive condition of life marked by contentment, robust health, ease, and success. Wellbeing refers to the overall state of an individual's physical, mental, emotional, and social health. It encompasses how people feel about their lives, their sense of purpose, life satisfaction, the quality of their relationships, and their ability to manage stress and engage in meaningful activities. Wellbeing is not merely the absence of illness but includes the presence of positive emotions, resilience, and a sense of fulfilment in various aspects of life.

CHAPTER ONE

OVERVIEW OF THE THESIS

1.0. Introduction

This thesis explores the lived experiences of family caregiving and support towards mental illness recovery in Ghana. It is grounded in a recognition that, across many parts of the Global South, mental health care is not primarily provided through formal psychiatric systems, but rather through families who absorb the emotional, financial, and practical responsibilities of care. Yet these forms of caregiving and support remain underexplored in both research and policy, particularly within recovery-oriented mental health frameworks, which are often shaped by Western individualistic assumptions.

The concept of mental illness recovery, frequently framed in terms of personal autonomy, clinical symptom reduction, or reintegration into social and economic life, exists within contexts where collectivism, spiritual beliefs, stigma, poverty, and strained health infrastructures influence everyday realities in a significant manner. In Ghana, families often serve as the primary and final points of care, manoeuvring through a landscape defined by limited mental health services, intricate religious and cultural beliefs regarding illness, and various methodologies of healing (biomedical, spiritual, traditional). These families, alongside the individuals under their care, cultivate survival strategies, resilience, and hope that do not always conform to prevailing academic or clinical paradigms.

Consequently, this study sits at the intersection of several bodies of literature: mental health and recovery studies, family caregiving research, African and Ghanaian mental health scholarship, and critical global mental health. In particular, it engages with critiques of the universal application of Euro-American psychiatric and recovery models in non-Western contexts. It draws on

anthropological, sociological, and social work perspectives to provide a nuanced understanding of mental illness and caregiving within the Ghanaian cultural and material contexts. The study, therefore, centres on family members, including both close (nuclear) and wider (extended) family relations, who are engaged in providing support during the recovery journey of their relatives diagnosed with mental health and psychological comorbidities. Adopting the definition in the Ghana Mental Health Act 846 (2012), Family Caregivers (FCs) are defined as:

> "Family members who look after a person with a mental health problem, whether in a domestic setting or not" (Mental Health, Ghana Act 846, 2012, pp. 38).

Evidently, the legal responsibility for delivering quality care to facilitate effective recovery resides with the entire family as a supportive care system, rather than with individual family members alone. The role of the family in mental illness recovery is intricate and multifaceted, often diverting attention towards changes in psychiatric symptoms. While supportive family relationships can enhance wellbeing and positively contribute to recovery, they may also represent sources of conflict, stigma, and burden. Findings from empirical studies (*e.g.*, Onken *et al*., 2007; Anokye, 2018; Fine, 1993; Read and Doku, 2012; Osei, Asare and Roberts, 2021b; Quinn and Evans, 2010) show that some FCs encounter emotional exhaustion, financial strain, and insufficient support from the healthcare system, which may consequently affect the quality of care they can provide. Concurrently, mental health service users (MHSUs) may grapple with issues of autonomy, miscommunication, and constraints imposed by family members that hinder their recovery objectives.

1.1. Problem Statement

Mental illness remains a significant yet frequently neglected public health issue in Ghana. With an estimated treatment gap exceeding 90%, a substantial number of individuals experiencing mental illness have minimal to no access to formal psychiatric care (World Health Organisation

(WHO), 2021). In this regard, family systems function as the de facto mental health support structure, playing a crucial role in the recovery trajectories of MHSUs (McVeigh, 2020; Van der Watt *et al*., 2017). The communal orientation prevalent in Ghanaian society, which places a premium on familial duties and interdependence, has resulted in families undertaking primary responsibility for caregiving, offering emotional support, overseeing treatment adherence, managing crises, and facilitating social reintegration (Nukunya, 2016; Dadson, Annor and Yendork, 2018).

Nonetheless, in Ghana, the limited public mental health services are concentrated in urban centres, leaving many without formal support (Ae-Ngibise *et al.*, 2010; Amuyunzu-Nyamongo, 2013; De-Graft, 2015; Read, Adiibokah, Nyame, 2009; WHO, 2012b). Stigma surrounding mental illness is pervasive, and families often navigate complex terrain, balancing biomedical advice with spiritual interpretations (witchcraft, curses, or evil spirits) and social expectations (Onken *et al*., 2007; Tawiah, Adongo and Aikins, 2015; Agyei, 2020; Abukari, 2016; Canton, 2018; Weobong *et al*., 2023; Bagasra and Mackinem, 2014). Despite these challenges, families remain central actors in recovery processes, providing not only basic care but emotional and moral anchorage. In this regard, the effective functioning of familial structures is often indispensable for members diagnosed with mental illness to gain access to traditional and professional services (Maundeni and Malinga-Musamba, 2013; Nukunya, 2016; Quinn, 2007; Reilly *et al*., 2013; Waller *et al*., 2019; Webber *et al*., 2015; Bouverie, 2016).

In recent years, mental health reforms in Ghana, exemplified by the Mental Health Policy 2019–2030, have underscored community-based care and human rights-based approaches. Nevertheless, these frameworks frequently fall short in adequately addressing the nuanced experiences of FCs and their relational dynamics with MHSUs. Interpersonal relationships within families typically foster stronger connections among members, underscoring values such as solidarity, reciprocity, and loyalty. Such dynamics render the family an invaluable resource that frequently provides substantial

support and care to relatives experiencing mental health problems. The role of the family in the recovery process becomes particularly salient during hospitalisation, discharge of patients from psychiatric hospitals to their homes and when seeking traditional treatment approaches (Lakey and Orehek, 2011; Balestrieri *et al*., 1992; Osei, Asare and Roberts, 2021b; Azman, Jamir and Sulaiman, 2017a; Egbe *et al*., 2014; Esan *et al*., 2019; Van der Watt *et al*., 2018; Owusu-Boakyewaah, 2011). Consequently, the interactions that MHSUs engage with others, including family members, can inevitably influence their capacity to seek assistance, cultivate a sense of agency, and establish purpose and meaning in their lives.

Despite growing recognition of the importance of family systems in mental illness recovery, there remains a significant gap in research and policy concerning the lived experiences of FCs and MHSUs in Ghana. Much of the existing mental health discourse focuses on institutional reform and service provision, with limited attention to the informal support systems that sustain MHSUs daily. Furthermore, there is a tendency to treat family involvement as inherently beneficial, without accounting for the relational tensions, cultural beliefs, and systemic constraints that can complicate the caregiving process, influencing both how FCs perceive their roles and how MHSUs experience support or lack thereof. Without a deeper understanding of the interactions between FCs and MHSUs, especially the dual nature of support as both enabling and potentially constraining, mental health interventions risk overlooking the relational foundation on which recovery is built. This study addresses this gap by examining the mutual experiences of MHSUs and their FCs by centring their voices and practices as legitimate, contextually grounded forms of knowledge and care. By exploring how family relationships contribute to or hinder recovery and highlighting FCs' own emotional and social realities, the study seeks to inform more inclusive, culturally grounded, and relationally sensitive approaches to mental health care in Ghana.

1.2. Research Questions

The study explores family relationships, roles, and involvement in recovery through the experiences of MHSUs and their FCs. The literature review informs the following research questions:

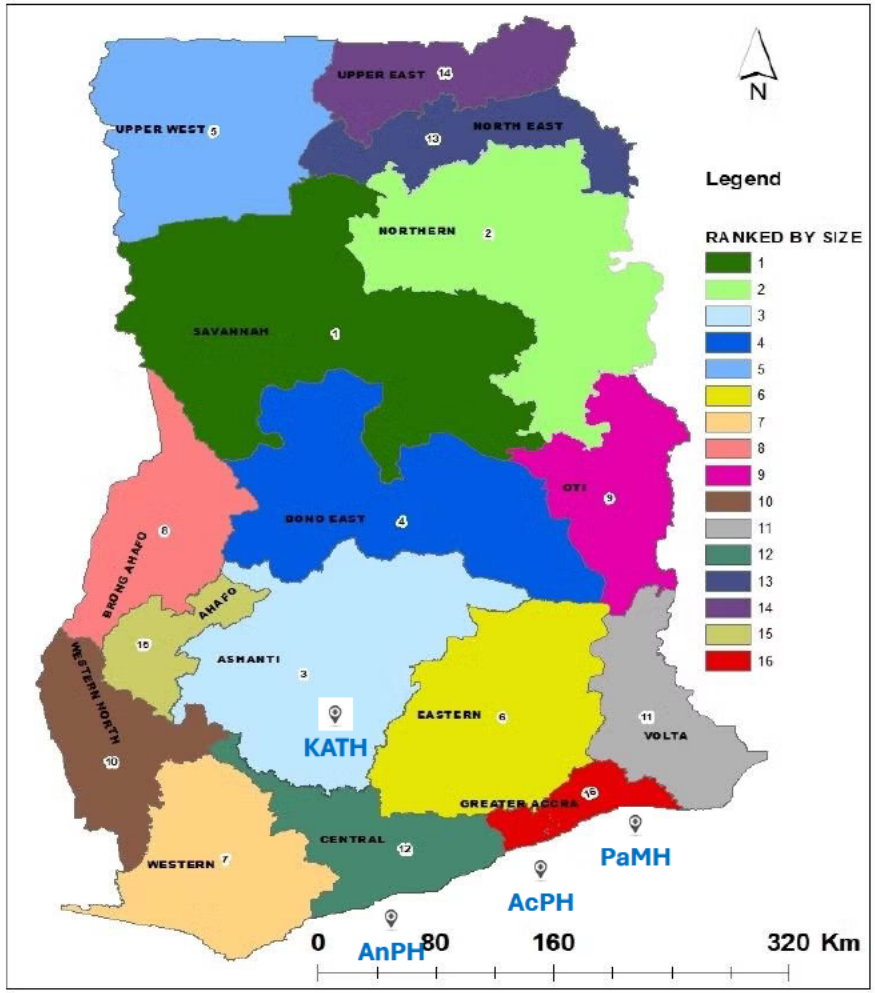
1. How do Ghanaian MHSUs perceive the interpersonal relationships, support, and involvement of FCs in their recovery journey?
2. What are the experiences of Ghanaian MHSUs about family relationships and roles in their recovery journey?
3. How do family relationships, on the other hand, become barriers to the recovery of Ghanaian MHSUs?
4. What are Ghanaian FCs' experiences with MHSUs in the recovery journey?

1.3. Scope of the Study

The study was conducted in one of Ghana's four outpatient mental health hospitals (*see* Figure 1). The selected hospital has been pseudonymised as *Ayaresabea* throughout the study to ensure complete anonymity and confidentiality. The researcher's established networks in Ghana, including rapport with *Ayaresabea's* medical and non-medical professionals, were beneficial in negotiating access (contact with the study population) and gathering data more manageably.

The presence of individuals experiencing mental health issues on the streets of Ghana necessitated the establishment of mental health hospitals by the state. This initiative, which commenced following Ghana's independence in 1957, represents a response to the challenges stemming from the legacy of colonialism, aiming to provide intervention and support for those affected (Osei, Asare, and Roberts, 2021a; Central Intelligence Agency, 2011).

Figure 1: Ghana's Major Outpatient Mental Hospitals in Perspective



Major Outpatient Mental Health Hospitals in Ghana

AnPH	Ankaful Psychartric Hospital
AcPH	Accra Psychartric Hospital
KATH	Komfo Anokye Teaching Hospital
PaMH	Pantang Mental Hospital

Source: Osei, Asare and Roberts (2021), History of Mental Health Care in Ghana.

Ghana has an estimated population of 35 million, with recent estimates indicating that between 2.4 million and 3.1 million Ghanaians are living with various forms of mental illness (MyJoyOnline, 2021). Research shows that out of the 2.4 million estimated to be suffering from moderate to severe mental illness, only 1.17% receive clinical treatment (Fournier, 2021). The other mentally ill persons, estimated to be around 2,783,052.8, representing 98.83%, are not treated in any of Ghana's psychiatric facilities but in their homes and traditional healing centres with over 45,000 traditional practitioners (Fournier, 2021; Roberts, 2001).

The Ghana Mental Health Authority (2022) forecasts that by 2030, the prevalence of psychotic disorders among Ghanaians is likely to increase. This anticipated rise is attributed to several factors, including population growth and the ramifications of urbanisation, such as unemployment, socioeconomic challenges, and poverty. Additionally, the insufficiency of health and social care infrastructure and the breakdown of traditional family structures due to globalisation may result in mental health issues becoming a considerable public health concern. Ghana currently has an estimated 2,463 psychiatric nurses, 39 psychiatric doctors, 244 psychologists, four occupational therapists, and 362 mental health social workers delivering mental healthcare services to over 35 million Ghanaians (Nyarko, 2022a; Evans *et al.*, 2019). Osei, Asare and Roberts (2021a) indicate that the median number of clinical psychiatrists per 100,000 Ghanaians is only 0.04%.

A similar trend is observed in the availability of psychiatric beds in Ghana's four outpatient psychiatric facilities, which are concentrated in the southern parts of Ghana (*see* Figure 1). The median number of beds per 100,000 Ghanaians is 0.34%. In addition, Ghana has fewer community-based mental health facilities providing mental health programmes for children, the elderly and their families in both rural and urban areas. The lack of psychiatric services is particularly acute in the slums, which are home to almost a quarter of the country's population, but where mental health resources are inadequate in both quality and quantity (Mfoafo-M'Carthy and Sossou, 2017; Robert *et*

al., 2013). Therefore, it is unsurprising that traditional healers (including diviners and spiritual doctors) and religious leaders (such as priests and imams) may continue to be a significant proportion of the treatment services sought by MHSUs and their FCs.

1.4. Overview of Research Design

This study's design follows Creswell's (2014) Explanatory Mixed-methods Design-Participant Selection Model and is structured into two distinct phases. The quantitative phase encompasses survey data collected from a simple random selection of MHSUs using a modified standard instrument based on Iapichino *et al*. (2016) shortened version of Cutrona and Russell's (1987) Social Provision Scale (SPS), derived from Weiss's (1974) Social Provision Theory. This instrument was then subjected to analysis employing descriptive and non-parametric statistical tools. The subsequent qualitative phase involves semi-structured interviews with a quota selection of MHSUs participating in the quantitative phase and their respective FCs. The qualitative data were transcribed and managed with NVivo data management software.

1.4.1. Overview of the Quantitative Phase

A total of 140 MHSUs (respondents) were randomly selected based on predetermined criteria (*see* Chapter Five). These respondents underwent a comprehensive screening conducted by mental health professionals at *Ayaresabea,* who evaluated their suitability and consent to participate in this study. After the screening stage, qualified respondents responded to the items on the modified standardised SPS-10 scale. This modified standardised scale assessed the degree to which MHSUs perceive specific social support provisions from their families throughout their recovery journey (*see* Appendices C). Subsequently, the collected responses were coded and analysed to generate descriptive statistics utilising the Statistical Package for the Social Sciences (SPSS), version 26.0. A series of hypothesis tests was conducted to elucidate the correlations, associations, and patterns present within the non-parametric survey dataset, informing Research Question One.

1.4.2. Overview of the Qualitative Phases

Six MHSUs (experiencing different levels of family support) and their corresponding FCs (six) were quota sampled for the exploratory sequential semi-structured interviews. Thus, participants were selected from the survey dataset and grouped into different levels of family support. Namely, MHSUs (respondents) experiencing high, moderate, and low levels of social support from their respective families to explore the particular ways family relationships, roles and involvement influence (negatively/positively) the recovery journey. Interviews were conducted in two stages with MHSUs in *Ayaresabea's* conference room and their FCs to ensure ethical adherence (*see* Appendices A, E, F, & G). *Ayaresabea's* medical staff screened MHSUs to ensure they were fit and had given their consent to participate. The interviews were audio-recorded and lasted an average of 80 minutes. MHSUs' and their FCs' narratives were transcribed and analysed using Braun and Clarke's (2006) qualitative thematic analysis approach. This study's qualitative stages aim to address Research Questions One to Four.

1.5. Significance of the Study

The significance of this study is underscored by its emphasis on the critical, yet frequently underexplored, role of FCs in the mental health recovery process within the Ghanaian context. In a nation where mental health services are persistently under-resourced and the stigma surrounding mental illness remains prevalent, families continue to play a pivotal role as the primary source of care and support for individuals experiencing mental health conditions. Consequently, this study is both timely and essential for several reasons:

Firstly, this study enhances understanding of mental illness recovery as a relational and culturally embedded process. Historically, most mental health frameworks in Ghana have emphasised traditional and biomedical treatment approaches, frequently overlooking the social and familial dimensions of care. By concentrating on the lived experiences of both MHSUs and their FCs, this

study underscores how family relationships can be both empowering and, at times, limiting. Grasping these dualities is crucial for designing interventions that accurately reflect the complex realities of caregiving within the Ghanaian cultural and socioeconomic context.

Secondly, the study amplifies the perspectives of MHSUs and their families, demographics frequently neglected in policy formulation, academic research, and practical applications. By documenting their experiences, this study fosters a more inclusive and human-centred comprehension of mental health recovery. It recognises these individuals' agency, challenges, and insights while advocating for incorporating their viewpoints into the planning and provision of mental health services.

Thirdly, the study's findings possess practical significance for Ghana's mental health policy and service delivery. As the nation proceeds with implementing its Mental Health Policy (2019–2030) and developing community-based care models, this research provides evidence to support more family-inclusive and culturally grounded strategies. It champions the need for heightened acknowledgement of FCs within policy frameworks, providing psychosocial and economic assistance for families, and enhanced collaboration between formal and informal care systems.

Lastly, this study possesses academic significance as it contributes to the limited body of literature concerning family caregiving and mental health recovery in sub-Saharan Africa. It offers an original, context-specific perspective on global mental health discussions and has the potential to serve as a foundation for further comparative research across various African contexts.

1.6. Organisation of the Study

This thesis is structured into ten distinct chapters. Chapter One introduces the study, providing crucial background information that includes the problem statement, research questions, the scope of the study, the research design and methods employed, the significance of the study, and the organisation of the thesis. Chapters Two and Three are dedicated to a comprehensive review of the

extant literature on mental illness recovery, encompassing perspectives from both Western and African/Ghanaian contexts, while identifying notable gaps.

Chapter Four presents the theoretical framework adopted for the study, culminating in developing a social recovery framework tailored to the Ghanaian context. Chapter Five elaborates on the study's philosophical framework and mixed-methodological approaches, detailing the sampling techniques, data collection methods and strategies, instruments utilised, analytical frameworks, and ethical considerations relevant to the study.

Chapter Six offers a reflective account of the fieldwork experiences involving MHSUs and their FCs in Ghana. Chapter Seven presents the survey results that support Objective 1. In contrast, Chapter Eight delineates the qualitative findings aligned with Objectives 2 through 4. Chapter Nine presents an integrated, triangulated, and explanatory discussion of the study's findings and their implications. Finally, Chapter Ten details the study's general recommendations, acknowledges its limitations, and articulates the contributions made by this study.

CHAPTER TWO

LITERATURE REVIEW-PART ONE

WESTERN PERSPECTIVES ON MENTAL ILLNESS AND RECOVERY

2.0. Introduction

The study's literature review is divided into two separate Chapters (Two & Three) that discuss relevant theoretical and empirical research findings pertinent to the study's objectives. Chapter Two provides an extensive review of the literature, predominantly from Western perspectives and comprises four sections. Western medical construction of mental illness and recovery is discussed in the first section. The second and third sections examine social support and social care systems in the context of recovery. The final section summarises this Chapter review, followed by Chapter Three, which explores family caregiving interactions and support, widely considered crucial in many African contexts, including Ghana, for MHSUs' recovery journey. Discussion on gaps in the literature is embedded in both chapter reviews. Reviewing the extant literature enables the researcher to identify points of divergence from earlier research, evaluate alternative methodological approaches, and assess the originality and validity of emerging conclusions. Identifying these divergences not only reveals critical gaps and limitations in current knowledge but also provides a rationale for the methodological choices adopted in this study, ensuring that the design and conceptual framework address the overlooked dimensions of family caregiving and mental health recovery in Ghana, thereby making an original contribution to the field.

2.1. Western Medical Construction of Mental Illness and Recovery

Recovery from mental illness is not a modern discovery; research traces its story through a long and influential history that continues to shape present-day perspectives (Bertolote, 2008; Foerschner, 2010). Rather than being linear, development toward mental wellbeing can be cyclical (Farreras, 2022). Understanding mental illness has its roots in discoveries in neuroscience, public

health, clinical psychiatry, and applied social science disciplines (psychology, social work). However, references to mental illnesses (*e.g.*, bipolar disorders, depression, sleep disorders, anxiety, schizophrenia, psychosis, obsessive-compulsive disorders, and eating disorders) have primarily promoted Western hermeneutics (Bartholomew, 2016; Edwards *et al*., 2004; Gone, 2011; Kirmayer and Pedersen, 2014; Kong *et al*., 2023; Vukic *et al*., 2011), setting a global mental health agenda for progressing a medical model towards recovery (Gagne, White and Anthony, 2007; Fernando; 2014; Kirmayer and Swartz, 2013; Adelson, 2007; Kong, Dunn and Parker, 2017; Oppong *et al*., 2016).

The medical model can be a helpful guide for diagnosis, prognosis and research into mental illnesses. Generally, mental illnesses have been linked to certain genetic, biological and psychological abnormal patterns (American Psychological Association (APA), 2013; Lemkau and Baltimore, 1955; National Health Service (NHS-UK), 2018). Some studies suggest that, genetically, the condition may be passed on from parents to children through genes (O'Hara *et al*., 2014; Hoffman *et al*., 2017; Costello, 2016; Harper and Çetin, 2008; Timimi, 2002). Biologically, the condition has been linked to an abnormal balance of brain chemicals (Lemkau and Baltimore, 1995; Rowland and Marwaha, 2018). Psychologically, the condition may be triggered by emotional trauma such as child abuse, sexual abuse, child neglect and grief (Schutt, 2016; Townsend, 2016).

Nonetheless, the medical model has been criticised by several researchers (Carlat, 2010; Kirsch, 2011; Whitaker, 2010; Moncrieff, 2008; Engel, 1977) for its sole use in global mental health action plans. Exclusive reliance on the medical model for treating mental illnesses results in insufficient understanding and inefficient or ineffective treatment approaches (British Psychiatry Society (BPS), 2013). World Federation of Mental Health (WFMH) (2014) report that mental illnesses may not only be caused by genetics/biological and psychological factors (personal weaknesses or character defects). The social environment (the immediate physical and social context) within which one interacts with other individuals could make a person susceptible to mental illnesses.

Dysfunctional family structures, substance abuse, death, economic hardships, and divorces are considered environmental stressors resulting from mental illnesses (Kanu, 2013; Kirby and Keon, 2006; Tew, 2013; Pilgrim and McCraine, 2013; WHO, 2013).

The treatment of mental illness as an underlying brain dysfunction is also prevalent in mental health literature on recovery approaches (usually on Western biomedical interventions). Several researchers propose that significant neuroscience breakthroughs link anomalies in neurotransmitters, structural or functional abnormalities in specific brain regions, and the circuitry that connects these regions to mental illnesses (Costello, 2016; Kpobi and Osei, 2014; Walkup *et al*., 2008). Although developments in neuroscience increase our understanding of brain functioning, it is challenging to determine whether these changes are triggered by neurological conditions or influenced by emotions and thoughts (Clare, 1976; BPS, 2013). Medical explanations of mental illness, according to Kong *et al*. (2023), often do not include mind, body, emotion, and spirit, as well as the interconnectedness with family, community (social relationships), or the social environment (Schön, Denhov and Topor, 2009; Tew *et al*., 2012; Tew, 2011).

In many Western societies (*e.g.*, United Kingdom (UK), United States of America (US), Canada, and Australia), the way people perceive mental illness, healing, and recovery is also being influenced by pharmacological advancements (Alonso *et al*., 2004; Farreras, 2022). For instance, children's "troubles" (emotional and behavioural problems), including Attention Deficit Hyperactivity Disorder (ADHD) and learning difficulties, are now characterised as mental illness (National Health Service (NHS)-UK, 2018; WHO, 2013). Receiving treatment requires a medical diagnosis of the specific "trouble". Likewise, the use of medications to alleviate the symptoms is limited to the diagnosis of mental illness and is recommended by mental health professionals. Most psychiatrists mainly employ medications to treat their MHSUs, referring them to psychologists or social workers if they think psychotherapy is necessary (Angell, 2011; White, 2011; NHS-UK, 2022).

For instance, data from several studies suggest that early identification and effective management with medication in childhood can reduce the severity of symptoms in later years (O'Hara *et al*., 2014; Costello, 2016; Harper and Çetin, 2008).

Medication as the dominant mode of treatment towards recovery coincides with the medical model's emergence over the past four decades, with the claim that chemical imbalances that cause mental illness in the brain can be alleviated with specific medicines (Townsend, 2016; Hsu *et al*., 2014). Many scholars propose that WHO's Model List of Essential Medicines (EML) should be utilised as a uniform list for diagnosing and treating mental illnesses with medication. For example, Kutcher, Murphy and Gardner (2008) discuss essential pharmacological medications (*e.g.*, risperidone, olanzapine, clozapine, fluvoxamine, fluoxetine) prescribed by medical professionals to help MHSUs recuperate. These medicines are commonly considered "miracle pills" by both the public and the medical profession (Angell, 2011). Nevertheless, Farre and Rapley (2017) argue that culturally relevant prognosis and medication ought to be the core focus for conceptualising mental illnesses as physical problems or biological entities that can be examined and treated pharmacologically.

2.2. Social Support for Mental Illness Recovery

Recovering from mental illness is a significant public health issue worldwide, with profound implications for individuals, families, and societies. Globally, mental health has gained increasing attention as a critical aspect of overall wellbeing, making recovery from mental illness a multifaceted approach involving clinical treatment, personal development, and, crucially, social support. In many Western contexts (*e.g.*, UK, USA, and Canada), social support mechanisms are embedded in formal and informal social structures, including healthcare systems, community organisations, and social networks (Kaplan, Cassel, and Gore, 1977; Terzian *et al*., 2013; Kogstad, Mönness, and Sörensen, 2013; Terry and Townley, 2019; Ferazzoli and Kpobi, 2024; Walker, 2005). These are collectively

the sources of support in MHSUs' recovery journey, configured by emotional and physical interactions essential for recovery (Hogan, Linden and Najarian, 2002; Langford *et al*., 1997; Morovati and Tonekaboni, 2008).

Social support is viewed as one of the key social determinants of good health; therefore, it is defined and measured in various ways. For instance, Cobb (1976, pp. 21) posits that 'social support is defined as information leading individuals to believe that they are cared for, loved, esteemed and are members of a network of mutual obligations.' Likewise, Cohen, Gottlieb and Underwood (2001, pp. 129) define social support as "social resources that persons perceive to be available or that are actually provided to them by non-professionals in the context of both formal support groups and informal helping relationships". The current study employs the concept of social support, as proposed by Cohen, Gottlieb, and Underwood (2001), which has been extensively applied in both research and practical settings. This definition addresses most of the pertinent elements and offers a clear and precise characterisation of social support. It is well-established from various Westernised recovery studies (*e.g.*, Finfgeld-Connett, 2005; House, 1981) that social support can be categorised into two main domains: structural and functional social support. Structural social support includes the amount, density and frequency of contact MHSUs have with their formal and informal social structures, while functional social support is the support provisions MHSUs receive (perceive to receive) from these social structures.

Data from several sources have identified that throughout MHSUs' recovery process, their social support structures evolve and change (*e.g.*, Anderson, Laxhman and Priebe, 2015; Van der Geest, Dapaah, and Kwansa, 2019). Initially, parents and other family members play a crucial role in providing the necessary assistance to navigate the social environment. Friends, partners, and external social networks (social care systems and professionals) also become important sources of support throughout the recovery journey. For instance, Lett *et al*. (2005) analysed MHSUs' social support

networks and the various roles of interpersonal connections in their recovery, viewed through the lens of *functional* social support. These social support networks included family members, friends, partners, community groups, and healthcare systems. The comprehensive review identified that these connections offer many forms of support, including emotional, tangible (material), informational, and appraisal assistance. Emotional support comprises having someone to talk to and feeling loved, while instrumental support involves practical help with daily tasks (Acoba, 2024; Bjørlykhaug *et al*., 2021). Previous literature on social support focuses particularly on its emotional and tangible (material) functions in recovery processes (*e.g.*, Cokrin, 1997; De Jong *et al*., 2016; Semmer *et al*., 2008). The emotional dimensions of social support encompass the delivery of care, empathy, affection, and trust. Tangible support, informational assistance, and appraisal support pertain to the provision of goods and services throughout the recovery process (Riahi, Verdinia, and Pourhossein, 2011; Marmot and Wilkinson, 2008).

Theorists categorise functional support into two types: "received functional support" (support that has been obtained) and "perceived functional support" (support that is thought to be accessible if required). Perceived functional support refers to MHSUs' subjective assessment of the expected availability of formal and informal support structures, which may be trusted resources for meeting essential needs in the recovery journey (Melrose, Brown and Wood, 2015; Lett *et al*., 2009; Whitley *et al*., 2008; Brummett *et al*., 2005). Antonovsky (1987) posits that "received functional support" is seen as one of the several resistance resources under his idea of "feeling of coherence", which encompasses comprehensibility, manageability, and meaningfulness. These components help individuals manage various types of stressful life experiences, as revealed in the study by Langeland and Wahl (2009). In contrast, Cohen and Syme (1985) and House (1981) demonstrate that "received functional support" has both primary and buffering influences on recovery from various illnesses.

The buffering effect will significantly benefit those enduring moderate to high stress levels, and its efficacy is likely contingent upon perception.

The work of Wessi (1974) offers the most comprehensive theoretical analysis of the structural and functional purpose of social support in MHSUs' recovery journey. Wessi's perspectives on social support are further discussed in the study's conceptual and theoretical frameworks (*see* Chapter Four). These ideas have been employed in the design of the study's data collection instruments (*see* Chapter Five). Empirical studies on this subject often enquire about participants' views on the availability of support or sufficiency of resources offered by others (*e.g.*, Schwarzer and Knoll, 2007; Rogers *et al*., 2004). Several researchers have recommended quantitative and qualitative measures of various types of social support to help understand the complexities of MHSUs' recovery journey (*e.g.*, Heitzmann and Kaplan, 1988; Revenson and Gurun, 2019; Wang *et al*., 2018; Hengartner *et al*., 2016; Sarason *et al*., 1987; Coffey *et al*., 2019). Nonetheless, researchers concur that it is essential to assess the functional and structural purpose of social support during the recovery process of MHSUs, as these components are significantly associated with health outcomes through both direct and buffering effects (Goldberg, Rollins and Lehman, 2003; House and Kahn, 1985; Ducharme, Stevens and Rowat, 1994). Following these perspectives, social support can be conceptualised as forms of assistance (including emotional, instrumental, informational, and appraisal) offered by individuals in MHSUs' social network, such as family, friends, peers, and the wider community (sources of support), to foster mental wellbeing.

2.3. Recovery and Social Care Systems

The recovery paradigm in mental health is fundamentally rooted in MHSU movements and professional initiatives from the late 1980s and early 1990s, which prioritise the psychosocial dimensions of engaging with and recuperating from significant mental health difficulties (Corrigan and Phelan, 2004, Centre for Mental Illness Services, 1999). From the outset, this perspective has

consistently demonstrated a desire to transcend the biopsychosocial model (Davidson and Strauss, 1995; O'Hagan, 2009). Nonetheless, it encounters significant criticism, particularly over its definition of recovery practice, with some contending that this movement increasingly emphasises an undue focus on individualism or personal recovery (Price-Robertson, Obradovic and Morgan, 2017; Tew, 2013). Consequently, it is easy to overlook the fundamental aspect of recovery as a relational process, being interconnected with others. It could be asserted that this history pertains to a broader spectrum than, for instance, how the psychiatric tradition engages with formal and informal structural aspects of social support towards mental illness recovery.

The recovery tradition has given rise to fresh perspectives that have profoundly impacted various aspects of the field. From fostering the growth of recovery communities to shaping social care policies, there has been a concerted effort to provide comprehensive support for individuals on their journey to recovery. Recovery does not inherently mean achieving a state devoid of symptoms. Instead, it revolves around taking charge of one's life and finding a meaningful and fulfilling role in society while developing personal skills to manage persistent discomfort (Anthony, 1993). Following this interpretation, recovery is a process that involves both the individual and their social environment. It involves resolving internal conflicts and re-engaging with social networks and activities, which may happen simultaneously and even reinforce each other (Terry, Townley, and Brusilovskiy, 2019; Topor *et al*., 2009; Hendryx, Green and Perrin, 2008).

Another terms of importance related to social care systems, social support and mental illness recovery are recovery capitals, social factors and cultural attitudes. Tew (2013) suggests that recovery capitals comprise five distinct types: economic, social, relationship, identity, and personal capitals (*see* Chapter 4.3.1). Many Western social care-oriented services work to varying levels with these recovery capitals to sustain the general wellbeing of MHSUs (Sælør *et al*., 2019; Webber *et al*., 2015;

Salehi *et al*., 2019; Tol *et al*., 2011; San Juan *et al*., 2021). Findings from several reviews on recovery recognise the importance of these capitals in the recovery journey of MHSUs (Tew *et al*., 2014; San Juan *et al*., 2021; Winsper *et al*., 2020). It was found that recovery *capitals* are synonymous with social support that helps MHSUs build resilience, cope with stress, and develop a sense of belonging and self-worth (Beckers *et al*., 2022; Bjørlykhaug *et al*., 2021).

Social factors, which can significantly impact the maintenance and promotion of health, have a substantial effect on the incidence, prevalence, and persistence of illnesses (Andrea, Siegel, and Teo, 2016; Wildman *et al*., 2021). In this respect, it is imperative to pay attention to social factors influencing mental illness recovery and received and perceived functional social support is one of those factors. Several studies emphasise the multifaceted relationship between social support and health and social care systems, suggesting that community-oriented mental health services can enhance recovery by integrating social support features, such as clubhouses and non-traditional therapeutic programs like gardening, football games (*e.g.*, Albert *et al*., 1998; Bjørlykhaug *et al*., 2021; Horghagen, Fostvedt and Alsaker, 2014; McKeown, Roy and Spandler, 2015; Prince *et al*., 2018; Smidl, Mitchell and Creighton, 2017). In Central and Eastern Europe, the transition to community-based care has shown that perceived support from mental health providers correlates with lower functional limitations, underscoring the importance of recovery-oriented principles (Roth *et al*., 2021; Berkman, Kawachi, and Glymour, 2014). Relational and personalised interventions in social support have shown more significant effects, indicating their potential benefit in mental health recovery (Marmot and Wilkinson, 2008; Bruhn, 1991; Tough, Siegrist, and Fekete, 2017). Previous studies (Broadhead *et al*., 1983; Schwarzer and Knoll, 2007; Wilkinson and Marmot, 2003; Antonucci and Akiyama, 1987; House, Umberson and Landis, 1988; George *et al*., 1989; Prince *et al*., 1997; Sherbourne *et al*., 1992) have considered the impact of personalised and relational social support on

recovery and concluded that MHSUs with less of these forms of social support are more likely to experience poor recovery outcomes, which has a bearing on their quality of life.

Many Western organisations have made significant strides in developing policies that promote mental health and support recovery. For instance, the European Union (EU) and WHO have been instrumental in advocating for mental health as a priority. Key initiatives include the EU Mental Health Compass and WHO's European Mental Health Action Plan for 2021-2025. These frameworks emphasise the importance of integrated care, community-based services, and reducing the stigma associated with mental illness (Thornicroft, 2008; Amand-Eeckhout, 2023; WHO, 2022; Thornicroft and Tansella, 2008; 2013). One of the primary focuses of these policies is the development of community-based mental health services. Unlike the traditional model of institutional care, community-based approaches aim to integrate individuals with mental illness into society, ensuring they have access to necessary services while maintaining social connections (Siette *et al*., 2017; Hopper, 2007). This shift reflects a broader understanding that recovery is not just about symptom management but also about enhancing quality of life through social inclusion.

Cultural attitudes towards mental illness vary across many Western contexts, influencing the availability and effectiveness of social relationships. Dahl and Van der Wel's (2016) cross-country analysis showed that in many European countries (such as UK, Italy, and Germany), there has been a gradual shift towards greater acceptance and understanding of mental health issues. However, stigma remains a significant barrier to recovery, often preventing individuals from seeking help or fully engaging with social support networks. Northern European countries, such as Sweden, Denmark, and Finland, tend to have more progressive attitudes towards mental health, with robust welfare systems that support mental health recovery. There have been concrete political strategies in Norway and Sweden aimed at reducing this problem. These countries emphasise the role of community and social inclusion, and there is a general cultural acceptance that seeking help for mental

health issues is a sign of strength rather than weakness (Gubrium and Lødemel, 2014). In contrast, some Southern and Eastern European countries (*e.g.*, Romania, Turkey, Greece and Albania) may still struggle with more traditional views on mental illness, where stigma and discrimination are more prevalent (Mental Health Europe, 2024). In these regions, mental illness is sometimes viewed as a personal or family failure, leading to social isolation and reduced access to support (Antic *et al*., 2023; Dahl and Van der Wel, 2016). Efforts to combat stigma in these areas are crucial for enhancing social support and improving recovery outcomes for MHSUs.

Community-based mental health services are a cornerstone of social support in many Western countries, reflecting the belief that individuals recover better when they remain connected to their families and communities (Bruhn, 1991; Bitter *et al*., 2020; Waller *et al*., 2018). These services often include multi-disciplinary teams that provide a range of supports, from psychological therapy to assistance with housing and employment. Examples of successful community-based models can be found across Europe. Italy is often cited as a pioneer in community-based mental health care due to the Basaglia Law of 1978, which led to the closure of psychiatric hospitals and the development of community mental health centres. This law fundamentally changed the approach to mental health care in Italy, emphasising the rights of people with mental illness to live in the community and access a range of social supports (Burti and Benson, 1996). Likewise, in UK, Recovery Colleges offer a unique approach to mental health support, providing educational courses designed to aid people in managing their mental health issues, developing new skills, and rebuilding their lives (Anfossi, 2017; Hayes, Hofmann and Lorscheid, 2022). These colleges are built on principles of co-production, where people with lived experience of mental illness work alongside mental health professionals to design and deliver the courses (Bowness *et al*., 2023). The emphasis on social welfare and community integration is solid in Nordic countries. Finland's "Open Dialogue" approach is a notable example, where the entire social network of the person experiencing mental health issues is involved in the

recovery process. This method has been shown to reduce hospitalisation rates and improve long-term outcomes (Bergström *et al*., 2018; Nakamura, Rask and Kojo, 2024).

The role of peer support, where individuals with lived experience of mental illness support others in their recovery journey, has gained traction across Europe. Peer support workers are increasingly integrated into social care and mental health services, providing empathy, understanding, and hope to those in recovery (Castelein *et al*., 2008; Bjornestad *et al*., 2017; Gidugu *et al*., 2015). This approach benefits those receiving support and empowers the peer supporters, who often find that helping others is a key component of their recovery (Lloyd-Evans *et al*., 2014; Forrester-Jones *et al*., 2012). For instance, in the Netherlands, peer support is recognised as a significant complement to traditional mental health services (Karlsson *et al*., 2017). Peer support groups, both in-person and online, offer safe spaces for individuals to share their experiences, learn from others, and establish social connections (Kaplan *et al*., 2011; Martire and Helgeson, 2017). The European Network of (Ex-)Users and Survivors of Psychiatry (ENUSP) is a prominent organisation that champions the rights of individuals with mental illnesses and promotes the use of peer support across Europe (Russo and Shulkes, 2015; Donskoy, 2015).

Recently, substantial evidence has emerged indicating that health and social care systems and services in several Western nations (*e.g.*, UK, Australia, Italy and Netherlands) are continually evolving to incorporate the social factors crucial to mental illness recovery (Bjørlykhaug, Bank, and Karlsson, 2020; Capogrosso *et al*., 2024). This evidence underscores the social perspectives and approaches that can significantly contribute to understanding and addressing mental health issues. Developed social care interventions and proactive programs often target individuals who experience limitations, such as those in challenging economic situations and underprivileged living circumstances, due to their susceptibility to mental health problems (Tew *et al*., 2019; Topor, Boe and Larsen, 2022).

Despite the progress made, the existing levels and varieties of social care services appear to fall short in integrating social approaches into mental health care, frequently providing insufficient support, which can lead to social exclusion (Cottam, 2018; Giacco *et al*., 2017; Richter and Hoffmann, 2017). Moreover, the ongoing stigma associated with mental illness continues to hinder recovery efforts. Social exclusion and health inequalities are rising global problems (Wilkinson and Pickett, 2020; Patel, 2016) and are significant components to include when exploring social support, mental health and recovery. Disparities in mental health care across countries need to be addressed to ensure that MHSUs and their families have access to adequate social support. Several researchers have suggested future directions for enhancing social support for MHSUs' recovery (*e.g.*, McCorkle *et al*., 2008; Tew, 2013; Cottam, 2018; Pevalin and Goldberg, 2003). Thus, continued efforts are needed to challenge and change cultural attitudes towards mental illness.

Public awareness campaigns, education, and media representation play critical roles in this endeavour. Ferazzoli and Kpobi (2024) propose the need to further develop and fund community-based mental health services, particularly in regions where institutional care still dominates. This includes investing in housing, employment, and social support programs that are crucial for recovery. Reupert *et al*. (2015) argue for promoting family support by expanding the role of family support within mental health services to enhance recovery outcomes. Training and integrating more peer support workers into mental health teams should be a priority. Antic *et al*. (2023) emphasise the importance of cross-border collaboration, enabling countries to benefit from sharing best practices and collaborating on mental health initiatives. The UN, EU, WFMH and WHO can facilitate this by creating platforms for knowledge exchange and joint action. Collectively, these studies offer valuable perspectives on the ecological aspects of mental illness recovery, which could be beneficial in shaping public mental health initiatives.

2.4. Summary

This Chapter has reviewed relevant research on Western perspectives on mental illness recovery. It has also explored social care systems and social relationships through Western theoretical views on the role of social support and social factors in the recovery journey of MHSUs. Social support is a phenomenon that involves interactions between people; therefore, when a person offers social interaction, it plays a vital role in health outcomes. In the recovery journey, it represents the frequency of support provisions that MHSUs perceive and report receiving from formal and informal social and healthcare systems. The review indicates that in many Western countries, social support alone is not sufficient; what is crucial is the belief in the existence of sustainable social care and support systems, including social relationships and interactions that are essential to the recovery journey. While significant progress has been made in developing community-based services, more work is needed to ensure that all MHSUs, regardless of their social and cultural identity or location, have the support they need. By continuing to innovate and collaborate, many Western societies can build a more inclusive and supportive environment for MHSUs' recovery.

Literature on African perspectives on mental illness and social support provisions in the recovery journey of MHSUs is examined in the following Chapter to situate the review within the context and objectives of this study.

CHAPTER THREE

LITERATURE REVIEW- PART TWO

AFRICAN PERSPECTIVES ON FAMILY CAREGIVING AND MENTAL ILLNESS RECOVERY

3.0. Introduction

Chapter Three continues the discussion on social support and recovery from mental illness that began in Chapter Two by exploring pertinent empirical studies conducted in Ghana and other African contexts. Specifically, this Chapter focuses on the extant literature on kinship care (including family agency and interactions, support provisions, and practices) for MHSUs' recovery. The Chapter concludes by exploring the barriers to the family's agency towards recovery, accompanied by a summary of the issues discussed.

3.1. Ghana's Sociocultural Aspects of Caregiving

Mental illness is a socially defined concept, implying that different Ghanaian cultural and ethnic groups have diverse ways of conceptualising its nature and causes, determining what is mentally healthy and unhealthy, and deciding what interventions, if any, are appropriate (Fournier, 2011; Nicholson, 2008; Aikins and Koram, 2017; Canavan *et al*., 2013). For instance, *Damm yare3* [mental illness], a term widely used among the Akans, is a taboo subject that attracts stigma in many Ghanaian urban and rural communities. A study conducted by Dadson, Annor and Yendork (2018) in a mental facility in Accra revealed that the European terms for defining mental illnesses such as depression, bipolar, and schizophrenia are not culturally acceptable amongst the population, while another study conducted by Quinn (2007) in the Northern region of Ghana found that community members responded with fear, avoidance and anger to MHSUs. The stigma linked to mental illness can be attributed to a lack of education, fear, religious reasoning, and general prejudice. When Quinn (2007) interviewed participants on their thoughts on the causes of mental illness, the majority of them

cited witchcraft/spiritual possession as the primary cause. Divine wrath and the will of God were seen as the second most prevalent reason. Significantly few cited genetics and drug misuse. These reasons are similar to the views of participants studied across Ghana's many rural and urban communities and other non-Ghanaian contexts (*e.g.*, Agyei, 2020; Abukari, 2016; Canton, 2018; Kpobi and Swartz, 2019a; Weobong *et al*., 2023; Bagasra and Mackinem, 2014). Of importance to this current study, Gyamfi's (2022) research found that family relationships and socio-economic status are possible triggers of mental illnesses, which have significant implications on the support families provide in MHSUs' recovery journey.

Social stigma embedded within interpersonal and intrapersonal interactions has meant that in many of these rural and urban communities in Ghana, mental illness is a hidden issue equated to a silent epidemic (Mfoafo-M'Carthy, Grischow and Stocco, 2020). Many households with mentally ill persons hide them for fear of discrimination and ostracism from their communities (Gordon, 2013; Oti-Boadi *et al*., 2024). Adult females from families known to have mental illness are disadvantaged since a history of mental illness severely reduces their marriage prospects (Read, 2016). The effect of silence on mental illness is further compounded by inadequate focus at the policy level (Osei, 2019; Omar *et al*., 2010). Lack of adequate national-level financial and technical investments in addressing mental health impacts the understanding of the issue in the Ghanaian context and the available avenues for care and support for families in sustaining the recovery journey of their relatives with mental illness.

Aspects of Ghanaian social environment do not nurture good mental health, mainly due to the myriad of religious beliefs, family conflicts and post-conflict situations (Mensah, 2024; Read and Nyame, 2019). Family dysfunctions and other major socio-economic disasters have an enormous impact on the mental health and psychosocial wellbeing of people. According to Osei, Asare and Roberts (2021b), rates of mental disorders tend to double after such emergencies. Although the family

remains an essential resource for support for MHSUs, widespread socio-economic challenges, frequent family conflicts and internal strife disrupt social life and lead to hunger and displacement for MHSUs. Family internal conflicts, which are resource-based, are commonplace and leave long-term mental health effects on MHSUs, including post-traumatic stress leading to relapse or worsening of their condition in the recovery journey. Van der Geest, Dapaah and Kwansa (2019) noted this as the experience of MHSUs with HIV/AIDS and other chronic diseases in the context of family-care processes in Ghana. The Ghana Statistical Service (GSS) (2021a) estimates that approximately 2.99 million Ghanaian households, including MHSUs and families, live below the national poverty line (less than £1.48 per day), with the majority residing in rural areas.

According to Dadson, Annor and Yendork (2018), the care of MHSUs is expensive and poses a burden on many Ghanaian households, and a lot of families avoid caring responsibilities, leaving MHSUs short on support in their recovery journey. MHSUs and FCs trying to access mental health services are also negatively affected by the high costs of formal healthcare (Awenva *et al*., 2010). The most common method of financing treatment in Ghana is through the National Health Insurance Scheme. Despite its introduction to cutting down on the cost of healthcare in Ghana, mental illnesses are excluded and involve out-of-pocket payments (Read and Doku, 2012; Yakubu, 2014). Additionally, MHSUs and FCs are not entitled to any disability benefits, as stipulated in the Ghana Mental Health Act 846, 2012 (Mwangi *et al*., 2023). As a result, most families and MHSUs do not receive any governmental support towards their long-term medical treatment, even though effective therapies exist for many mental health conditions (Dzokoto *et al*., 2021; Barker *et al*., 2021; 2022; Yaro *et al*., 2023). Even while the vast majority of families are prepared to care for and financially support the immediate needs of MHSUs (provision of food, housing/shelter, and medical bills), those dealing with chronic or severe mental illnesses may deplete the financial resources of even the most

willing and able family members (Addo *et al*., 2018). Suddenly, MHSUs may find themselves financially unable to support their recovery journey.

In many African contexts, socio-economic difficulties, including poverty, are one of the primary causative agents of mental illness (Opoku-Boateng *et al*., 2017). Poverty and psychological difficulties are closely related, implying that individuals living in poverty are more vulnerable to mental illness, while those with pre-existing mental illness are more likely to become trapped in poverty due to their decreased capacity to function optimally (Daliri *et al*., 2024; Addo *et al*., 2018). MHSUs may experience feelings of isolation and loneliness as they navigate their recovery journey, which can be exacerbated by poverty and the challenging socio-economic situations that families face (Osei, Asare, and Roberts, 2021b; Adu, Jurcik, and Grigoryev, 2023; Anum, Akotia, and De-Graft Aikins, 2024). Consequently, the level of support MHSUs receive from family and other sources, such as mental health services, is significantly related to the quality of their mental health, which in turn affects their progress in recovery.

Nukunya (2016) indicates that although Ghanaian families are known for their affinity, reciprocity, solidarity and intimacy among their members, many households often do not foster open communication. There is a plethora of evidence to suggest that due to socio-economic challenges and inadequate social welfare institutions, most families often practice silence culture and work to avoid and conceal difficult conservations concerning child abuse, including incest, negligence and avoidance of care for members with chronic illnesses, such as HIV/AIDS and mental illnesses (*e.g.*, Gordon, 2013; Van der Geest, Dapaah and Kwansa, 2019). These issues go unresolved for years and often make the family space a breeding ground for internal conflicts, trauma and unexpressed emotions. As a result, MHSUs are disadvantaged in expressing their actual needs and having them met. MHSUs are more vulnerable to all forms of abuse within the family space, in society and even in the facilities and institutions that are expected to care for them (Read, 2019; Read, Adiibokah and

Nyame, 2009). MHSUs' safety in mental health facilities and at home is not always guaranteed, and more significant action is required to improve this aspect of care.

The family is at the heart of Ghanaian culture and society, and the term refers to both the nuclear (close) and extended (wider) family. The family's existence and survival largely depend on family and kinship ties, both of blood origin and marital relationships (Darko, 2016). As a result, the family handles each member's development, care, and disease management (Abekah-Carter *et al*., 2024). While the Ghanaian family structure is regarded as the hub for caregiving, globalisation and migration gradually break traditional norms and values that bind family members in providing communal support (Yarney *et al*., 2015; Doku and Minnis, 2016). As urbanisation becomes more widespread and the extended family system breaks down, the availability of critical care for MHSUs becomes increasingly scarce (Dadson, Annor, and Yendork, 2018). The breakdown of traditional family structures and values could also be contributing to poor mental health because these result in children, youth and adults who are poorly prepared to cope with the stresses of life and who may turn to the streets as a coping mechanism (Nyarko *et al.*, 2020). Migration to urban areas has meant nuclear families are on the rise, thereby reducing the ability to pull manpower and resources to care for MHSUs (Tawiah, Adongo and Aikins, 2015; Narh, 2019). The rhetoric amongst family members is that those willing to sacrifice their prospects must accept the responsibility and the burden of care. Although religious and cultural beliefs offer motivation to take on the caregiving tasks, most family members find out that it is financially unrewarding to look after family members with chronic illnesses.

3.2. Family Agency Towards Recovery

Family agency (kinship care) towards its members afflicted with diverse infectious (HIV/AIDS, malaria, tuberculosis, hepatitis), chronic diseases (cancer, Alzheimer's, dementia and other mental health conditions, diabetes, epilepsy, asthma) and disability (physical and psychological

impairments) has long been a topic of discussion in most African countries (Monteiro, 2015; Read *et al.*, 2006; Rentinck *et al*., 2006). In such discussions, the African family (nuclear or extended relatives) is frequently considered a valuable cultural resource instead of Western institutional and biomedical care models.

According to Dapaah and Spronk (2016), the optimum context for intimacy, solidarity, and security that appropriate care necessitates is commonly defined as a family home (as multiple family generations frequently live under one roof). Therefore, the task of caregiving for effective recovery lies with the whole family as a supportive care system, not just individual family members (Anokye, 2018; Mainoo, 2018). Read and Nyame (2019) argue that how family caregiving is enacted in practice is determined by family life as lived within individual connections rather than specified networks of household composition. Given that most African families are communalist and collectivist, their members may be seen as belonging to the entire extended family, not just the nuclear family (Gyekye, 1996; Liu, 2016; Faydi *et al*., 2011). This implies that terms like cousin, uncle, and aunt are either non-existent or have completely distinct cultural meanings. Consequently, relationships of affection and trust between FCs and MHSUs are influenced by imagined perspectives of family lineage and the home.

In Ghana, it was once the practice that people who became weak, sick, or frail were taken to their maternal relatives' homes for proper care (Dapaah and Spronk, 2016; Dsane, 2009). Many African countries (Benin, Burkina Faso, Mali, South Africa, Togo, Nigeria) value these practices due to the necessity to retain family ties and culture (Asuni, Schoenberg, and Swift, 1994; Olopade, 2014; Den Hertog and Gilmoor, 2017; Sorsdahl *et al*., 2009). Nonetheless, much of the responsibility for caregiving falls on women, who are typically regarded as the primary caregivers in most African societies (Olenja, 1999; MacNeil, 1996). This places significant pressure on women, who are already overburdened with responsibilities for the family's overall health and wellbeing, including providing

household food security, managing limited family resources, and guaranteeing their children's education and wellbeing (Owoo and Lambon, 2021; Ofori-Atta *et al*., 2010).

In most African societies, mental health and illness are cultural constructs, even when assessed by biomedical models (Olafsdottir and Pecosolido, 2011; McGough, Wynaden, and Wright, 2017). Several social health scientists ascribing to traditional and social recovery models contend that all societies have their own unique concepts about wellbeing, which influence perceptions, experience, coping and treatment (*e.g.*, Littlewood, 2002; Opare-Henaku and Utsey, 2017; Kirmayer, 1988; Conrad and Barker, 2010; D'Andrade, 1995; Kleinman, Eisenberg, and Good, 1978; Adebowale and Ogunlesi, 1999). For example, in Ghana, traditional beliefs regarding mental illness and other chronic sicknesses long ago involved ideas of religion, spirituality and superstition (witchcraft or sorcery) (Ae-Ngibise *et al*., 2010; Quinn, 2007; Quintanilla, 2010; Kim, Crouch and Miner, 2015). Similarly, source evidence in other African countries demonstrates widespread views that epilepsy was classified as a mental illness like any other illness and does not require clinical treatment (Asuni, Schoenberg, and Swift, 1994; Kabir *et al*., 2004; Hugo *et al*., 2003). These ideas, over time, may influence how people understand and conceptualise mental illness and recovery. Additionally, it may encourage pluralistic health-seeking behaviours, including the use of hospitals, prayer camps, and traditional healers and herbalists (Arias *et al*., 2016; Amissah-Essel, Enyan, and Asiedu, 2022; Read and Kpobi, 2025).

Many traditionally oriented Africans believe that every individual is made up of spirit (received from the father), soul (received from God), and blood (obtained from the mother) (De-Graft Aikins, 2015; Mainoo, 2017). These categorisations determine whether an illness is linked to the physical (connected to the blood) or associated with the spiritual. Any illness warrants a deep investigation to determine which of the three components of the MHSU is troubled or affected and which curative or healing measures are appropriate. Any hasty investigation could lead to a

misdiagnosis and could result in treatment failure or a fatality. Orthodox medicine practitioners are often viewed as incompetent since they "ignore" the spiritual aspect of disease management (Jacob, 2017; Liu, 2016; Kpobi and Swartz, 2018a). Therefore, it is crucial to understand how culture influences the construction of and response to mental illness and recovery.

The majority of literature on Africa's mental health future maintains an idealised family view. Due to the involvement of family members in caregiving, most political leaders are eager to keep that "romantic image" of the family alive in order to economise on state funding of care for people with mental health problems, disabled, chronically sick, and the elderly (Hsiao *et al*., 2006; Van der Geest, 2016; Asare, 2012; Appiah, 2022). Consequently, little is known about how mental illness affects family life and material support in specific scenarios. For instance, in Ghana, MHSUs may cause enormous misery for both close (nuclear) and wider (extended) family members since it sometimes necessitates the sale of family assets such as land, cocoa farms, or other valuable assets in order to pay for treatment (Read and Doku, 2012). As a result, every effort is made to spiritually protect family members, as spiritual ailments are considered the most expensive (Read, Doku, De-Graft Aikins, 2015). Regardless of the reality, WHO's Comprehensive Mental Health Action Plan (CMHAP) 2013–2030 calls for MHSUs to be able to remain with their families and for family "empowerment and involvement" in mental health care (WHO, 2021).

Several authors have considered the efficacy of WHO's CMHAP, citing the effects of stigma and socio-economic challenges for families to facilitate MHSUs' recovery (*e.g.*, Hage, Schwartz and DeMartino, 2017; Roe, 2016; Al-Habeeb, Helmi, and Qureshi, 2016; Tharayil, 2019). These authors point out the problematic living situations of families, maintaining that MHSUs and their FCs live in communities where the stigma surrounding mental health problems and other infectious and chronic diseases exists. Stigma often leads to social isolation and loneliness for MHSUs, their FCs and other family members. Philips *et al*. (2012, pp. 682) assert that:

> "Stigmas affect not only the individuals bearing them but also those who are closely associated with stigmatised individuals and groups. The problems faced by stigmatised persons spread out in waves of diminishing intensity amongst those they come in contact with, especially family members".

Stigmatisation extends beyond just MHSUs and their families; it also affects families dealing with various health conditions, including HIV/AIDS, physical impairments, and disabilities (*e.g.*, Zuurmond *et al*., 2022; Grischow *et al*., 2018; Takyi, 2013; Van der Geest, Dapaah and Kwansa, 2019; Dako-Gyeke, Asampong, and Oduro, 2017; Ocran, 2022a; 2022b; 2023; Mwangi *et al*., 2023). Because of the illness's stigma and dread, it is very common for families to refuse to admit that a family member has it. Usually, families try to avoid the embarrassment that comes with it as much as possible. The trend has always been (for families that acknowledge the illness) to isolate such individuals from the family and society (Barke, Nyarko and Klecha, 2011; Read and Doku, 2012). In extreme cases, people do not even marry into the family for fear of getting a mental illness (Alem, Jacobson, and Hanlon, 2008; Monnapula-Mazabane and Petersen, 2022). While scientific evidence from family, twin, adoption and molecular genetics research (*e.g.*, Caspi *et al*., 2003; Gottesman, 1991; Kety *et al*., 1994; Stahl *et al*., 2019; Smoller and Finn, 2003; Sullivan, Kendler and Neale, 2003) exits to support some aspects of this myth (genetic transmission of mental illness), addressing its ongoing prevalence in some African communities presents a significant opportunity for education and awareness, alongside the necessity to address socio-economic factors (such as poverty, lack of access to healthcare, and education disparities) that affect these communities.

3.3. Perceptions of Mental Illness and Recovery

There is much discussion regarding how mental illness is recognised and characterised differently in different cultures and traditions and how this may affect family and society's knowledge, recognition, response and support (Fitzpatrick *et al.*, 2017; Conrad and Barker, 2010;

Esan *et al.*, 2019; Quinn and Evans, 2010; Iacovelli, 2018; Goldman and Grob, 2006). Nonetheless, there is still a dearth of literature in developing contexts (including Ghana) exploring social aspects of recovery. Broadly speaking, there are two models that explain how people's perceptions and attitudes toward mental illness are influenced by culture: universalism and relativism (Swartz, 1998). The universalist or "etic" approach considers mental illness identification, diagnosis, treatment and therapy generalisable (Patel, 1995). In comparison, the relativist claims that the universalist model's culturally bound characteristics limit its general application. Consequently, it advocates for evaluating mental illness within a culture and its context, understanding its underlying importance and its connection to other components of that culture (Kleinman, 1991). The relativist position is to some extent supported by the significant variations in recovery rates between cultural contexts.

Many researchers and experts have recognised both models' flaws and created new models that combine their methodological abilities (*e.g*., Addei *et al*., 2012; Anyan *et al*., 2024; Arthur *et al*., 2020). For instance, a common strategy is the use of vignettes bearing close correspondence with diagnostic manuals (such as International Classification of Functioning, Disability and Health (ICFDH) and Diagnostic and Statistical Manual of Mental Disorders- (DSM)), in which participants identify instances of mental illness based on descriptions of people who could satisfy the criteria for a mental health problem (Atakora and Asampong, 2020; Canavan *et al*., 2016; Asafo, 2021; Kirmayer, Fletcher, and Boothroyd, 1997; Marthy and Segal, 2015; Pescosolido *et al*., 1999; Phelan *et al*., 2000). This method has several advantages and could be influential in determining knowledge and familiarity with existing mental illnesses. For a more comprehensive review of the strengths and weaknesses of these diagnostic manuals, interested readers should consult Frances and WidigerOsei (2012), Karter and Kamens (2019), and Widiger and Gore (2012). Semi-structured and in-depth interviews have also been conducted to highlight the subtleties and distinct ways each culture defines mental illness (Kirmayer *et al*., 1993; Opare-Henaku and Utsey, 2017; Wynaden *et al*., 2005). Other

research has blended predefined descriptions in vignettes with interviews (*e.g.*, Mamah *et al*., 2013; Appiah *et al*., 2020b; Weobong *et al.*, 2009; Van der Geest and Krause, 2012; Psaki and Hindin, 2016; Arthur, 2018; Forster, 1962).

The relationship between thought and the expression of thought through language has been a subject of extensive discourse, positing that language reflects the perspectives of a community and significantly shapes their cognitive processes (Asante and Oppong, 2012). Generally, people's perceptions of mental illness in Ghana and other African contexts can be culturally constituted regarding societal belief systems and expressed in different languages (Osei, Asare and Roberts, 2021b; Quinn and Evans, 2010; Obeng, 2004). Earlier studies, including those by Fosu (1981) have explored the ways in which the Akans categorise illnesses and how the recognised causes influence their decisions regarding healthcare options and approaches. Other researchers in Ghana, such as Abukari (2016), have explored how Dagombas theorise mental illness and healing. Dzokoto *et al*. (2023) investigated the representation of mental illness within a Ga community. Annor *et al*. (2024) researched how individuals affected by stigmatised communicable diseases employ linguistic and pragmatic techniques to convey their experiences and attain certain therapeutic benefits. People believe victims (MHSUs) have been possessed by 'evil spirits', causing their behaviours to deviate from the acceptable norms in the family and society (Akyeampong *et al*., 2015; Osei, Asare and Roberts, 2021a; Opare-Henaku and Utsey, 2017; Quinn, 2007).

Most families perceive mental illness as a "tragedy" that has befallen them (De-Graft Aikins, 2015; Quinn and Evans, 2010) and a dreadful incident that has tarnished the family's reputation (Doughty and Tse, 2010). Murphy *et al*. (2015) posit that people may associate the cause of the illness with the family, significantly if mental illness had affected a member (who may be living or dead) before, thereby casting shame on the family. The concerns that families and MHSUs experience result from their meaning of mental illness and recovery (Gyekye, 1995; Gberie, 2017b; Read, 2016).

Recent studies by Agyekum (2020) show that families try to come up with a plausible definition of mental illness and recovery to apply to their relatives. Some families may develop meaning from reviewing past experiences through cultural beliefs to make sense of the present experience of their relative with mental illness.

A report by Mcveigh (2020) showed that families of MHSUs in the Northern parts of Ghana use a variety of explanations for their relative's behaviour, and their acceptance of the mental illness is based upon a complexity of factors, including religion, age, gender, societal norms and superstition. For instance, elderly women are sometimes labelled as "witches' when they become demented and manifest neuropsychiatric symptoms. They are usually sent to "prayer camps" or "witch camps" by their family members in an attempt to treat or conceal the illness from others (Ae-Ngibise *et al*., 2010; Benyah, 2023). At worst, they are abandoned and left wandering alone on the streets, begging/stealing food to stay alive or being banished from the community by their neighbours to maintain the image and reputation of the family and community at large (Opare-Henaku and Utsey, 2017). According to Osei, Asare and Roberts (2021b), these traditional beliefs and practices persist among rural populations in the central and northern parts of Ghana. Traditional village life appears to be more preserved in rural regions (Ardayfio-Schandorf, 1994), as do traditional beliefs and attitudes concerning mental illness (Quinn, 2007). People may continue to have traditional views regarding mental illness due to a variety of circumstances, including the influence of religion or spiritual churches ("shrines", "witch camps", and "prayer camps") and discourses in the media (Wilińska and Boateng, 2022; Dzokoto *et al*., 2018; Mfoafo-M'Carthy, Sottie and Gyan, 2016).

Evidence from cross-cultural studies has revealed that people's responses and attitudes towards mental illness are more adverse within traditional contexts (*e.g.*, Osafo, 2018; Ambugo, 2014; Ngissah, 1977; Boroffka and Olatawara, 1977; Franklin *et al*., 1996; Helman, 2000; Prince, 1964). Families tend to redefine behaviours as symptoms and expect that available treatments would

treat “the problem”. For example, a study by Ovuga, Boardman and Wasserman (2005) described how families felt disappointed when the desired changes were not apparent after consulting traditional healers and biomedical professionals. It appears that deterring the cause is of greater importance to families, as it is believed to be transmissible to other relatives and may lead to consequences in the future, including difficulties in employment, marriage, and social position, as well as potential impacts on royal lineage (Kyei *et al*., 2014; Amonoo *et al*., 2023). Consequently, revealing their uncertainty confirms the notion that mental illness is not just like any other illness (Read *et al*., 2006).

The findings of Watson, Kelly, and Vidalon (2009), by contrast, revealed that family identifies themselves with their relative (MHSU) and, as such, prefer to describe mental illness like all other illnesses, thereby perceiving it as a “normal” illness. The findings confirm studies conducted in various African countries (*e.g.*, Awaritefe, 1977; Boroffka and Olatawara, 1977; Franklin *et al*., 1996; Gberie, 2017a; Monteiro, 2015; Ngissah, 1977) regarding views, attitudes, and responses concerning mental health problems. These studies revealed that people believe mental illness is a chronic disability and that victims (MHSUs) may or may not recover. This indicates a need to understand the various societal perceptions of mental illness and recovery.

According to Amfo, Houphouët and Dordoye (2018), exploring people’s linguistic expression of mental illness as a reflection of human thought and culture may correlate with human behaviour, the fabric of the home and society. Thus, people’s genuine acceptance of MHSUs as capable individuals and their willingness to socially engage with them without prejudice. Research like this suggests that traditional and professional healthcare providers should do their best to understand the cultural norms and language usage of the areas where they provide services (Ansah and Klugah, 2020). This is necessary for gaining insight into how MHSUs’ families and communities view mental illness. This understanding lays the groundwork for public health education and, later on, for practitioners to effectively communicate with MHSUs and their FCs. A thorough understanding of

the MHSUs' culture and language is essential for making correct diagnoses and providing effective nursing care.

As mentioned previously in Chapter Two, there is a growing body of cross-cultural literature that recognises recovery does not necessarily imply becoming 'symptom-free' (remission of mental illness symptoms) or the complete restoration of health, as typically suggested by the biomedical model of recovery (Duff, 2015; Pilgrim and McCraine, 2013; Van der Watt *et al*., 2017). Instead, it involves reclaiming control over one's life, negotiating a valued and satisfying 'place in the world', and finding personal strategies for managing any ongoing distress experiences (Reupert *et al*., 2015; Tew *et al*., 2012). The practicality of these ideals fits within the Ghanaian virtue of kinship care, which makes recovery both a personal and a social process in which resolution of internal distress occurs alongside social re-engagement in ways that may be mutually reinforcing to MHSUs, their families and communities (Smalls-Mantey, 2019; Appiah *et al*., 2022; Cudjoe and Chiu, 2021). It is dangerous to assume that Ghanaian families only share a biomedical view of mental illness and understand their relatives' (MHSUs) treatment plans and recovery journeys (Handerer *et al*., 2021; Grossman and Gruenewald, 2017). Hence, understanding families' perspectives on mental illness and recovery is critical since it plays a vital role in bringing MHSUs to the attention of varied 'disease' treatment and management (traditional and biomedical).

3.4. Family Practices and Support Provisions in Recovery

Ghana has an interesting and diverse spectrum of cultures and religious systems, and a variety of mental health treatment and management options. Caregiving is frequently portrayed as a methodical and logical process involving seeking assistance and adopting approaches that are consistent with one's beliefs and conveniently located (Quinn and Evans, 2010; Gyekye, 2003). Fosu (1995), for instance, argue that caregiving approaches towards recovery from mental illness in Ghana depend on the family or society's belief systems, area of residence (locality), age and ethnicity and

available financial resources. Hence, family perspectives (the process by which they develop an understanding of mental illness), family resources (including various types of support), and geographical location may influence approaches to treatment and recovery.

Through a series of case illustrations from anthropological observations and interviews or ethnography approaches, Van der Geest, Dapaah and Kwansa (2019) demonstrate how sickness and health are corporate family and social concerns in Ghana. In disease management, it is common practice for concerned family members to convene and discuss how to handle the situation. This rendezvous, Osei, Asare and Roberts (2021a) describe as a 'lay therapy managing group' adopted by families more significantly in managing chronic diseases, including mental illness. Thus, a collective of clan members or relatives (extended and nuclear family members) meets with the afflicted member to define the health problem's nature and search for a remedy. This group becomes responsible for making logistical and financial decisions regarding the diagnosis and treatment of the illness throughout its course. The rationale for this approach may lie in the belief that the cause of the illness derives from the family or clan, so the wellbeing of all concerned requires collective action. Nonetheless, Read and Nyame (2019) indicate that, in their contributions to family caregiving in Ghana for MHSUs, adult females, particularly mothers, are most interested and involved in caregiving over time.

The presence of family support in the recovery journey of MHSUs offers both physical and psychological benefits and is considered a factor that reduces (and protects against) psychological distress (Adu *et al*., 2024; Borbor, 2019). Family members' involvement in MHSUs' recovery journey facilitates their movement toward conditions of hope, purpose and wellness, making MHSUs aspire for meaningful social life. This highlights the need for families to create acceptable and enabling living conditions to support MHSUs' recovery. From the African literature on kinship care, it is observed that the support provided by family comes in many different forms and carries with it

functional purposes (*see* Chapter Two). It includes emotional support, a form of social support where family members offer comfort and reassurance to MHSUs experiencing distress. Family members, both near and far, offer hope and understanding, which is crucial for MHSUs to cultivate resilience and navigate their challenges effectively. In a study conducted by Adjieteh, Amponsah and Amoanoo (2017), MHSUs maintained that emotional support experienced by family made them feel loved and cared for, which helped them manage their presenting problems. This implied that the presence of family, their engagement in conversations (whether it made sense or not), and their listening ears made MHSUs feel wanted and valuable members of their family.

Family members' provision of tangible services and financial assistance during MHSUs' recovery journey is one example of instrumental support. MHSUs may rely on family members to help with various personal tasks and help around the house, including meal preparation, personal hygiene, cleaning their living space, and transportation to and from medical appointments, medical, energy and housing bills (Arku *et al*., 2011). Informational and appraisal support characterises the guidance, suggestions, or insights purposefully provided by family members to enhance the wellbeing of MHSUs (Borbor, 2019). An example could involve FCs restating the doctor's or herbalist's information to MHSUs regarding their treatment protocols, informing them of any modifications to their medication, conveying details from other family members concerning social events and invitations, offering guidance to assist MHSUs in their decision-making, and reminding them of their positive traits and achievements throughout their life's journey. The family's tangible services and involvement in MHSUs' recovery journey help MHSUs to relearn social skills; however, it is crucial for FCs to supervise MHSUs and not take charge of the resocialisation process.

There is evidence that most families in Ghana use various strategies for managing mental illness recovery (*e.g.*, Badu, Mitchell, and O'Brien, 2019; Read, 2017; Ae-Ngibise *et al*., 2010; Lambert *et al*., 2020). This includes biomedical (psychiatry hospitals/clinics) and traditional

approaches (traditional/faith-based healing). For example, Osei, Asare and Roberts' (2021a) review of the history of mental health care in Ghana showed that most families in rural parts of Ghana prefer treatments from traditional and faith healers compared to psychiatric hospitals. Although indigenous forms of care for MHSUs are increasingly recognised and documented as necessary, mental health professionals are concerned that such approaches can lead to human rights breaches and abuse (Appiah, 2013; Grischow and Mfoafo-M'Carthy, 2022; Read, 2019; Edwards, 2014). These vulnerable individuals (MHSUs) receive inhumane and harmful treatment from family members and personnel from these camps (Gyimah *et al*., 2023). This includes beatings, herbal concoctions, forced fasting, shackling/chaining to a tree/post, sexual abuse and many unreported inhumane practices. These practices may be viewed as part of the cultural tradition of exorcism— the removal of the evil spirit that inhabits the individual with a mental health problem (Amponsah, 2019; McVeigh, 2020; Kumari, 2020). In urbanised areas, most affluent families seek formal psychiatric services as the first point of call and may visit "prayer camps" for additional support (Appiah-Poku *et al*., 2004; Opare-Henaku, 2014). Ae-Ngibise *et al*. (2010) maintain that access to psychiatric hospitals is usually problematic for families in rural areas who cannot afford professional mental health services. In such situations, traditional or "faith" healers become their last resort.

3.5. Family Interpersonal Relationship in Recovery

Family is an essential social institution, especially in Africa. Invariably, most of the world's population lives in family settings or units. Mondal (2016b) regards the family as a living system of individuals— an individual is born in the family, grows in it, works for it and dies in it. Therefore, family plays a vital role in the socialisation of individuals. The interactions between members of the family have a considerable influence on the formation of the family's social identity, as well as on the development of social responsibility and moral self-control and social functioning, health and wellbeing. Given this, it is indisputable that the family unit serves as the foundation of social

organisation (Nukunya, 2016). Thinking of families as living systems, with all of the dynamics it entails, is fairly innovative since it challenges conventional orthodoxies that see emotional and psychological disorders as individual issues. In this approach, Weobong *et al*. (2023) maintain that family members own and drive care initiatives.

In the Ghanaian setting, like in other African countries, family extends beyond familial relatives (Kuyini *et al*., 2009). It often takes a "village" to nurture its members (Ferazzoli and Kpobi, 2024). More specifically, the extended family structure ensured the survival of communities and, by extension, Ghanaian (African) civilisations before the arrival of Europeans and, particularly, the introduction of formal healthcare systems (Akerele, 2020; Forster, 2012; Twumasi, 2005; Ofori-Atta and Ohene, 2014). Indeed, the family's broad network served as its foundation in that era. Kurankye (2017) argues that traditional extended families exemplified societal norms, beliefs, values, and aspirations. Consequently, the organisation of responsibilities in disease management is shaped by the perceptions and beliefs of the family and community regarding what constitutes care. This is a crucial perspective on interventions, as the communal nature of these societies indicates that health choices are not solely the individual's responsibility. Instead, families play a pivotal role in influencing health-seeking behaviours and the selection of care pathways (Read and Nyame, 2019; Asare, 2012). A significant factor in this family dynamic is the agricultural way of life in rural and remote Ghana areas, necessitating all family members' participation in daily tasks. This can also influence the types of health interventions deemed appropriate.

Nevertheless, the nature of family interactions during recovery requires clarification in the literature. Little is said about what occurs in the family home, possibly because of the folk laws and cultural adages that bind family members to take great pains to conceal complex family issues from the public (Abukari, 2016; Bindura, Chinyanganya, and Muguti, 2013; Agyekum, 2010). What is known from the literature about family interactions is the sharing of living spaces and places within

communities, as well as acts of reciprocity and solidarity. From culture to culture, the term "family" may have different meanings, including social engagements. In modern Western cultures, the term has come to be used generically to include relationships beyond blood ties (Anderson, 2007). Hence, it is crucial to ask MHSUs who they consider family throughout their recovery journey. As mentioned in the previous sections, the two Ghanaian family structures follow a common culture, with their members celebrating all family festivals and functions together. They are a coherent group of people bound by blood ties (Kpoor, 2015; Agyemang, Asamoah and Obodai, 2018; Ofori-Dua, 2014; Oppong, 1977). With globalisation and increasing urbanisation, people have become more individualistic and consider family secondary (Kutsoati and Morck, 2014). Although many family members live away from each other, they share responsibilities and regularly call on members for emotional and financial support in times of adversity (Amoah, Osei-Tutu and Adjei, 2023; Clark, 1999; Oppong, 1977). While children grow up, there is a division of labour among them, which aims to nurture them to become responsible (Durkheim, 1993). Specifically, older siblings are expected to support parents with household chores, such as cooking and caring for younger siblings, sometimes even working to supplement the family income (Aboderin, 2004). Therefore, every member plays a role in enhancing the family's wellbeing.

In the research conducted by Dsane (2009) on historical care traditions in Teshie (a town in Ghana), participants highlighted that reliable care for the elderly was exclusively associated with the maternal family. Opoku *et al*. (2018) and Zuurmond *et al*. (2019) discuss the challenges faced by families in Ghana caring for their children with impairment (disability), noting that it is primarily mothers who exhibit sustained concern over time rather than fathers. Read and Nyame (2019) argue, in their contribution to this issue, that the sanctity of the family (abusua in Twi) and the home (efie in Twi) have been recognised for a long time, particularly during the era when functionalist anthropologists discussed the balance within African households. They voiced concerns that societal

shifts, such as industrialisation, could disrupt the fabric of traditional family life. They viewed family conflicts and dysfunctions as transient challenges, anticipating a return to equilibrium. Ghanaians have consistently expressed admiration for the harmony and closeness within their families, frequently contrasting it with what they perceive as the detached, self-centred, and contentious nature of Western family dynamics. Instances of Western families entrusting the care of their elderly parents to unfamiliar carers (such as social workers, care workers, and support workers) served as compelling evidence of their discontent (Van der Geest, Dapaah and Kwansa, 2019). There are also critical reflections on familial dynamics and connections. Underneath the surface of seemingly harmonious interactions, family members might harbour concerns about the threats posed by bayie (witchcraft), often intertwined with feelings of jealousy among close kin. Jealousy within families is likely a universal phenomenon; it may take on a sinister, destructive, and even deadly form when felt and shown by members. The closeness that characterises the family unit also serves as its most significant weakness.

In a study by Read (2016) exploring concepts such as madness, cosmos, and recovery in rural Ghana, some participants described experiencing jealousy and *bayie* in their interactions with family members. The internal adversary is acutely aware of the vulnerabilities of those around them, gaining effortless entry into their lives, sharing meals, engaging in conversation, and resting side by side—these acts of intimacy are indicative of camaraderie and foster the enactment of *bayie*. Family members confiding in the researcher about their anxieties frequently reinforced their insights with folk sayings like *dua a ebɛn ne yɔnkɔ na etwi* (If a tree is near another tree, they rub each other) and *aboa a ɔhyɛ wo ntoma mu, na ɔka wo* (It is the insect in your own cloth that bites you). Acquaintances can foster not just disdain, but also feelings of uncertainty, exposure, and apprehension. When exploring the complexities of family caregiving in disease management, it is essential to consider the underlying tensions and unspoken doubts that may lead MHSUs in specific circumstances to shun the

closeness and familiarity of their own households, opting instead to confide in external support sources whom they feel more comfortable with than their own kin. This appears to be the approach taken by individuals suffering from HIV/ AIDs, as exemplified in Van der Geest, Dapaah and Kwansa's (2019) study, as well as individuals with known disabilities facing stigmatisation.

3.6. Barriers in the Recovery Journey

Research shows that social exclusion and stigma make it difficult for MHSUs to locate their 'place' in the family and society. For example, a study by Kushitor *et al*. (2018) found that although MHSUs (participants) claimed they had recovered, this did not reflect the views of family members and neighbours. It is well documented in the Ghanaian literature that the notion that MHSUs may reclaim their status within the family and opportunities for employment and social engagement is minimal (Ae-Ngibise *et al*., 2017; Darko-Gyeke and Asumang, 2013; Read, Sakyi and Abbey, 2020). According to Mensah (2021), Ghanaian societies view MHSUs as always in a state of heightened emotions such as anger, mood swings and talking basabasa (in a confused, disorderly, and meaningless way) and wandering as destructive behaviours for economic productivity. Likewise, Opoku-Boateng *et al*. (2017) note that the Ghanaian context does not recognise MHSUs' usefulness and how they could be reintegrated into society and have gainful employment to lead meaningful lives. Even within the wider social contexts, perceptions about MHSUs are largely stigmatising, and recovery is viewed as questionable and pointless with little to no government funding (Abekah-Carter and Oti, 2022; Appiah-Poku *et al*., 2004; Osei, Asare and Roberts, 2021b; Bonsu and Yendork, 2019). It is believed that though MHSUs' symptoms are likely to diminish with medication, it is highly expected for them to harm others and present aggressive behaviours (Read *et al*., 2024). People are often wary of engaging with them or altogether avoid them.

This scepticism is deeply rooted in the Ghanaian social and cultural fabric, which essentially leads to social exclusion and discrimination against MHSUs and their families (Read and Doku, 2012;

Harden *et al*., 2023). For example, an informant in Amfo, Houphouët and Dordoye's (2018) study noted in Twi (Akan language) 'nnyɛ mfomso da sɛ wubesusuw sɛ obi a wabɔ dam ho atɔ no. ɛda adi sɛ wɔbɛtow ahyɛ wo so', translating as never assume that a mad person has recovered. They are likely to attack you. Other participants in Kpobi and Swartz's (2018b) study indicated that mad people are unpredictable and may still have aggressive tendencies to scare or harm people. Dadson, Annor, and Yendork (2018) note that MHSUs often feel insecure living with family members and struggle to reestablish respectful, supportive, and mutually beneficial connections. To corroborate this assertion, Mensah (2021) found that the role of MHSUs in the family is often unnoticeable, as they are frequently hidden in their homes and not permitted to engage in public activities. MHSUs are, to some extent, regarded as disabled, unable to reclaim economic power, and therefore undermined by their current social context. Most of their interpersonal relationships are estranged, and there are few to no social interventions that might promote greater acceptance and challenge stigma (Tawiah, Adongo and Aikins, 2015; Read and Doku, 2012).

Researchers have reported that FCs are at risk for physical strain, including fatigue and sleep disturbances (Odue *et al*., 2018; Grandón, Jenaro, and Lemos, 2008; Gharavi *et al*., 2018). One consequence, as argued by Given, Sherwood and Given (2011), is that the quality of care to MHSUs is reduced when FCs are experiencing a burden. FCs are hidden patients themselves, with adverse, severe physical and mental health consequences from their physically and emotionally demanding caregiving tasks (Kyei-Arthur, 2013). Caregiving encompasses a range of responsibilities, including direct care and assistance with daily living activities. More specifically, medication intake, follow-up visits, baths, managing incontinence, changing clothing, transportation, and shopping are all included in care delivery tasks (Whittingham *et al*., 2011; Antonio, Kwakye and Essel, 2023).

Interestingly, most Ghanaian literature does not adequately capture the physical strains that FCs experience in performing daily living activities during the recovery journey. For example,

assistance with bathing does not encompass bathing a person who is resisting a bath. Helping with medications does not adequately capture the hassles of medication administration, especially when the MHSUs are receiving multiple medications several times a day. Keeping their living spaces clean does not capture the number of times FCs have to clean within a day. Providing care could threaten caregivers' overall health, compromising their ability to remain caregivers. Much of the literature on social support shows that caregivers devote much time and energy to caring for their loved ones while seldom caring about themselves. Liu, Heffernan, and Tan (2020) contend that due to insufficient rest, caregivers frequently overlook their own wellbeing, even in times of illness, and seldom pursue medical assistance.

3.7. Summary

This Chapter has examined the literature on family support towards mental illness recovery from African perspectives, with particular attention to evidence from Ghana that situates the study's objectives. The review also highlights gaps between Western and African accounts of recovery, noting that recovery rates in the West are not consistently better than those reported in LMICs, with some evidence indicating more favourable outcomes in the latter (Hopper and Wanderling, 2000; Cohen *et al.*, 2008; Jablensky and Sartorius, 2008; Patel, 2014). This challenges assumptions of Western superiority and underscores that recovery in African societies, including Ghana, is often sustained through social, cultural, and family resources (Ae-Ngibise *et al.*, 2010; Read, 2012; Ae-Ngibise *et al.*, 2015; Osei and Roberts, 2014). Several key issues arising from these differences have been explored, which this study seeks to further corroborate and contrast through participants' perspectives. The next chapter reviews a series of theories to help shape an understanding of the complexities of MHSUs' recovery journeys within the Ghanaian social recovery framework.

CHAPTER FOUR

THEORETICAL FRAMEWORK

4.0. Introduction

This Chapter sets out the study's theoretical framing for understanding family support for recovery in a Ghanaian context. It consolidates the most relevant theories explaining how family ties and support facilitate the recovery journey of MHSUs. It draws insights from systemic-based theories of relationships, resilience, and sustainability, including Urie Bronfenbrenner's (1979) Ecological Systems Theory/Model to include Leamy *et al.*'s (2011) Recovery Model, Murray Bowen's (1976) Family Systems Theory, Jerry Tew's (2013) Recovery Capitals and Robert Weiss's (1974) Social Provisions Theory, in exploring the contextual issues in recovery from mental illnesses through the experiences of MHSUs and their FCs.

These theories were selected to identify the specific significance of family relationships and roles in hindering and promoting recovery. The process of reforming intimate, familial connections may indicate progress or recovery for some individuals. However, it is crucial to recognise that the journey towards recovery is unique to each person and necessitates a nuanced understanding of family interactions that hold significance and meaning in the recovery journey.

Such conceptualisation of the recovery journey requires triangulating these systemic-based theories that emphasise resilience, control over problems and symptom resolution, as well as the quality of family relationships and the role of family members as caregivers in MHSUs' recovery journey. In doing so, the study adopts a theoretical synthesising and abductive approach (Burau and Andersen, 2014; Hopper and Hoque, 2006; Saunders, Lewis, and Thornhill, 2019) to examine interpersonal relationships and their influence (positive/negative) through the experiences of MHSUs and their FCs during the recovery journey. Silverman (2013) indicates that abductively triangulating theories to study the same phenomenon is applicable when a single theory fails to capture the

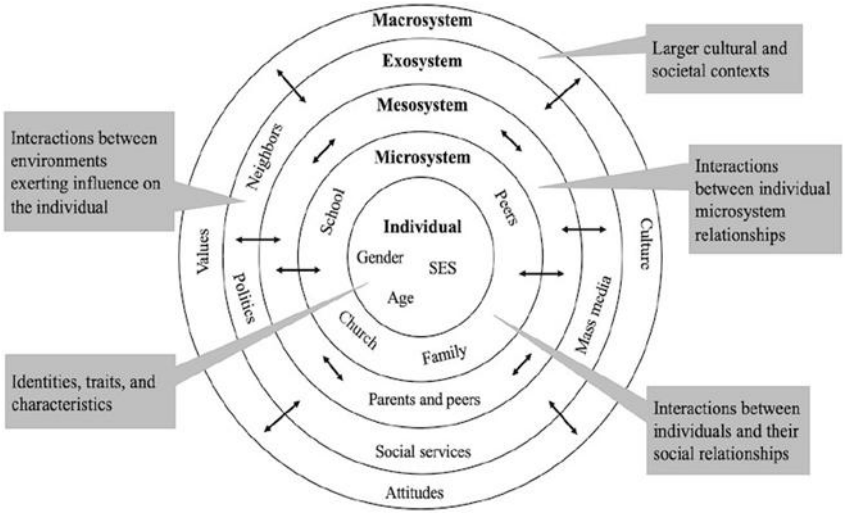
multifaceted dimensions of the research questions; thus, synthesising multiple theories can enhance the empirical insights of the research (Hoque, Covaleski and Gooneratne, 2013). Therefore, the triangulation of various concepts from the identified theories provides a holistic approach to explaining the experiences and contributions of FCs and MHSUs in the recovery journey.

The Chapter is divided into six sections. Sections 4.1 and 4.2 explore the proposition of ecological systems theory linked with family systems theory, focusing on resilience and sustainability. It analyses the systemic context of MHSUs' experiences and their FCs to characterise recovery-enabling relationships and supports that can exacerbate mental illness symptoms. Section 4.3 examines resources for recovery by exploring forms of capital for recovery and social provisions theory. Section 4.4 explores the concept of recovery, examining the social and medical approaches/models for recovery, and then attempts to construct a social recovery framework that provides a multi-layered explanation of the research phenomenon in the Ghanaian context. Section 4.5 discusses the implications of theoretical triangulation and the study's theoretical framing, with a conceptual design that encompasses various practical concepts from these theories to explain the study. The Chapter concludes in section 4.6 with a summary.

4.1. Ecological Systems Theory

The various facets of human development can be better understood through the lens of Urie Bronfenbrenner's (1979) Ecological Systems Theory. This concept focuses on the intricate interplay of processes and relationships within systems that influence human development and behaviour. From Bronfenbrenner's perspective, understanding human development necessitates comprehending the entire system. He depicted the environmental systems as layered like "Russian nesting dolls": microsystem, mesosystem, exosystem, chronosystem, and macrosystem (*see* Figure 2). This complex model emphasises the impact of an individual's surroundings, traits, and circumstances on their progress in life.

Figure 2: Ecological Model



Source: Bronfenbrenner (1979) The Ecology of Human Development.

The model has evolved from its original ecological focus to a more comprehensive bioecological model, incorporating the dynamic interactions among biological, psychological, and environmental components (Bronfenbrenner, 1994). The principles it embodies have influenced various perspectives in applied and social sciences as well as education (*e.g.*, Bookchin, 2007; Dahlberg and Krug, 2002; Lehmann and Coady, 2007), particularly in developmental psychology, social care, and mental health. Consequently, scholars and professionals have been inspired to consider how cultural and societal factors shape personal development and behaviour (Mainoo, 2017; Halsall, Manion and Henderson, 2020; Keyes, 2013; Mutumba and Harper, 2015; Reupert, 2017).

Drawing on the perspectives of Bronfenbrenner's ecological model, the study's theoretical framework aimed to identify crucial mechanisms that explain the reciprocal interaction between MHSUs, their families, and their environment during the recovery journey from mental illness. This framework is not intended to prescribe specific interventions to MHSUs and their FCs. However, it offers a holistic view of their living situations within the context of Ghana.

4.1.1. Tenets of the Ecological Systems Theory/Model

4.1.1.1. The Microsystem: Immediate Environment and Interactions

As shown in Figure 2, MHSU is at the model's core, embedded in the personal, physical and social networks of relationships with FCs, which are an integral part of their immediate living space and web of interactions that make up the microsystem. Thus, the microsystem represents the immediate environment surrounding MHSUs, encompassing their daily interactions with immediate and wider family members. This level of the ecological model is essential in shaping MHSUs' development, as it accounts for direct experiences and relationships that influence behaviour, beliefs, and values in the recovery journey. Family dynamics, including family structure, play a vital role in this context. At the microsystem level, personal characteristics such as temperament, cognitive abilities, physical attributes, place, and power can significantly impact MHSU's recovery journey.

In many African societies, including Ghana, the microsystem encompasses both nuclear and extended family relations, characterised by unique patrilineal and matrilineal lineages (Dsane, 2009; Nukunya, 2016). The responsibility of caregiving is often situated within these kinships and lineages, based on the ideals of reciprocity and communality (Read and Nyame, 2019). Achieving personal success requires building social capital, mutual support, and assistance, which are the building blocks of solid social bonds (Van der Geest, 2002). Family-care processes in Ghana are backed by a moral judgement of kinship solidarity, intimacy, and support (Van der Geest, 2016). Therefore, receiving caregiving from non-kin or strangers is frequently viewed with suspicion as an immoral family failing and a bizarre Western custom (Van der Geest, Dapaah, and Kwansa, 2019; *see* Chapter Three).

4.1.1.2. The Mesosystem: Connecting the Different Microsystems

The interrelationships and linkages among the several microsystems that comprise an individual's life constitute the mesosystem. It includes the relationships between family members, peers, and other social groups. This level of Bronfenbrenner's ecological model highlights the

importance of understanding how different microsystems work together to influence an individual's development. Awenva *et al*.'s (2010) study on barriers to mental health care in Ghana revealed that MHSUs' and FCs' limited access to formal social support in the community may result from their absence of informal social support, which occurs in the mesosystem. Hence, the level of support and quality of interpersonal relationships between MHSUs and wider family members can positively or negatively impact their recovery journey (Harandi, Taghinasab, Nayeri, 2017). Likewise, the interactions between MHSU's immediate family, peer groups, and community may influence the development of social skills and values. Recognising these intricate linkages helps uncover contextual elements that influence an individual's mental health development.

4.1.1.3. The Exosystem: Indirect Influences on Individual Development

The exosystem comprises the broader social and environmental contexts that indirectly impact MHSUs' recovery journey. This level of the ecological model includes factors such as community resources, government health and economic policies, as well as mental health and social care policies and the availability of mental health services. Although MHSUs may not have direct contact with some of these elements, they can still significantly influence their recovery journey or development. For example, Yendork (2020) argues that MHSUs and FCs living in neighbourhoods (rural/urban areas) with limited access to quality healthcare may face developmental challenges due to these environmental factors.

In addition, MHSU's workplace environment and job security can indirectly affect their wellbeing (Darko-Gyeke and Asumang, 2013; Read, Sakyi and Abbey, 2020). Therefore, environmental factors such as socioeconomic status, family resources, government socioeconomic health policies, and neighbourhood quality can shape MHSUs' and FCs' experiences within this system (Roberts, Mogan and Asare, 2014).

4.1.1.4. The Macrosystem: Cultural and Societal Forces at Play

An individual's physical, psychological, and emotional health and development are influenced by a wide range of cultural, social, and ideological factors, collectively known as the macrosystem. The macrosystem encompasses the influence of traditional beliefs, norms, practices, values, customs, and social standards on all aspects of human development.

Cultural contexts can shape society's perception of mental illness and foster stigmatisation and social exclusion attitudes towards MHSUs and their families (Adeponle, Whitley and Kirmayer, 2012; Frost, 2011). For example, in Ghana, it is a cultural practice or norm to investigate the health status of an individual and their family before marriage. More often than not, families with chronic illnesses and mental health problems are deemed unworthy of marital association (Nukunya, 2016; Baffoe, 2013).

Marital association within the Ghanaian context is not just an agreement between two individuals in love with each other; it involves both families and a rigorous examination and judgement of family norms, health conditions, socio-demographic status, including age, income, religion, current/previous marital status, genetic status (blood group and genotype/sickle cell) and extends to judgement of women's (in both family) ability to give birth to healthy children of sound minds (Nukunya, 2016). Families engage in this scrutiny to ensure the continuity of their lineage and protect their image within the community (Dadson, Annor, and Yendork, 2018; Read, 2013; Moro *et al*., 2022).

It is not surprising, given the empirical Ghanaian literature, how MHSUs and family members perceive and interpret their experiences, ultimately influencing their attitudes, relationships, and developmental outcomes. For example, research has revealed that many MHSUs and their families attribute mental illness to spiritual causes, which influences their health-seeking behaviours and

stigmatisation (Edwards, 2014; Mensah, Inuwa and Otu, 2021; Dadson, Annor and Yendork, 2018; Mensah, 2021; Kyei *et al*., 2014).

4.1.1.5. The Chronosystem

Bronfenbrenner's ecological concept culminates in the chronosystem, emphasising time's influence on an individual's development. This dimension recognises how significant life changes, individual experiences, and historical events affect the processes of growth and development. As people go through various life phases, they may encounter various challenges, including economic and health problems and opportunities that shape their development. For example, MHSUs experiencing divorce or loss of jobs may undergo significant relational and economic changes, which can impact their recovery journey in various ways.

The chronosystem also recognises that societal and cultural changes over time can influence an individual's development. Harden, Gyimah and Osei (2023) indicate that a shift in MHSUs' attitudes and societal perceptions of mental illness, together with the introduction of health and social care services and advancement in health technology in Ghana, has the potential to influence the life experiences and prospects of people across generations. Sadly, this is not the current state of attitudes towards MHSUs as rights holders in Ghana. It is often thought that family members and health practitioners are in the best position to make treatment decisions. Over the years, people with lived experience of mental illnesses are stigmatised, discriminated and socially excluded, which does not comply with human rights standards (Barke, Nyarko and Klecha, 2011; Gyamfi, Hegadoren and Park, 2018).

Having provided a descriptive explanation of Bronfenbrenner's ecological systems model in relation to the Ghanaian context, the subsequent sections delve into the general implications of this

perspective in family caregiving linked to family system theory, resilience, challenges and the family's capacity to support itself as a microsystem.

4.1.2. Ecological Systems Theory Implications on Family Caregiving

The ecosystems model provides a helpful framework for understanding how family support influences mental health recovery in Ghana. Given the country's extended family structures, cultural beliefs, and limited mental health resources, families play a central role in shaping the recovery journey. This model helps explain the different levels at which family support interacts with other societal structures to impact mental health outcomes. Family members have the most immediate and direct influence on an individual's mental health recovery. Families in Ghana are predominantly extended rather than nuclear (as observed in most Western countries), meaning individuals often receive support from a wider network of relatives, including grandparents, aunts, uncles, and cousins, who provide emotional, financial, and sometimes spiritual support ensuring that individuals with mental illness are not left to struggle alone. This can provide a strong communal safety net for its members experiencing mental health challenges. However, decision-making is often collective, which can sometimes limit personal autonomy in seeking mental health treatment. Stigma is prevalent, and family members may hide mental illness or prioritise traditional healing over formal medical intervention.

The Ghanaian context of a household (microsystem) is situated within an extended family (part of a mesosystem), with potentially quite different rules, behaviours, and interactions applying within micro and mesosystems. The mesosystem would also include other microsystems (*e.g.*, healthcare) in which the individuals with mental health difficulties participated, but other members of their households were largely excluded. Thus, family caregiving in Ghana is inherently embedded within broader frameworks of health, economic and social care institutions, and local infrastructures, which shape the delivery and support of care (Read, 2023; Gyeke and Asumang, 2013). With the

advent of global health, sovereign countries are drawn together by multinational networks influencing health policy and services at an ever-increasing rate. For instance, WHO (2021b) and other researchers (such as Bhana *et al*., 2010; Benotsch *et al*., 2004; Seckinelgin, 2005; Owusu *et al*., 2021) advocate support of community-based treatment and task shifting for people with disability, including MHSUs and donor funding sources that drive interventions by Non-Governmental Organisations (NGOs), such as in the HIV/AIDS epidemic and COVID-19 pandemic.

These contemporary healthcare strategies have shifted substantial responsibility for treatment and managing chronic conditions to family members, who are often tasked with administering care under the supervision of medical personnel stationed at clinics or conducting home visits (Read and Van der Geest, 2019). The incorporation of medical routines into everyday domestic life reflects how global health policies now permeate family life, challenging conventional boundaries between personal spaces, institutional and global mandates. What some scholars have termed "chronic homework" (Read, 2014; Mattingly *et al.*, 2011; Feierman *et al.*, 2010) reflects the ongoing demands placed on families to provide sustained care, frequently testing their capacity to meet ethical obligations informed by spiritual, communal and Western biomedical standards. Thus, ideas surrounding mental health, disability, ageing and kinship caregiving are increasingly shaped by global currents. These include transnational migration, exposure to global and social media, international disability advocacy, religious networks, and the outreach efforts of NGOs (Badu *et al.*, 2018; Mondal, 2016a).

Although family caregiving is commonly portrayed as an expression of traditional kinship responsibilities, it is actually situated within a broader nexus of cultural values, evolving public health policy, and worldwide economic transformations (Das and Addlakha, 2001; MacGregor, 2018; Badu *et al.*, 2022). Anthropologists have conceptualised this complexity through the notion of *family assemblage*, which accounts for how family life and caregiving are configured not only by

relationships within the home but also by policies, physical environments, and socio-material resources (Price-Robertson *et al.*, 2017). This framework highlights the adaptive and constructed nature of caregiving, arguing that family-based care emerges from fluctuating conditions, rather than unfolding within rigid, unchanging domestic norms.

Consequently, family caregiving should be viewed as deeply intertwined with wider infrastructural systems. These extend far beyond formal medical facilities to encompass access to basic necessities, including housing, transportation, and sanitation. FCs' ability to manage their MHSUs' mental distress or long-term conditions is not solely determined by emotional ties or cultural beliefs, but also by the availability of tangible supports and the institutional mechanisms that enable or constrain their agencies and resilience.

4.2. Systems Theory- Family as a Microsystem (*Resilience and Sustainability*)

Murray Bowen's (1976) family systems theory provides insightful tenets and constructs that effectively explain the role of the family in MHSUs' recovery journeys. Bowen's family systems theory originated from Ludwig von Bertalanffy's (1968) general systems theory (Rogers, 2010; Margasiński, 2015). The basic tenet of systems theory is that the parts of the system functioning as a whole produce more significant results than the sum of each part functioning independently.

Families influence the cognitive processes, affective experiences, and behavioural patterns of their members, resulting in a perceptible sense of shared social and emotional experiences (Goldenberg and Goldenberg, 2013). Members look for and respond to the wants, expectations, and upsets of others. As a result of these connections and reactions, family members' actions depend on each other. When one person's functioning changes, others' functioning will probably change in response. There is always some degree of interdependence within families, albeit the exact amount varies from family to family, but it remains constant. These reciprocal interactions and

interdependence probably developed as a means for families to stick and work together to provide for their members' basic needs (feeding, housing, emotional support, and protection). However, the same processes that foster unity and cooperation can become even more intense under more stressful conditions (chronic physical and mental illnesses), which in turn might cause issues (Bowen, 1976; Mainoo, 2018).

In the recovery journey from stressful conditions (chronic physical and mental illnesses), interdependency and interconnectedness among family members are valued more than individualism (Tew, 2013). As such, the family treats the illness affecting one member as one that affects all. In this regard, the person with mental health problems is primarily supported by the family to ensure recovery. When family member(s) develop mental illness(es), it disrupts the normal order of the family (West and Honey, 2015). The stability of the family may be in question, resulting in increased entropy. Entropy refers to the family becoming disorganised, and disruption may show up (Mainoo, 2018). However, to overcome the possible destruction, family members plan to seek treatment for MHSUs so that they can function and regain their functioning, benefiting the whole family. Homeostasis, which refers to the natural tendency of the family to work towards achieving equilibrium (Rogers, 2010), influences the active members to provide various forms of support to restore power to the person with a mental illness.

The family, as a system, desires that all members function and fit well in its structure to ensure balance (Yoshimura and Galvin, 2017). Achieving this aim requires a constant flow of support from "stronger" family members to the "weaker" ones (Margasiński, 2015). In this context, the person with mental illness (within the family) is considered a weaker member who needs to be supported to achieve equilibrium. As mentioned earlier, the family, as a system, assigns socially acceptable roles to its members, allowing the family to become functionally stable by each member interactively performing their role. However, when a member develops a mental illness, he or she is rendered

incapable of efficiently performing his or her roles. Other members may assume some roles on the MHSU's behalf, but greater functioning of the family is achieved when the individual recovers and assumes those subjective roles. Members taking on caregiving responsibilities go out of their way to make others feel more comfortable. This reciprocal interaction stirs up interest in other members to actively work toward obtaining wellness for the mentally ill persons within the family (Das and Addlakha, 2001; Manderson and Block, 2016; Pinto, 2009).

Nonetheless, due to the chronic nature of mental illnesses, family members providing care may become overwhelmed at some point. This anxiety can grow when it spreads from one family member to another. The emotional closeness of family members is more of a burden than a source of comfort as anxiety levels rise (Bowen, 1976). When one or more family members take on the role of caretaker for a loved one, it's not uncommon for them to experience feelings of helplessness, isolation, and loneliness (Dadson, Annor and Yendork, 2018; Marinho *et al*., 2022; Cohen and Mickay, 1984; Gitlin and Hodgson, 2018). Examples include blaming oneself excessively for other people's problems because they have unreasonable expectations of oneself, or letting other people nervously dictate one's thoughts and decisions to the detriment of one's own autonomy. The most accommodating family member is also the most likely to suffer from physical and emotional exhaustion since they "absorb" the stress felt by the system. This calls attention to the value of ethnography in uncovering the intimacies and intricacies of family life as enacted within specific relationships and interpersonal interactions. Chronic disability and sickness and the need for care can challenge kinship relations and expectations of gender and generational roles, as well as conceptions of social responsibility and ethical behaviour (Read and Van der Geest, 2019; Livingston, 2005; MacGregor, 2018; Rapp and Ginsburg, 2011; Gitlin and Hodgson, 2016). Such challenges may lead to adaptation, improvisation, and invention in the provision of care and the kinship imaginary, igniting family conflict (Das and Addlakha, 2001; Mattingly, Gron, and Meinert, 2011).

The section above outlined two significant theories that explore the family as a recovery hub in African and Ghanaian contexts. It is now important to discuss resources for recovery in these contexts by exploring theories on recovery capital, social provisions, support and the recovery model to characterise family interpersonal relationships and MHSUs' place in the ecosystem.

4.3. Resources for Recovery in the Ghanaian Context.

Numerous ethnographic examples of caregiving in the Ghanaian contexts highlighted the importance of family and the family home (*e.g.*, Read, 2013; Van der Geest, Dapaah and Kwansa, 2019; Read and Van der Geest, 2019; Martyns-Yellowe, 1992; Ohaeri, 1998; Quinn, 2007; Ukpong, 2006). When MHSUs think about the ideal place to receive the kind of personal attention, group support, and space needed for healing, they often picture their own homes and families. Families playing an active role in their loved ones' treatment is in line with deinstitutionalisation efforts in mental healthcare, which aim to bring treatment to those living with mental illness closer to home (Chan, 2011; Liu, Lambert, and Lambert, 2007; Von Kardorff *et al*., 2016; Dadson, Annor and Yendork, 2018). For this reason, FCs are essential to the wellbeing and progress of those who have mental illness.

The review of Ghanaian literature shows that FCs provide various forms of instrumental support (emotional, physical and financial) to MHSUs in different treatment settings (hospital, homes, and traditional healing centres) (Anokye, 2018; Nartey *et al*., 2019; *see* Chapter Three). A key objective of this study is to investigate the recovery processes through which interpersonal interactions within families in Ghana contribute to mental health. This concept analysis thus focuses on the relationship between the influences of FCs' support, both its availability and adequacy, on the recovery path of MHSUs. Tew's (2013) social recovery capitals framework and Weiss's (1974) social provisions theory provide a lens for examining these connections in relation to Bronfenbrenner's (1979) ecological model and Murray Bowen's (1976) family systems theory.

4.3.1. Forms of Capitals for Social Recovery

Within the family's context, MHSUs are grounded in each individual's social, emotional, and cognitive resources, which focus on managing stress during the recovery journey. Families' support provisions include sharing and caring behaviours and practices that help MHSUs navigate stressful life experiences (Sackey, 2009; Van der Geest, Dapaah, and Kwansa, 2019). These activities have been conceptualised by Tew (2013) as *recovery capitals,* enabling sustainability in the process towards social recovery. It encompasses personal, identity, social, economic, and relationship capitals. These capitals have been discussed in the follow-up sections.

4.3.1.1. Personal Capital

This term refers to MHSU's internal resources, including emotional resilience, coping skills, self-esteem, and confidence, which are influenced by their experiences of support or marginalisation within their social contexts (Tew, 2013). Thus, personal capital is crucial for navigating the recovery journey and maximising external resources. It encompasses the knowledge, skills, and education needed for MHSUs to manoeuvre through systems and institutions. Essential elements encompass individual capability, awareness of emotions, and an attitude of constructive thinking or acquired optimism (Mancini, 2007; Tomer, 2003; Seligman, 1991). Uphoff (1999) posits that having a diverse set of active coping and problem-solving techniques empowers MHSUs to tackle challenges and recover from setbacks or disappointments. Mainoo (2018) characterises personal capital as cognitive social capital, which involves understanding social norms and adopting pro-social behaviours. This understanding enables MHSUs to access mental health services, comprehend their rights and benefits, and effectively advocate for themselves.

Read (2019) reports that MHSUs frequently lack essential aspects of personal capital, rendering them susceptible and unprepared to cope with life pressures that could have contributed to

their mental health problems. This circumstance can disrupt how MHSUs think and feel, hindering their ability to access the personal capital they previously depended on. Any recovery to take root must be based on the revival of a coherent self that can navigate its own path and restore meaningful connections with its social surroundings (Tew, 2013). Without personal capital, MHSUs may struggle to engage socially. Conversely, it is often through positive social interactions and affirmations that MHSUs can rebuild their personal capital reserves.

In Ghana, personal capital development is intricately linked to cultural, spiritual, and community values. Mental health issues are commonly seen as resulting from spiritual factors like witchcraft, curses, or divine wrath (Ae-Ngibise *et al*., 2010; Read and Adiibokah, 2021). Consequently, recovery often occurs beyond the biomedical framework, typically within faith-based or traditional healing practices. Spirituality is central to Ghanaian life and a vital source of personal capital. Faith in God or traditional deities provides hope, meaning, and emotional support (Sorsdahl *et al*., 2010). Religious communities often foster a sense of belonging and purpose, reinforcing a positive identity and motivating MHSUs to persevere in the face of adversity. However, this reliance on spiritual frameworks can also expose MHSUs to harmful practices, such as chaining or enforced fasting in prayer camps, which may erode autonomy and self-dignity (Ofori-Atta, Read and Lund, 2010). MHSUs frequently employ culturally embedded coping mechanisms such as storytelling, music, or community rituals. These methods facilitate emotional release, connection, and continuity of identity (Avotri and Walters, 2001).

Family and community structures play significant roles in fostering—or, at times, undermining—personal capital. Extended family networks can offer material and emotional support, but they may also reinforce stigma or limit autonomy, particularly for women or individuals with more severe conditions (Doku, Wusu-Takyi and Awakame, 2012). Hope and future orientation are

crucial markers of personal capital. Despite the prevalence of poverty and a lack of mental health infrastructure, many MHSUs in Ghana maintain aspirations for education, employment, and family life (Omenyo and Weyer, 2014). This future orientation propels MHSUs' agency toward healing, whether through religious devotion, medication, or traditional healing pathways. Agency is also demonstrated in the way MHSUs navigate multiple healing systems. In the absence of coordinated care, individuals often move between hospitals, herbalists, and churches, guided by self-belief, experience, affordability, and trust (Read and Adiibokah, 2021). This demonstrates that personal capital is not merely about internal resilience, but also about strategic engagement with one's social and cultural environment.

Despite these strengths, the development and expression of personal capital are often constrained by structural factors. Ghana faces a serious mental health resource gap, with limited access to psychiatrists, social workers, and medication (WHO, 2022). Stigma remains a significant barrier, both within families and broader society, often leading to isolation, delayed treatment, and internalised shame (Roberts, Mogan and Asare, 2014). Gender inequality further exacerbates the situation. Women with mental health conditions are often excluded from marriage, parenting, and decision-making roles, reducing their sense of agency and value (Avotri and Walters, 2001). Poverty compounds these challenges, limiting access to nutritious food, stable housing, and education—all of which are essential for sustaining personal capital (Doku, Wusu-Takyi and Awakame, 2012).

4.3.1.2. Identity Capital

A sense of self-worth and a coherent personal identity are crucial in sustaining recovery. This includes developing a positive self-concept beyond the label of mental illness, often facilitated by meaningful roles in work, family, or community life. Nonetheless, MHSUs may experience multiple overlapping identity issues that can diminish the efficacy of their identity capital (Stets and Burke,

2000). Elements of self-identity may appear fragmented and unmanageable, becoming progressively estranged from any formerly assumed understanding of their self-identity. For instance, upon diagnosis or manifestation of mental illness, MHSUs may experience role loss or role strain, especially if they can no longer fulfil valued roles.

Drawing from Cooley's (1902) looking-glass self, where self-concept is shaped by how others perceive us, in Ghana, the stigma attached to mental illness (often seen as spiritual or shameful) can profoundly affect how MHSUs see themselves. MHSUs may experience social discrimination due to socially marginalised labels, such as 'mentally disabled', 'crazy', 'loony', and 'nutter' (Read, 2012b; Ae-Ngibise *et al*., 2010; Cruwys *et al*., 2014). This reflected appraisal can lead to internalised stigma, low self-esteem, and withdrawal from society. It may also lead to external tensions, potentially exacerbating mental illness symptoms and diminishing self-esteem (Mainoo, 2017; Yanos, Roe and Lysaker, 2010). For example, a man previously seen as a strong provider may struggle with being labelled "mad" or "possessed," which conflicts with traditional expectations of masculinity. The process of social stigmatisation can assign a devalued identity to individuals, disrupting their existing social, personal, and economic relationships, complicating the establishment of new connections, and undermining self-esteem (Read *et al*., 2006; Jones, 2024). While previously esteemed statuses and attributes may be permanently diminished, experiences with mental health problems can also reveal troubling dynamics related to these aspects (Ridge and Ziebland, 2006; Schön, Denhov and Topor, 2009; Quinn *et al*., 2014). Consequently, the journey of forming new identities can possess certain emancipatory qualities, yet it must be navigated according to the expectations or labels within one's social environment.

Recovery is not static; it is a journey of identity transformation. MHSUs may oscillate between identities (*e.g.*, patient, survivor, citizen) and gradually build a more cohesive, empowered

self-concept. In Ghana, this transformation is often influenced by spiritual narratives, collective identity (*e.g.*, shared cultural values), and resilience in the face of adversity (Read, 2016). This transformation may give "'currency' to wider social participation, social inclusion, and access to specific forms of bonding or bridging social capital" (Tew, 2013, pp. 367). While recovery may be a multifaceted journey, the ability to adopt identities that are acknowledged and esteemed by society is probably mirrored in a deep-seated sense of self-worth. Discovering methods to embody the essence of a competent individual with valuable contributions can be essential for recovery (Ofori-Atta, Read and Lund, 2010). This underscores the importance of validating one's sense of self—seeking affirmation from others regarding one's identity. Encouraging supportive interactions with family, friends, or experts plays a crucial role in affirming positive self-concepts and assisting MHSUs on their journey to reintegrate and restore their sense of dignity. For instance, when an employer within a community views a recovering individual as competent and accountable, it strengthens their self-concept as a professional rather than labelling them as "a mad person."

4.3.1.3. Social Capital

Social networks, relationships, and community support play a critical role in recovery. This form of capital, according to Malmberg-Heimonen (2010), includes both bonding capital (strong ties with close family and friends) and bridging capital (weaker ties that connect individuals to wider social opportunities, such as peer support groups or employment networks). These features of social life can enable MHSUs to pursue shared objectives and develop mutual acquaintances and recognition (Puttnam, 2007; Weiss, 1974). Substantial social capital helps reduce isolation and enhances a sense of belonging (Van der Geest, 2002; 2016; Agyei *et al*., 2024a). Bourdieu (1986) contends that social capital (as with economic capital) may be seen as a resource to which certain people may be privileged to have access, but others may be excluded.

Other studies have identified barriers to mental health service utilisation in Ghana. For instance, research in the Bolgatanga Municipality (in Ghana) highlighted factors such as stigma and mental health illiteracy as significant obstacles preventing individuals from seeking mental health care (Daliri *et al*., 2024). Nukunya (2016) argues that within traditional settings or family spaces in Ghana, individuals in the realm of affairs may deploy certain negative conversation strategies to make MHSUs excluded and feel it is their fault. These barriers not only impede access to necessary services but also contribute to the persistence of psychological distress and its associated socioeconomic consequences. Social stigma and discriminatory attitudes against individuals with mental health conditions have been documented as pervasive issues in Ghana (Mfoafo-M'Carthy and Grischow, 2021). Such societal attitudes can exacerbate the challenges faced by MHSUs, including difficulties in maintaining their presence in social networks or taking on a false persona in order to fit in (Poortinga, 2006).

Research findings show that addressing these stigmas is crucial for improving both mental health outcomes and networking opportunities for MHSUs (Dadson, Annor and Yendork, 2018; Ibrahim *et al*. 2016; Kpobi and Swartz 2019; Opare-Henaku and Utsey 2017; Read, 2012a; Read, Adiibokah, and Nyame 2009; Read and Nyame 2019; Roberts, Mogan, and Asare, 2014; Smalls-Mantey, 2019; Van Der Geest, 1998). It is imperative that MHSUs' social context is non-stigmatising and offers acceptance, providing opportunities for meaningful voluntary and paid occupation, educational participation and recreational activities such as attending festivities (community festivals) and family gatherings (funerals, weddings, naming ceremonies for babies, Christmas celebrations). Creating such contexts may involve specific work to change social attitudes and behaviours within the social mainstream, both at the family and societal levels, to offer a sense of fellowship and belonging, thereby sustaining MHSUs' recovery outcomes (Mezzina *et al*., 2006; Thornicroft, Deb and Henderson, 2016; Seebohm and Gilchrist, 2008).

4.3.1.4. Economic Capital

Economic capital is crucial for recovery outcomes, as financial stability and access to material resources play significant roles in determining outcomes. It enables individuals to secure safe housing, access services, and maintain a basic quality of life, enhancing overall wellbeing. Research shows that when MHSUs are supported to re-enter mainstream employment and reap rewards and opportunities, it positively affects their social functioning and mental health symptoms (Burns *et al*., 2009; Daliri *et al*., 2024). The value of economic capital extends beyond monetary aspects; it also influences social interactions and work-based engagements by allowing individuals to adopt socially valued productive identities (Borg and Kristiansen, 2008). MHSUs feel more in control of their lifestyles, empowered to make their own choices about how to use funding for various services and basic needs. This empowerment allows them to participate more effectively in mainstream social activities instead of burdening family members (Onken *et al*., 2002; Roberts *et al*., 2013).

Nonetheless, it is widely reported that MHSUs face ongoing discrimination concerning employability, leading to a shift in their positioning regarding social relations of production and consumption (Doku and Minnis, 2016; Asare-Doku, Osafo and Akotia, 2023). Financial strain from long-term unemployment can undermine recovery prospects; additionally, many MHSUs and their families may be driven into poverty (Mattsson *et al*., 2008; Osei, Roberts and Crabb, 2011; Akpalu *et al*., 2010). A significant study examining the relationship between psychological distress and unemployment in Ghana utilised data from the Ghana Socioeconomic Panel Survey, encompassing 5,391 adults (Canavan *et al*., 2013). The findings revealed that approximately 21% of adults experienced moderate or severe psychological distress. Notably, individuals with moderate psychological distress had more than twice the odds of being unemployed compared to those with mild or no distress. The association was even more pronounced among men with severe psychological distress, who had over 12 times the odds of being unemployed compared to their counterparts with

mild or no distress. This study underscores the significant impact of psychological distress on employment status in Ghana, highlighting the need for targeted mental health interventions to address unemployment among MHSUs.

Applying Tew's (2013) concept of economic capital to the Ghanaian context underscores how poverty, unemployment, and systemic underinvestment create a cycle of exclusion for MHSUs. Economic disadvantage is both a cause and a consequence of mental distress, shaped not only by individual circumstances but by the structural and cultural conditions in which people live. Addressing mental health in Ghana, therefore, requires not only clinical interventions but broader social and economic reforms that enhance the financial capital of those affected.

4. 3.1.5. Relationship Capital

Research into recovery highlights the critical role of relationships with significant others (Mead and MacNeil, 2006; Tew, 2013). It involves mutual support, shared spaces, recognition, acceptance from family, peers and neighbours, religious institutions/faith-based communities, health professionals and services to facilitate their recovery (Read and Adiibokah, 2021; Roberts *et al*., 2018; Ae-Ngibise *et al*., 2010; also *see* Chapter 2.2-2.3). Thus, the way in which MHSUs recover is influenced by the people around them (Topor *et al*., 2009). Even at its most basic level, social interactions reveal the communal character of recovery. It is one way to examine the social aspect of MHSUs' recovery through the interpersonal relationships they have with others in their social environment. In many African societies, relationship capital is shaped by collectivist values, religious belonging, family dynamics, and emerging peer support structures. While robust social connections can significantly support the recovery process, these very ties can also reinforce stigma, exert control, and contribute to marginalisation, frequently mirroring the stress or diminished self-worth of others (Hooley, 2007; Kuipers *et al*., 2006). Thornicroft *et al*. (2016) emphasise fostering capacity

development within these connections by improving communication skills (open dialogue), which allows the quality of relationships to facilitate better and sustained recovery.

Caring for and supporting one another is primarily the responsibility of members' immediate families in many African societies (Foster and Isobel, 2018; Onken *et al*., 2002; Anokye, 2018; Roberts *et al*., 2008; Daliri *et al*., 2024). Family members have a solid grasp of each other's backstories, experience the highs and lows of family life together, create an incredibly strong social support network, consequently engaging in the shared meanings of recovery with MHSUs (Tooth *et al*., 2003; Denhov, 2003; Ofori-Atta, Read and Lund, 2010). However, these relationships can be ambivalent—family members may provide care but also stigmatise, isolate, or subject MHSUs to traditional or religious interpretations (*e.g.*, demon possession) and harmful interventions (*e.g.*, deliverance/exorcism) that are disempowering (Doku, Wusu-Takyi and Awakame, 2012).

Central to this study is the influence of *recovery capitals* on MHSUs' recovery journey within the family space, which is akin to Urie Bronfenbrenner's (1979) microsystem and Murray Bowen's (1976) theorisation of family system —the hub for recovery for many MHSUs in African communities, including Ghana. In the Ghanaian context, MHSUs and FCs have their own perspectives on what it means to be recovered. Desire for symptom-freeness, improved symptom coping, working towards symptoms severity reduction, or successfully managing mental illness to live a meaningful life are some of the meanings of recovery found in the Ghanaian literature (Dadson, Annor and Yendork, 2018; Ibrahim *et al*., 2016; Kpobi and Swartz, 2019; Opare-Henaku and Utsey, 2017; Read, 2012b; 2019b; Read, Adiibokah, and Nyame, 2009; Read and Nyame, 2019; Roberts, Mogan, and Asare, 2014; Smalls-Mantey, 2019; Van Der Geest, 1998). These studies demonstrate that recovery from any form of illness in Ghana occurs within the context of Ghanaian households, with support provided by family, health services, and traditional healers, primarily aimed at achieving a cure.

However, Read (2013) argues against treating or managing symptoms alone, instead focusing on building the resilience of MHSUs and supporting FCs throughout the recovery process. Recovery can be short-term or long-term; hence, it is an ongoing process. It's normal to encounter difficulties or setbacks along the way, but these can be opportunities for MHSUs to learn or practice the skills they have developed during recovery. In the Ghanaian context, families play a critical role in helping MHSUs relearn social and engagement skills (Anokye, 2018)**.** Therefore, the resocialisation of services through the provisions of social and emotional support lies within the quality of the intimate relationships between MHSUs and their families, whether wide or close family members as caregivers. It is a well-established fact that human beings cannot live in isolation from each other, and the recovery journey is not an individualistic process (Rose, 2014).

Views of family caregiving as an activity in and of itself have cast doubt on the traditional Africanist study of social structures and processes (Read and Nyame, 2019; Doku and Minnis, 2016). These viewpoints show how family life is intrinsically unstable and contradict the overdetermined idea of the family as the location of care. The importance of doing things together in the context of family ties is highlighted by Bourdieu's (1990) focus on "practical kinship". Carsten (2000, pp.16) argues that relatedness, which he defines as a "constant process of getting linked to individuals", is just as susceptible to disjuncture and detachment. Caring for others, as seen in the work of Van der Geest, Dapaah, and Kwansa (2019), is not only a natural part of family life but also a way for people to connect with and show compassion to individuals who are not biologically related to them.

While family members may be expected to take care of loved ones with mental illness, this can lead to feelings of resentment or uncertainty (Manderson and Block, 2016). As a result, individuals engage in "a maintenance work of kinship to ensure a safety net of support in times of incapacity," as Hayley MacGregor puts it in her study (2018, pp. 2). In this manner, ideas of worth and morality are continually running through care, dictating who deserves what, who is to blame, and

what is at risk. However, care needs may understandably cause family friction and strife (Sackey, 2009; *see* Chapter Three).

The different types of *recovery capital* discussed earlier offer a conceptual framework for recognising what might be crucial in helping MHSUs achieve or regain self-efficacy and social competence, facilitating recovery initiation and maintenance. This framework emphasises that these different forms of capital are interconnected and that recovery is most effective when MHSUs can access and strengthen multiple forms of capital as part of a coherent and integrated therapeutic strategy. Therefore, it is crucial to consolidate medical interventions and social structures to enable long-term, sustainable recovery. In this study, Tew's (2013) *recovery capitals* framework offers a lens to evaluate MHSUs' life chances (including their potential for achievement to sustain their wellbeing), transitions and to capture their experiences, especially in challenging contexts where social power relations may have contributed to their predicaments in the first place and where stigmatising and exclusionary social responses to their mental health status may create further barriers to social and economic inclusion (Opoku-Boateng *et al*., 2017; Read, 2013). Topor *et al*. (2009) contend that the availability of these capitals in the recovery journey may be relevant in understanding how MHSUs may or may not be able to navigate their way through an episode of mental distress that may be disruptive to their previously held identities, lifestyles and social relationships.

4.3.2. Weiss's (1974) Social Provision Theory

In a number of settings, including those with and without significant levels of psychosocial distress, Robert Weiss's (1974) social provisions theory helps to examine the connection between social relationships and support in times of distress. In his 1974 work, Weiss outlines six distinct "provisions" (social functions) that can be derived from meaningful social interactions: social integration, attachment (emotional support), reassurance of worth, reliable alliance (material support), guidance, *and opportunity for nurturance.* These provisions can be broadly classified into two main

groups: assistance-related and non-assistance-related. The first group consists of provisions that are directly related to stress-related problem-solving: *reliable alliance* (the assurance that other family members will be there to help in a practical way) and *guidance* (advice/information/direction).

According to Weiss, *guidance* is typically derived from individuals in close connection with MHSUs such as biological and quasi parents (guardian/foster parents), friends, peers, employers, mentors, whereas family members (close or wider family relations) are the most common source of *reliable alliance*s. *Reassurance of worth* (recognition and approval from others around them of their abilities, worth, and competencies) *social integration*, *attachment (emotional support)* compromises the non-assistance-related provisions. In both high- and low-mental distress situations, the non-assistance-related provisions seem to have favourable impacts, but they do not directly help with problem-solving. It is likely that cognitive processes modulate their effects (*e.g.*, motivation, self-efficacy, and empowerment, outcomes for resilience, coping, and beliefs for causal attribution).

Several studies have adopted Weiss's social provisions theory to assess important properties of interpersonal social relationships. For instance, Cutrona and Russell (1987) found that scores on the social provisions were predictive of certain kinds of interpersonal relationships and each social provisions. For example, *attachment* is typically provided by an intimate romantic/dating relationship, whereas friendships typically provide a sense of *social integration*. *Reassurance of worth* is provided by work relationships, whereas *reliable alliances* are usually provided by kin relationships. Relationships with children, spouse, mentors or other people (who may be dependent on the individual) are often the source of *guidance* and *nurturance*. Weiss acknowledges that various people or phases of life may place a greater emphasis on specific provisions; hence, all six provisions are necessary for people to feel adequately supported to promote quality health. Although most provisions come from specific types of relationships, it is possible to get more than one provision from the same individual. Nevertheless, a deficit in particular social provision may result in social

and emotional loneliness—emotional loneliness occurs due to the lack of an intense and relatively enduring relationship with one other person, whereas social loneliness occurs due to the lack of relationships with a group of individuals with whom one can participate in social activities.

Weiss (1974) predicts that emotional loneliness results from deficits in the *attachment* provision, whereas social loneliness results from deficits in the *social integration* provision. His description of individuals' close connections can be linked to Urie Bronfenbrenner's (1979) depiction of interactions between individuals and their social relationships in the ecosystem (*see* Figure 2). It also corroborates Tew's (2013) recovery capitals, indicating that one's perceptions of their own abilities to cope with a certain situation tend to predict how they would actually deal with that situation. Therefore, it stands to reason that MHSUs' ability to manage stressful events in their recovery journey and its adverse effects are positively correlated with the degree to which the input of helpful family members strengthens their self-efficacy. *Social integration* of MHSUs occurs within a social context, characterised by dynamic and reciprocal interactions among the person, nurturing environment, and behaviour (Tew, 2013). In the absence of major stress, individuals with abundant *reassurance of worth* would also be expected to function more effectively because of enhanced self-efficacy and self-esteem. Similarly, one would anticipate that MHSUs with a lot of positive reinforcement will be more productive even when there is not much stress because their self-efficacy and self-esteem are higher throughout the recovery journey.

Weiss's Social Provisions Theory (1974) was selected because it captures a wide variety of family interpersonal functions and active support, some of which are important in recovery from stressful life events, and others that are essential in maintaining life satisfaction in general, regardless of the type of mental distress. Gyamfi *et al*. (2020) define active support as MHSUs receiving and providing care, or "mothering," themselves and others in their social environment. While this theory has primarily been applied in studies on international contexts (*e.g.*, Cicognani *et al*., 2008; González

et al., 2023; Caron and Tempier, 2004; Muñoz-Bermejo *et al*., 2020; Ayala *et al*., 2012; Cabañero-Martínez *et al*., 2006; Santini *et al*., 2015; Cutrona and Russell, 1987;1991; Tanaka, Kawakami and Ohtsu, 2010; Okada *et al*., 2019; Sischka, Albert and Kornadt, 2024; Wang *et al*., 2023; *see* Chapter 5.4.1), its principles are highly relevant in the Ghanaian mental health landscape, where social support is deeply embedded in cultural norms and community life.

In Ghana, traditional and communal support systems often serve as the primary sources of emotional and practical support, especially in the face of limited formal mental health infrastructure. Research in Ghana has demonstrated that family and community ties significantly influence coping mechanisms and resilience among individuals experiencing psychological distress (Osei *et al*., 2015). This aligns with Weiss's concept of *attachment* and *reliable alliance*, suggesting that the presence of trusted and dependable relationships can act as a protective factor against mental illness. Furthermore, the provision of *reassurance of worth* and *social integration* is particularly important in Ghanaian communities, where stigma associated with mental health conditions remains prevalent (Ae-Ngibise *et al*., 2010). Individuals who are integrated into social networks and receive validation of their roles and values within the community are more likely to experience positive mental health outcomes. Faith-based groups, social clubs, and close and extended families often serve as informal support structures that fulfil these provisions, providing emotional reassurance and a sense of belonging.

Though there is limited direct application of Weiss's Social Provisions Scale in Ghana, studies on social support and mental health in sub-Saharan Africa suggest that the theory's components are culturally adaptable and relevant (Khumalo, Ejoke and Oppong, 2021; Gumede and Sibiya, 2018; Sweetland, Belkin and Verdeli, 2014; Myer *et al*., 2008; Aidoo and Harpham, 2001). Studies from Ghana, for instance, Owusu-Ansah *et al*. (2018), highlight the role of social connectedness and communal care in managing depression and anxiety among urban populations in Accra. Akutey, Apaak and Ansah (2024) employ the social provision theory scale to investigate the relationship

between job demands and burnout in Ghana's public senior high school teachers. This indicates the potential for using Weiss's framework to inform culturally sensitive mental health assessments and interventions in Ghana. The key components of Weiss's social provision theory can be compared to some Ghanaian literature on social support for MHSUs (*see* Table 1). This perspective is the first of its kind to be used directly in the design of a social recovery mental health framework befitting the Ghanaian context (*see* Figure 4 in Chapter 4.4.2.6) and the survey data collection instrument in phase 1 of this mixed-methods study (*see* Chapter 5.4.1), adding to the originality of this study.

Table 1: **Comparison of Weiss's Social Provisions Components with some Ghanaian Literature on Social Support**

Weiss (1974) Social Provisions Constructs	Oti-Boadi *et al.* (2024)	Gyamfi *et al.* (2020)	Cohen *et al.* (2012)
Social Integration	Social acceptance & Affective support	Social Inclusion	Network Support (Families & SelfHelp Groups)
Attachment	Emotional & Esteem Support	Emotional Support	Belonging & Self-esteem Support
Reassurance of Worth	Affirmation support	Independent living skills (active support*)	
Reliable Alliance	Material Support (Financial), Loyal Support	Economic empowerment, Trustworthy alliance	Tangible Aid (financial, housing, food, clothing)
Guidance	Instrumental Support (adaptation and resocialisation)	Medication compliance	Information and Appraisal Support

Source: Research's Construct, 2024

4.4. Recovery Model

Mental illness recovery is a multifaceted topic that has been examined from several angles (clinical, personal, and social) by researchers. The subject of much attention in the debate around mental illness recovery is whether healing is concurrent with recovery and whether it is possible to cure mental illness. No reasonable response to this contentious issue can be offered without first doing a comprehensive analysis of the recovery paradigm. This paradigm developed out of the MHSUs' movement of the 1970s, which started in the US but quickly spread to the UK and other nations (Anthony, 1990; Jacobson, 2000; Unzicker, 1989; Harding *et al*., 1987; Houghton, 1982; Deegan, 1988). The aims of the recovery paradigm, as outlined by Leamy *et al.* (2011), include building resilience, validating personal experiences, developing coping mechanisms, and enhancing quality of life to achieve long-term health and productivity for MHSUs.

First-hand narratives from MHSUs reveal that they possess inherent abilities and resilience, which enable them to thrive as more autonomous individuals and become more valuable members of society (Jacob, Munro and Taylor, 2015). According to Onken *et al*. (2007), personal transformation is a key component of recovery. In their description of the essence of recovery, they propose two levels of transformation: the first occurs when MHSUs begin to hope that they can rise above their challenging conditions to improve. The second level of transformation is experienced when MHSUs take steps to act toward the intended state of wellbeing through adherence to a medical treatment plan and suitable practices prescribed to bring about recovery. This may result in a shift from feelings of despair, sorrow, rage, loss, and sadness to a state of hope, optimism, and agency over one's own choices. This shift in emotions is described by Biegel *et al*. (2013) as a key aspect of the recovery process. Several studies have reported that MHSUs may experience a change in their emotions from hopelessness to optimism and a sense of control over their own behaviour as the crux of the recovery journey (Davidson *et al*., 2005; Ramon, Healy and Renouf, 2007; Bonney and Stickley, 2008).

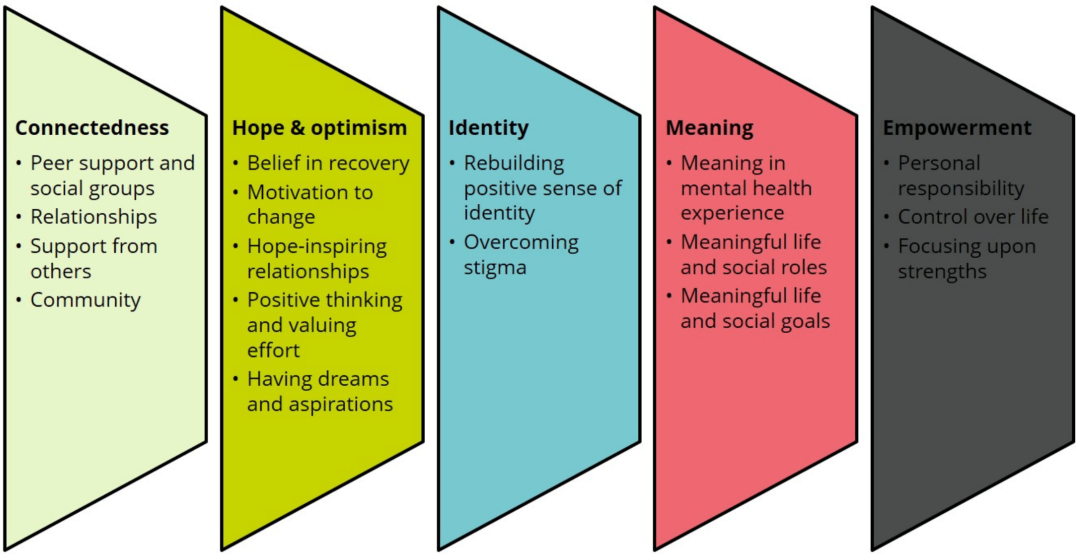
MHSUs' inherent strengths (efficacy and capabilities), resources, and shortcomings are all factors in the recovery process, ultimately leading to improved functioning (Biegel *et al*., 2013; Kramer, 2002; Mancini, 2007; Tew, 2015).

Recovering from mental illness is a non-linear process with unique stages to better functioning (Edwards *et al.*, 1983; Grobbelaar, 2010). Prochaska and DiClemente (1983) outlined five stages that MHSUs go through while recovering: pre-contemplation, where MHSUs are receptive to change but often do not give it much consideration; contemplation, where MHSUs start to desire transformation in their difficulties; preparation, where MHSUs are less committed to making positive changes; action, where MHSUs take decisive and concerted effort to improve their situation; and maintenance, where MHSUs strive to sustain the progress they have achieved to avoid relapse (Grav *et al*., 2012). Instead of following a linear progression to better functioning, the recovery process is more akin to a recycling development within a social systemic framework characterised by periods of both progress and setbacks (Kramer, 2002; Onken *et al*., 2007; Coffeng *et al*., 2014). Therefore, recovery from mental illness is not a matter of will and self-discipline alone. It is the combination of both personal and social processes (in which internal resolutions of distress take place alongside social re-engagement) in ways that may be mutually reinforcing, according to Warner (2004), can lead to a full recovery from mental illness —how this is characterised—in terms of symptom remission, or "clinical recovery," or, more crucially, how MHSUs are able to participate fully and meaningfully in society as "social recovery"—is an important consideration (Tew, 2011; 2013).

There is no endpoint to the journey toward recovery from mental illness; along the way, one may find purpose in their lives, build strong connections, gain confidence, become more integrated into society, learn to cope, and establish a solid foundation for their recovery (Elm *et al*., 2016). There is no sane-insane dichotomy in recovery; rather, symptoms are considered a normal part of life. Therefore, moving past the devastating impacts of mental illness and into meaningful living entails

finding new significance and direction (Anthony, 1993). Despite the limits imposed by the illness, it is possible to live a fulfilling, optimistic, and meaningful life (Tew, 2011). Leamy *et al*. (2011) emphasise that each MHSU's recovery journey is very individualistic, while Repper and Perkins (2006) contend that the recovery journey is interconnected with MHSUs' social and community networks. APA proposed several indicators of transformation in MHSUs' wellbeing as often essential components of recovery (APA, 2012). However, Leamy *et al*. (2011) have classified them under the concept of CHIME (*see* Figure 3), an abbreviation of connectedness, hope and optimism, identity, meaning and purpose and empowerment. This framework defines the personal recovery journey of MHSUs.

Figure 3: The CHIME Framework for Personal Recovery.



Source: Leamy et al. (2011).

Several Western countries, including Australia, UK, and US, have used CHIME and seen positive outcomes (Slade *et al*., 2014; Leamy *et al*., 2011; Brijnath, 2015). Nevertheless, CHIME is constrained in three ways: Firstly, there is a dearth of research that specifically addresses the question

of whether and to what extent MHSUs receiving primary and community care experience recovery-related themes.

Secondly, the mental health problems that are most often focused on are depression, bipolar disorder, and schizophrenia, despite the wide range of mental disorders classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR). DSM-5-TR is a manual by the APA for the standardisation of language and criteria for the classification of mental disorders, and it is widely accepted and used in many Western societies for formulating mental health care policies, directing practices and service provisions (Widiger and Clark, 2000; APA, 2013). Mental health professionals frequently refer to the DSM-5-TR when conducting clinical evaluations (both to identify and convey MHSUs' diagnoses) and are extensively utilised by healthcare researchers when classifying MHSUs (participants/respondents) for study (First *et al*., 2018; Evans *et al*., 2013). Recovery from these disorders has primarily been the focus of research. These conditions often require secondary specialist services, which mental health professionals and researchers have attempted to address (First *et al*., 2014; Bellack, 2006; Mansell, Powell *et al*., 2010; Todd, Jones, and Lobban, 2012).

Lastly, CHIME has been mainly implemented in white populations. People of colour and other black ethnic minority communities have also been underrepresented —much less is known about how it has worked in these communities (Leamy *et al*., 2011; Slade, Adams, O'Hagan, 2012). Additionally, studies on its use in LMICs, such as Ghana, are scarce. Seeking to avoid a skewed view of mental illness recovery, proponents of the CHIME framework are calling for more diverse ethnic groups to participate in future empirical studies on recovery. These studies should focus on how specific cultural factors, such as stigma, religion, and spirituality, influence the process. Researchers should keep in mind that issues of power and race impact recovery and social interactions and relationships across time.

4.4.1. Social *Versus* Medical Approach to Recovery

The term "recovery" is nebulous and difficult to pin down. Depending on each geographical area's cultural, health, and social systems, it may have diverse meanings. Across many Westernised societies, recovery is described as something meaningful that MHSUs experience, health and social services promote, and that government systems facilitate (Jacobson and Greenley, 2001a; Slade *et al*., 2014). However, in many developing societies, including Ghana, the specifics of precisely what is to be experienced, promoted, or facilitated—and how—are often not well understood either by MHSUs, FCs or the mental health professionals and policymakers who are expected to facilitate their recovery (Raitakari *et al*., 2018; Read, 2019; Walker and Osei, 2017; Gyamfi *et al*., 2022).

Ghana's mental health regulations place a heavy burden on FCs, who are often the ones to decide whether members with mental health problems should be admitted to a hospital or given traditional treatment. Ofori-Atta, Read, and Lund's (2010) review of the Ghana Mental Health Act (2012) discovered that there is no protection of MHSUs' rights, which may result in abusive family practices and neglect. Bedi, Amanor, and Amedome (2021) also noted that, with no guidelines regarding the family's role in the recovery journey, uncertainty and problems may arise when the family's role is not specified or controlled. Addressing these gaps is crucial to ensure that the rights of all individuals in MHSUs' recovery journey are safeguarded and respected.

Recovery from mental illness was primarily portrayed in the early writings as a personal journey that happened inside the person receiving treatment with medication and was fought for entirely by that person (Deegan, 1998; Frith and Johnson, 2003; Tomer, 2003; Osei, Asare and Roberts, 2021b). These perspectives emerged from a Western medical model of recovery that prioritised patient symptom management through pharmaceutical means (clinical recovery) (Piat and Lal, 2012; Warner, 2004; Tew, 2013; Yanos *et al*., 2008). According to earlier research, a common thread among the several ways MHSUs describe their recovery is going back to their original state

through medical interventions (Anthony, 1993; Leete, 1989; Sullivan, 1994; Mueser *et al*., 1997; Read, 2012a). Although this can be valuable for alleviating some MHSUs' challenging conditions, the effectiveness of medical interventions in enhancing recovery rates over the long term appears to have been fairly consistent (Tew, 2013; Smalls-Mantey, 2019; Roberts, Mogan and Asare, 2014; Warner, 2004).

Consequently, in recent times, several studies have proposed a different approach that overlooks the individual aspects of recovery to encompass the MHSU's role (as actor(s) in the recovery process), social and cultural contexts in which recovery unfolds (Davidson, 2003; Tew, 2013; Uphoff, 1999; Whitley *et al*., 2009; Adeponle, Whitley and Kirmayer, 2012). From a global perspective, comparing populations suggests that social and cultural aspects are crucial in deciding whether individuals may achieve long-term mental health recovery (Tew, 2013; Bark, 2023). One example is the WHO's (2012a) finding that recovery rates in Europe are half as good as in more traditional societies in Asia and Africa. In these regions, western medicine may not be as prevalent, but the social and cultural attitudes may be more supportive of helping people reintegrate into valued social roles.

The concept of social recovery in mental health is not simply about surviving with a diagnosis, but finding purpose, connection, and fulfilment through it (Hopper *et al.*, 2007). Rather than merely responding to symptoms, this perspective offers a comprehensive outlook that aims to take MHSUs beyond the back-footedness of survival and into the agency of a meaningful life (Slade, 2009). It considers the MHSU's unique, subjective experience and incorporates that into their treatment plan to help them find meaning and hope in interpersonal relationships and social interactions (Topor *et al*., 2022). The recovery journey varies for each MHSU and their family. There is no one-size-fits-all model that applies to every MHSU.

Several studies have revealed that mental illnesses are not simply a collection of symptoms as postulated in the medical model of recovery (*e.g.*, Brijnath, 2015; Roberts, 2011). In simple terms, the medical recovery approach focuses primarily on medications that modulate the neural system and brain chemistry. In this approach, the process of recovery entails mental health professionals treating the underlying biological conditions for mental health problems through the prescription of medication (Chaudry, 2022). Conversely, the social approach towards recovery prioritises MHSU's perspective and lived experiences when it comes to mental health treatment. It's a fluid, integrated strategy that adapts to MHSU's changing requirements and demands. It is currently shaping psychiatric practices globally (SCIE *et al*., 2007; WHO, 2012a). In providing person-centred care, mental health professionals or support services have acknowledged the diversity of experiences that exist (Topor *et al*., 2022; Gyamfi *et al*., 2022).

This concept of recovery is not simply about treating symptoms but rather about offering a more holistic approach to healing and empowerment. It is founded on the idea that recovery from mental health problems is possible when reclaiming control over one's life and negotiating a valued and satisfying 'place in the world' (Bradshaw, Armour and Roseborough, 2007). The social recovery model bases treatment on concepts of resilience, self-agency, and social inclusion (Frost *et al.*, 2017). Proponents of the social recovery paradigm posit that many clinical or psychiatric treatments' stated goals have not been achieved (Warner, 2004; Hooper *et al*., 2007). Clinical and pharmacological interventions towards recovery have their advantages. Still, treatments that depend only on antipsychotic medication can have unpleasant side effects and may not be enough to help individuals lead happy, healthy lives (Chaudry, 2022). Indeed, Read *et al*. (2006) evidence that medicalisation and related practices can have negative consequences on MHSUs in terms of reducing expectations, removing agency and responsibility, and unintentionally normalising social exclusion and stigma.

Consequently, MHSUs may internalise these effects, which can weaken their self-esteem and social confidence (Yanos *et al*., 2015; Girma *et al*., 2022; Read, 2014).

The social model of recovery is a framework that does not attempt to diminish MHSUs but instead advocates for them to exist with dignity within their families and communities (Tew, 2013). For this recovery approach to happen, there must be a collaboration between all elements of the systems at play in the MHSUs' environment (Ahmed, Bruce and Jurcik, 2017), as understood through Urie Bronfenbrenner's (1979) Ecological Systems Theory/Model (*see* Figure 2), Tew's (2013) social recovery capitals framework and Weiss's (1974) social provisions theory and Murray Bowen's (1976) family systems theory. The intricate interplay of these systems' processes and relationships can either facilitate or impede MHSUs' recovery journey, forming the backdrop of this current study.

4.4.2. Social Recovery Framework-African/Ghanaian Perspectives

This section provides a more detailed examination of the various elements of social recovery capitals, social provisions, ecological model and family systems theory from an African/Ghanaian perspective to assess the factors that can make a difference in determining how MHSUs may be enabled to recover and sustain their wellbeing in the longer term. What may be missing from this framework is a focus on spirituality and customs, which would be subsumed in the intra- and interpersonal family relationships and the importance of this in the recovery journey. In some ways, this belief in a cure coming from a higher authority is remarkably similar to a belief in the medical model of cure. Both tend to take away power and agency from MHSUs and their FCs, as well as the ordinary interactions of family and social life.

4.4.2.1. Healing and Wellness

Healing is considered the primary focus of the recovery process and involves a continual process of positive change in mind, body and spirit (LeCount and Koberstein, 2000). Onken *et al*.

(2007, pp. 2) defined healing (a component of recovery) as "a painful process of adjustment, movement and growth beyond the catastrophic, multiple and recurring traumas of mental illness." The argument made by the APA (1994) that support networks (including professionals) and treatment modalities do not necessarily target the cure of the illness, but rather to improve social functioning of the individual, is corroborated here by Onken *et al* (2007). Thus, the tuning of the mind and controlling detrimental symptoms promote the recovery process. Not only does the healing process rely on managing symptoms, but also on restructuring the total self to overcome stigmatisation and discrimination, which is rooted in the cultural fabric of society (Mfoafo-M'Carthy and Grischow, 2021).

However, other theorists and researchers argue that healing implies eradication or reduction of symptoms, which is parallel to cure (Davidson and Strauss, 1992; Tooth, Kalyanasundaram and Glover, 1997). They believe that symptoms can be eradicated or drastically reduced through strategic plans and recommended behavioural patterns, such as identifying early symptoms and developing a crisis plan to manage them, adopting a healthy diet, engaging in regular exercise, maintaining good sleep patterns, and pursuing adult life roles. However, this view (of associating recovery with cure) has been vehemently opposed in most mental health literature. The greater degree of consensus is that recovery has two main parts: reducing or doing away with psychiatric symptoms (clinical recovery), and the second, which is personal/social recovery is concerned with improving self-autonomy and social functioning of the individual (Tew, 2013; Gyamfi, Hegadoren and Park, 2022; Slade, 2009; Biegel, 2013).

Wellness is a subjective positive change obtained by individuals with mental illness and can be measured as the drastic reduction of psychiatric symptoms and disability and a gain of control over the detrimental conditions associated with the condition by the patient (Allott, Loganathan and Fulford, 2002). It is worth noting that wellness is not limited to symptom reduction, but also involves

the application of coping strategies to promote health and overcome the challenges and stresses posed by the condition (Jacobson and Greenley, 2001b; Onken *et al*., 2007). The process of recovery involves a back-and-forth, rise-and-fall pattern, with periods of wellness and relapse, which is far removed from the cure, which involves the thorough eradication of a condition at a single point in time. It can be inferred that recovery from mental illness is not necessarily an absence of psychiatric symptoms but also a psychological and social development toward living a meaningful and functional life with or without symptoms of illness. As a result, a person can be said to have recovered and yet continue to take psychotropic drugs.

4.4.2.2. Meaning, Purpose and Identity

When MHSUs can reassert their agency in choosing their own responsibilities and following their own dreams, they are considered to have made a full recovery (Anthony, 1993; Tew, 2013). This encompasses MHSUs' ability to engage in meaningful pursuits such as education, employment, family, parenting, developing meaningful connections and relationships, community involvement, and activism (Bonnie, and Judith, 2006; Leamy *et al.,* 2011; Miller, 2000; Onken *et al.*, 2002; Read, Sakyi, Abbey, 2020). For instance, in Ghana and many African countries, when it comes to everyday life and interpersonal relationships, spirituality is known to impact what is worth claiming and how people relate to one another, which in turn gives people a sense of meaning and purpose (Kpobi *et al*., 2023; Read and Van der Geest, 2019; Ae-Ngibise *et al*., 2010; Onken *et al*., 2007; Quinn, 2007).

According to Atobrah (2013), reciprocity, interpersonal acceptance, mutuality, and a sense of social belonging are significant factors that inform Ghanaians' communal nature. These factors give credence to Tew's (2013) social capital and Weiss's (1974) social provision theory (*see* Chapter 4.3.1-4.3.2). It is these elements that Read (2013) indicates help Ghanaian MHSUs and their FCs find meaning and purpose in their experiences and, above all else, help MHSUs regain a strong sense of who they are (if it had been lost or taken away). Finding meaning in the experiences of the recovery

journey can be challenging for MHSUs, especially when faced with the usual deluge of unsolicited criticism emanating from both immediate (family members) and broader social circles (Gyekye, 1996).

A research review on recovering self-identity in schizophrenia shows that MHSUs find meaning in their lives through learning to control their social interactions and negotiating public spaces in a way that is both safe and meaningful and by creating and maintaining a safe psychological space at home, where they can grow in knowledge and develop a diverse set of interests, a strong sense of purpose, and a sense of self (Sells, Stayner and Davidson, 2004; Lawrence *et al*., 2021). Also, as Cook and Jonikas (2002) pointed out, MHSUs are more likely to steer their own recovery when they can recognise oppression in their social networks and find innovative strategies to combat it. Therefore, helping MHSUs in their recovery journey to make and stick to plans that boost their health in all areas by taking advantage of opportunities and making good decisions in their social environments increases the likelihood that they will experience a "life worth living" (Sen, 1993; Hopper, 2007).

As Tew (2013) rightly indicated, regardless of the type of mental health issue, MHSUs' ability to take back control of their lives, mend broken relationships, and develop a positive and accepted sense of self may all be necessary steps in the road to recovery. Dealing with the effects of oppression or social defeat, including stigmatisation, as well as overcoming experiences of severe personal and social displacement, may be necessary steps in this direction. Even while MHSUs may have to deal with persistent relapses, these personal and social development processes can provide the groundwork for a fulfilling and purposeful life. Therefore, MHSUs' capacities to accelerate transformation in their recovery journey are enhanced by a supporting network, of which the family is an indispensable component (Johnson, 2000a; *see* Chapter 3.4).

4.4.2.3. Hope, Religion and Spirituality

Hope forms the bedrock of recovery, the internal energising force that stimulates change and promises a better life for MHSUs (Read, 2016; Repper and Perkins, 2006). Hope is defined as the expectation of better things, which include a reduction in symptoms, improved physical surroundings, or emotional support, and drives a person toward a better life (Jacobson and Greenley, 2000; Lunt, 2000). Felton and Carpinello (2000) discussed that both the individual's and others' (especially close relatives) optimism for positive change in the current condition of the MHSUs is instrumental in recovery. A study by Davidson, Lawless, and Leary (2005) about the concepts of recovery cited hope and aspiration as essential elements on which the recovery journey rests. Hope is a product of the interaction between MHSUs and individuals in their immediate environment, especially family members. It necessitates putting one's trust in another while risking disappointment, failure and further hurt (Kramer, 2002). In this sense, a positive interaction where others express hope for better change and wellness by referencing others who have recovered from similar situations fosters hope in the MHSUs, while negative expressions hamper hope (Onken *et al*., 2007; Abayneh *et al.*, 2017).

In many African communities, religion and spirituality are affiliated with the notion of hope for recovery with its inherent expectation of better things through faith and spiritual efficacies (Ensink and Robertson, 1999; Corrigan and Ralph, 2004; Onken *et al*., 2002; Ndetei, 2007; Meissner, 2004; Kilonzo and Simmons, 1998; Crawford and Lipsege, 2004; Cocks and Moller, 2002; Alem *et al*., 1999; Gureje and Lasebikan, 2006; Jacob *et al*., 2007). In Ghana, faith, driven by religion and spirituality, has been identified as a cornerstone in many MHSUs' recovery journeys and primarily informs their health-seeking behaviours (Adu, Jurcik, and Grigoryev, 2023; Read, 2019; Bartlett, 2016). Studies on hoping for healing and the health-seeking behaviours of MHSUs and their families in Ghana revealed that hopes for a permanent solution to the myriad problems that plagued MHSUs were fuelled by their anticipation for a long-term remedy and were informed by the prospect of its

spectacular display at religious worship centres, including Christian and Muslim churches, and Traditional shrines (Read, 2016; Ae-Ngibise *et al*., 2010; Lambert *et al*., 2020; Nartey *et al*., 2019). A study by McLeod (1981) found evidence that supernaturally inspired authority is vital in health and recovery discourses in Ghana. Hence, healers (traditionalists and clinicians) need to demonstrate spiritual powers and medical efficacies by performing miracles and curing diseases to appeal to MHSUs' and FCs' faith, thereby gaining trust in their services (Read, 2016; Kpobi, 2018; Read, Jilka and Singh, 2023).

Hope is primarily based on the beliefs many Ghanaians hold in a spiritual deity's power to heal and save lives, often fuelled by the numerous religious bodies within the Ghanaian community and the media (Ae-Ngibise *et al*., 2010; Read, 2016; Abukari, 2016; Quinn, 2007). To this very day, Ghanaian popular media outlets, including newspapers, TV and radio, continue to spread accounts of miraculous happenings experienced or overheard, adding an air of mystery and intrigue to daily life and discourses on mental health and recovery (Osei, Asare and Roberts, 2021a; Read, 2023; Mfoafo-M'Carthy, Sottie and Gyan, 2016). These stories captivate, delight, and speculate, evoking both praise and criticism of the moral basis of such supernatural abilities and their allure to FCs and MHSUs. Nonetheless, finding hope and keeping it alive encompasses not just faith and spirituality, but also a self-belief that endures and the courage to persevere even when faced with challenges.

4.4.2.4. Socio-Cultural Context and Stigma

Rebuilding or forming (new) meaningful human relationships and regaining functioning are central to mental illness recovery. It is explained that mental illness primarily affects an individual's ability to perform socio-cultural roles and relate meaningfully to others, and as such, obtaining a status where these functionalities can be reclaimed is considered recovery (Johnson, 2000b). Interaction with persons who have recovered from mental illness, as well as significant others, is found to speed up recovery (Onken *et al*., 2007). Vodde and Gallant (2002) also comment that

establishing meaningful relationships with others is a resourceful cure to isolation, a situation that causes and strengthens mental illness. They further observed that the recovery element of social functioning also involves taking up family roles and other responsibilities, thereby making MHSUs fit as well as a social actor.

Empirical qualitative studies poignantly highlight the experience of loss, loneliness, and the desire for meaningful human connection (Bradshaw, Armour and Roseborough, 2007; Davidson and Strayner, 1997; Davidson, Stayner, and Haglund, 1998). Yet these individuals have fewer social contacts compared to the general population, and their relationships are characterised as one-dimensional in that they receive more than they give (Cohen and Sokolvisky, 1977; Wallace, 1984). Other studies have reported that 50% of persons with schizophrenia have no friends or important relationships (Breier *et al*., 1991). Many individuals have conflicted relationships with family members and may no longer have contact with these individuals. For others, family is the primary source of support, but the burden experienced by family members can be overwhelming (Marsh and Johnson, 1997). MHSUs' care demands a substantial time, energy, and emotional investment from FCs, which profoundly affects their day-to-day functioning (Chan, 2011; Dadson, Annor, and Yendork, 2018).

Social exclusion is widely recognised as a consequence of mental illness, shaped not only by clinical factors—such as intense symptomatology, neurobiological impairments, cognitive processing difficulties, and limitations in social judgement and interpersonal skills (Topor *et al.*, 2009; Mfoafo-M'Carthy and Sossou, 2017; Bradshaw, Armour and Roseborough, 2007)—but also by social and structural conditions. Davidson *et al*. (2001) emphasise that environmental and systemic obstacles significantly intensify this isolation, impeding meaningful social reintegration, including community participation. Among these barriers, stigma plays a critical role. Corrigan (2002, pp. 35) characterises stigma as "the social embodiment of disempowerment," highlighting its role in perpetuating harmful

stereotypes about MHSUs. Stigmatisation contributes to exclusion by fostering misconceptions, often portraying individuals with mental health problems as dangerous, incapable of autonomy, or inherently dependent. Empirical research from the US and UK has identified three dominant public attitudes towards MHSUs: fear-based exclusion due to perceived threat, authoritarian control rooted in assumed incompetence, and patronising benevolence viewing those with psychotic distress as childlike and in need of care (*e.g.*, Brockington *et al.*, 1993; Taylor and Dear, 1980).

These findings corroborate recent studies on Ghanaian attitudes towards MHSUs and persons with disabilities as rights holders in Ghana (Harden, Gyimah and Osei, 2023; Read, 2020a; 2020b). Family members control MHSUs' treatment decisions and their inclusion in social activities, with MHSUs having no say in what is in their best interest. This often leads to coercive and discriminatory practices in their recovery journey (Bonsu and Yendork, 2019; Gyamfi, 2022; Mensah, 2021; Asafo, 2021). The pervasiveness of discrimination and social stigma creates a loss of socio-economic opportunities for MHSUs. They are less likely to be hired or approved for an apartment lease (Opoku-Boateng *et al*., 2017; Daliri *et al*., 2024). They are more likely to be falsely accused of violent crimes, as Corrigan (2002) noted. The effects of self-stigma are corrosive as well. Studies show that people with mental health problems have reduced self-esteem, demoralisation and engulfment in a mentally ill identity (Agyei *et al.*, 2024b; Bradshaw and Brekke, 1999; Corrigan, 1998; Lally, 1989; Link, 1987; Ay-Woan, *et al*., 2006; Chuang, Wu and Wang, 2023).

The idea of family-oriented recovery practice is embedded in Ghana's social and cultural fabric (Read and Van der Geest, 2019; Atobrah, 2013; Geekie and Read, 2009). The support provided by FCs enables MHSUs to reconnect, receive advice, seek suggestions or encouragement when needed, and engage with others who share similar interests as well as the broader aspects of social inclusion in community activities. This support is crucial for MHSUs to sustain their recovery towards living a meaningful life, corroborating Tew's (2013) assertion that recovery may involve MHSUs'

abilities to negotiate significant changes and transitions in relation to finding a new place within social settings; access to varied forms of capital may make a profound difference in how and whether they can achieve a sustainable social recovery.

An analysis of the international literature suggests that recovery involves five key processes that interlink with one another: empowerment, motivation and reclaiming self-control (Tew, 2013); reestablishing positive personal and social identities (including dealing with the impact of stigma and discrimination) (Topor *et al*., 2009); connectedness and social inclusion (McGinty, 2023); hope and optimism about the future (Leamy *et al*., 2011); finding meaning and purpose in life (Gillard, Turner and Neffgen, 2015). Viewed against such criteria, current practices within many mental health services in Africa may not always be supportive of recovery and may instead engender passivity, hopelessness and an internalised assumption that it is only mental health professionals who can "make MHSUs better" (Read and Nyame, 2019; Mensah, 2021).

A dimension often overlooked is the role of family relationships, culture and spirituality in determining healing/recovery from mental illnesses in the context of African societies. What may be needed is a focus on MHSUs' quality of interpersonal relationships within the family setting and examination of barriers or opportunities for them to reclaim a 'positive place in the world'. Such a perspective foregrounds issues of family agency and empowerment in relation to social re-engagement and has the potential to provide a foundation for connecting international perspectives on socially sustainable recovery frameworks.

4.4.2.5. Socio-Economic Context

As has been discussed earlier (*see* Chapter 3.3), mental health in Ghana, like many low- and middle-income countries (LMICs), is deeply influenced by socio-economic factors. The intersection of poverty, social exclusion, limited healthcare infrastructure, and traditional beliefs significantly

shapes the experiences of MHSUs. Poverty is both a cause and a consequence of mental illness. Economic hardship increases vulnerability to mental disorders through chronic stress, social exclusion, and poor living conditions (Patel *et al.*, 2018). Conversely, mental illness can lead to a decline in economic productivity and increase the risk of unemployment or underemployment. People with mental illness in Ghana face difficulties securing and maintaining employment due to stigma, lack of skills training, and discriminatory attitudes among employers. Osei (2006) notes that MHSUs are often seen as unfit for work, contributing to economic dependency and marginalisation. Efforts to promote social inclusion through community-based rehabilitation and supported employment are limited and under-resourced (Eaton *et al*., 2011). Social protection policies in Ghana are insufficiently inclusive of persons with psychosocial disabilities, further entrenching economic vulnerability. MHSUs often face barriers to accessing mental health services due to costs associated with transportation, medication, and informal caregiving. Roberts *et al.* (2018) found that many individuals with mental illness in Ghana delay or avoid seeking medical treatment due to financial constraints, often turning to traditional or faith healers instead.

The above socio-economic circumstances of MHSUs strongly corroborate Tew's (2013) social recovery perspective on *economic capital* (*see* Chapter 4.3.1.4). Economic capital refers not only to material resources such as income, housing, and employment but also to the broader capacity to participate in society and exercise choice and control. In the Ghanaian context, as discussed above, deficits in economic capital emanate from structural inequalities, which are often magnified for MHSUs. MHSUs live in conditions that compromise access to adequate nutrition, housing, healthcare, and education (GSS, 2021b). Roberts *et al.* (2018) contend that limited economic resources reduce individuals' resilience to life stressors and limit their ability to access support or meaningful activity, thereby increasing vulnerability to mental distress. Research shows that sustained economic resources can offer routine, purpose, and social identity, all of which are vital to

mental wellbeing (Onken *et al*., 2002; Roberts *et al.*, 2013; Addo *et al.*, 2018). The absence of these in Ghana's socio-economic landscape contributes to the chronic marginalisation of MHSUs. Even where individuals recover, reintegration into the workforce is often hampered by persistent social stigma and a lack of employer support, reducing opportunities for rebuilding economic capital (Eaton *et al*., 2011). Daliri *et al*. (2024) also highlight the buffering role of informal support from family or community networks as sources of economic capital, where state-sponsored mental health support is minimal. These can be compromised by economic pressures on families or cultural beliefs that lead to the rejection of people with mental illness (Read and Doku, 2012; Maahs, 2015). In some cases, MHSUs are disowned or institutionalised in prayer camps, stripping them of not only economic capital but also agency and dignity (Human Rights Watch, 2012; Read and Colucci, 2023).

Ghana has a severe shortage of mental health professionals, with approximately 0.05 psychiatrists per 100,000 people (WHO, 2021). Mental health services are primarily centralised in urban areas, particularly in Accra (Ghana), making them inaccessible to many rural populations (Agyapong *et al*., 2015a; 2016). The Mental Health Act of Ghana, 2012 (Act 846) sought to decentralise mental health care and integrate it into primary health services. However, implementation has been slow due to limited funding and lack of infrastructure (Eaton *et al.*, 2011; Agblevor *et al*., 2023; Ferazzoli and Kpobi, 2024; Opoku *et al*., 2017; Jopling *et al*., 2025). Despite the passing of the Act, mental health remains underfunded—receiving less than 1% of the national health budget (WHO, 2021). The underfunding of Ghana's mental health system reflects a broader pattern of structural neglect. Tew's (2013) framework invites attention to how macroeconomic policies and institutional priorities shape the distribution of economic capital. The insufficient allocation of resources for community mental health services or income support mechanisms for people with chronic diseases, including mental illness, results in a systemic erosion of their economic resources accessible to them.

Civil society organisations, such as the Ghana Mental Health Society, have played a crucial role in advocating for community-based mental health services and socio-economic empowerment programmes for MHSUs (Agyapong, Osei, and Robert, 2008; Osei and Roberts, 2010; Options Consultancy Services, 2022; Bonsu, 2018). Other NGOs, such as BasicNeeds-Ghana, have supported MHSUs in rural areas in signing up for the Livelihood Empowerment Programme (LEAP). However, these remain patchy and reliant on donor funding (Basic Needs-Ghana, 2019; WHO, 2022; Gobena, 2016). Without sustained structural investment, efforts to restore economic capital to MHSUs remain fragile. Thus, sustained government commitment and investment are essential for systemic change. Strategies must include integrating mental health into primary care, stigma reduction campaigns, and social support mechanisms like conditional cash transfers and vocational training.

4.4.2.6. Family Interaction: Coping and Resilience

Given the non-linear nature of the recovery journey and the chronicity of many mental illnesses, coping and adjustment strategies play a crucial role in helping MHSUs recover (Jaiswal *et al*., 2020; Harris *et al*., 2019). Coping skills endow MHSUs and their FCs with techniques to adjust to changing circumstances healthily, thereby building resilience (Smith, 2000; Rutter, 2006; Jordan, Malla and Iyer, 2020). Although there is a dearth of literature in Ghana identifying the coping and resilience framework of MHSUs and FCs in the recovery journey, Read's (2013) study on practical kinship care of mental illness in Ghana points out that the coping strength of MHSUs is influenced by the available resources in their environment, which is an intersection of material and structural resources (strong institutions, economic and welfare programs) and social support network (such as family, friend, and neighbours). Kravetz and Roe (2007) identified two models of coping in the mental illness arena: illness-focused and wellness-focused. Illness-focused coping applies when the individual recognises the ill condition, which is chronic or disabling and adopts appropriate strategies to live with it comfortably. Strategies include medication, bed rest and other appropriate means. With

respect to wellness-focused coping, MHSUs direct attention from the illness to a healthy one to create meaningful functioning.

One of the most critical aspects of mental health and coping is adaptive resilience, which is not just about the capacity to bounce back from adversity (Read *et al*., 2013; Leitz, Laccase and Cacciatore, 2011). Adaptive resilience is defined as the relative utilisation of coping abilities above defence mechanisms (Onken *et al.,* 2007; Gooding *et al*., 2019). This capacity allows MHSUs and FCs to change situations instead of having difficult experiences changing them (Geekie and Read, 2009). Bark (2023) contends that FCs' and MHSUs' ability to enjoy life and balance life activities to achieve resilience is essential in the recovery journey. MHSUs' ability to adapt to others in the recovery journey may mean letting go of hurt feelings and making peace with others, missed chances and time (Read, 2013; Topor *et al*., 2022; Poloni *et al*., 2018).

Srivastava (2011) indicates that positive mental health outcomes for MHSUs recount the ability to adaptively withstand and cope with the stresses in the recovery journey. Rutter (1985) posits that humans possess the innate capacity to connect with others (social competence), think critically (metacognition), take initiative (autonomy), make plans, and have faith in the future (a sense of purpose and future orientation). Even without a supportive atmosphere, some people can demonstrate these abilities, but it is in a nurturing setting that they are most likely to do so (Tew, 2013; Srivastava, 2011; Masten *et al*., 2021; Jaiswal *et al*., 2020). Building adaptive resilience requires more substantial social and personal resources for MHSUs to recover sustainably, rather than limiting risk or 'fighting' acute difficulties (Tew, 2013; Sumskis, Moxham, and Caputi, 2017; Harris *et al*., 2019; Kim, 2005).

According to a systematic review of research on resilience in adult mental health, FCs and MHSUs, both benefited from coping and adaptive skill development; this helped with the management of personal characteristics and difficulties, which could or might not be considered symptoms of mental illness, throughout the recovery process (Ayed, Toner and Priebe, 2019). It was

found in the review that to build adaptive resilience, FCs and MHSUs have to take it upon themselves to become experts in recognising potential stressors and crisis points, as well as in understanding and developing their own unique coping mechanisms (Ayed, Toner and Priebe, 2019). Here again, the importance of building meaningful relationships with people cannot be overstated when sustaining the recovery journey. That could mean rediscovering or creating a place in the social spheres, or it could mean rediscovering or creating a set of values, beliefs, or practices that serve as a compass in life.

Consequently, this study is also theoretically well-grounded in Bateson's (1972) idea of the family as an ecosystem, which views MHSUs as being generated through power and relationship networks. From these critical vantage points, achieving social and relational equilibrium can be a powerful resilience strategy on the road to recovery. In fact, the most crucial aspect of recovery in a mental health setting, according to studies on the social aspect of recovery conducted by Schön, Denhov and Topor (2009) and Tew *et al.* (2012), is the formation or restoration of cherished social relationships and functions, such as sibling, parent or friend. Scoping review participants aimed to control and balance their meaningful personal connections to use them as resilience tools, reflecting these research and theoretical positions. For instance, in the setting of mental illness in Ghana and elsewhere in sub-Saharan Africa, an imbalance in these social dynamics, including immediate and wider family relationships, is observed as a factor contributing to the worsening of suffering in MHSUs' living conditions and a notable lack of resilience (Kpobi *et al*., 2023; Rosenberg, 2002; Read, 2013; Van der Geest, Dapaah and Kwansa, 2019; Read and Van der Geest, 2019; Martyns-Yellowe, 1992; Ohaeri, 1998; Quinn, 2007; Ukpong, 2006).

4.4.2.6. Study's Conceptual Framework

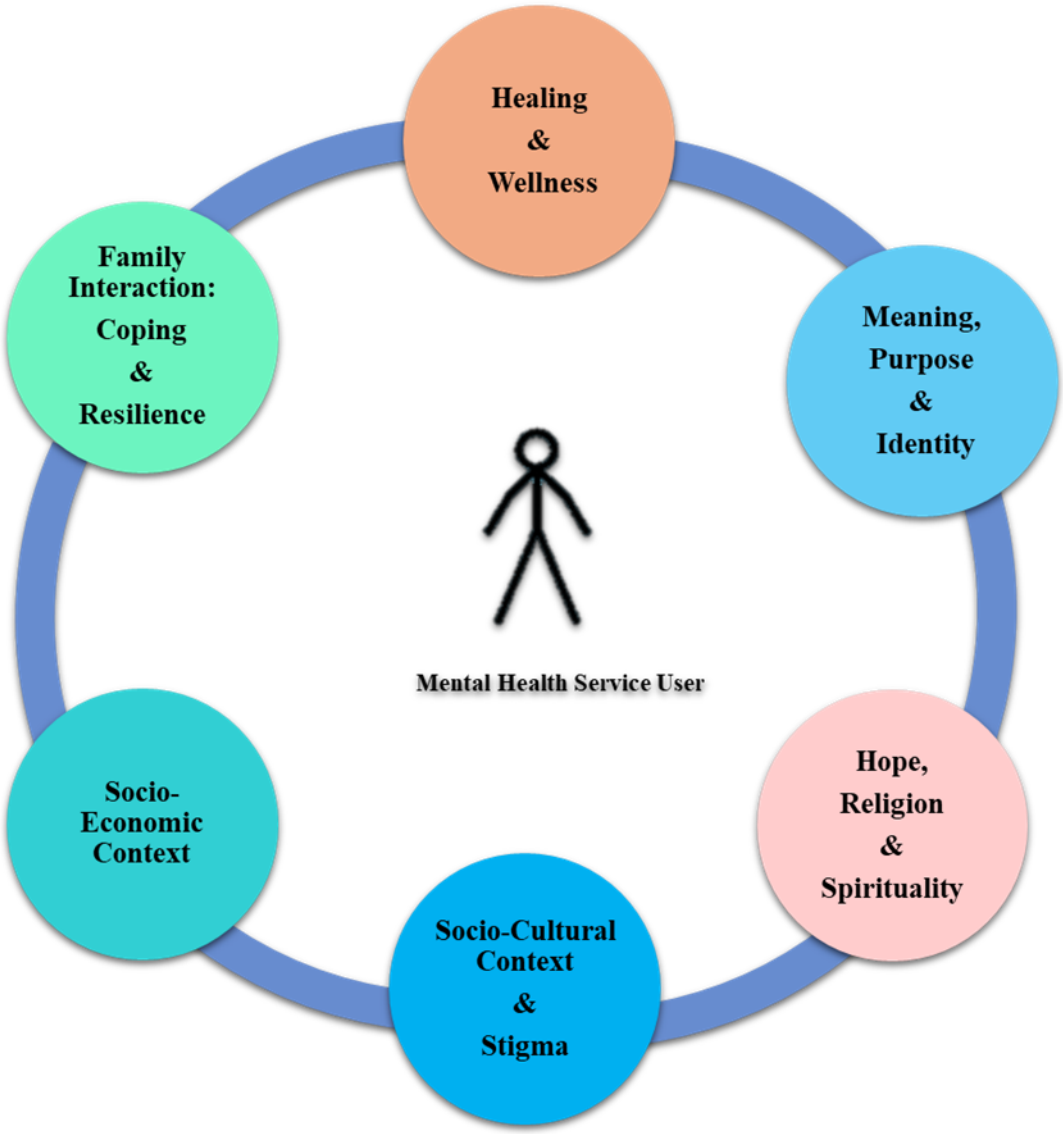
The subsequent section picturises the framework for conceptualising social recovery in the Ghanaian context. It draws from diverse streams of social approaches to recovery. It meticulously

navigates between generic and specific concepts to effectively explain the application of each theory and the study's contribution to knowledge. Therefore, the ideas presented in the extant literature on family caregiving and social support, as well as the theories employed in the study, have been summarised in a conceptual framework diagram below (*see* Figure 4).

The framework hangs on the assumption that when a person develops a mental illness, people within the immediate social environment (especially family members) provide some support to the person to promote recovery. This implies that the recovery journey of MHSUs is sustained by their personal efficacies, support, and meaningful interactions with family members (as caregivers), as well as the broader socio-economic context.

Figure 4 below illustrates Ghana's social recovery model. This is intended to convey the concepts of the theories explored in the literature that relate to the study's aims.

Figure 4: Social Recovery in the Ghanaian Context



Source: Researcher's Construct, 2024.

4.5. Implications of Theoretical Triangulation

The previous sections of this Chapter have discussed critical issues related to the personal and social processes of recovery through an overarching ecological model, augmented with family systems, social provision theory, and recovery capitals, to identify the nature of family relationships and the contextual factors shaping how MHSUs and FCs navigate the recovery journey.

Thus far, the theoretical discussion has revealed substantial intersections between these theories; however, prior studies offer some caveats to their application. For instance, Cutrona and Russell (1983) advise researchers to take extra care in limiting the range of relevant concepts to avoid tautologies and clarify their assumptions to strengthen the explanatory power of the social provisions' theory. It is essential not only to test-tile factor structure of multidimensional social support measures but also to look for differential patterns of association with outcome measures. Otherwise, components of social support that are frequently available to the same population but differ with respect to culture, function, and health implications may be mistakenly collapsed into a single category. It is crucial to ensure that the assessment of social support is not confounded with other factors such as social desirability, depression, or neuroticism. Nevertheless, the importance of supportive relationships per se in mental illness recovery may be questioned.

Similarly, Carmichael and Hadžikadić (2019) caution that no theory can thoroughly analyse human behaviour and system complexity for every scenario. Hence, the nature of statistical analysis depends on the perspective and degree of interest. Furthermore, human interpersonal relationships are more complex, necessitating reflexive judgements when exploring analogies regarding their characteristics in health and social recovery approaches (Chiva-Gomez, 2003). For instance, ecological and family systems theory/model emphasise aggregate outcomes and behaviours because the whole is greater than the sum of its parts (Rogers, 2010). Such aggregate patterns are beneficial for embedding sustainability in social recovery processes. Aggregation has some relevance to theorists, but context and embeddedness play a greater role in their analysis (Ahmed, Bruce and Jurcik, 2017). The interpretation of sustainable recovery processes requires the deconstruction of aggregates, which can produce more insights into context-dependent interactions between MHSUs and their FCs in an empirical setting, especially in most African settings, considering the role of spirituality and religion in informing the health-seeking behaviours of MHSUs and FCs. For this

reason, Western concepts of family and social approaches to recovery may be too rigid for mental health recovery discourses in Ghana.

Applying the theories mentioned above follows the same underlying assumption about the social nature of recovery. However, it draws on insights from different Western theories concerning social support and family inclusiveness in the recovery journey of MHSUs. Exploring social approaches to recovery from Western contexts presents a unique learning opportunity to identify distinct explanatory toolkits that can be reformulated and translated into Ghanaian contexts by critically examining the cultural and social aspects of family caregiving in healthcare.

The examined theories are adopted in two ways to address the research questions. Firstly, recovery and the nature of family interpersonal relationships and support provisions are currently viewed as a multidimensional construct. Weiss (1974) and Tew (2013) prescribed factors for determining social support in any given social relationship, which is needed to understand the recovery journey of MHSUs and the support provided by FCs to augment the process. Because of MHSUs' personal attributes, including self-efficacy towards personal recovery (as described by Leamy *et al*., 2011, in the recovery model) and/or the social and cultural context of Ghana, MHSUs who have access to one component of family support and provisions often have access to several other kinds of support. Thus, although family support provisions may differ in function, they may covary as a function of MHSUs, thereby obscuring their separateness in the recovery journey. By mapping the nature of interpersonal relationships, we can gain a deeper understanding of the roles FCs play in the recovery journey of MHSUs.

Secondly, because there are apparent differences in the concepts of family, culture, spirituality, mental healthcare, and social care systems, there are relational and social constructs that cannot provide an equivalent explanation or be used to elaborate on aspects of mental illness recovery

in the Ghanaian context. These concepts remain relevant but distinct in each context and should not be misinterpreted or used interchangeably. Some instances include family and cultural boundaries serving different purposes, including the hegemony of authority figures within the traditional family system, who define the expectations of 'best and customary' conduct for MHSUs' recovery (Nukunya, 2016). These relational dynamics are not treated as distinct because they often intersect within the traditional Ghanaian family setting. This emphasises the agency and power dynamics that sustain and transform the family system in the Ghanaian context, as well as the influence of governing healthcare policies and regulations, such as the Ghana Mental Health Act (2012) and the Mental Health Authority.

4.6. Summary

In summary, exploring diverse theoretical frameworks has provided a lens through which to explain the experiences of FCs and MHSUs. Several researchers have demonstrated that insights can be gained from Western theories, which can be adapted to suit the Ghanaian context (*e.g.*, Agyapong, 2021). The review of the theoretical literature is not intended to provide a solution but rather an understanding of the varying family caregiving circumstances in the trajectory of recovery from mental illnesses. Developing the study's conceptual and theoretical framework enables a holistic view of the recovery journey of MHSUs, rather than examining it in parts, through the prism of social and environmental interconnections. Thus, this framework may offer a lens into the interactions between MHSUs and their families in their social environment, especially in issues related to providing and receiving social support and care during recovery from mental illness. This impact on personal and social agencies directly affects psychological growth and recovery. It may be seen as sustainable when MHSUs can reengage and reconnect with the interrelated systems within their social environment. The next Chapter describes the study's methodological choices.

CHAPTER FIVE

RESEARCH METHODOLOGY

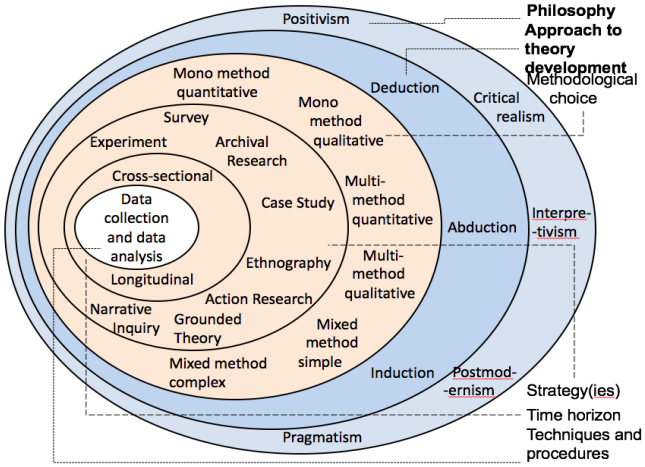
5.0. Introduction

This Chapter outlines the researcher's methodological considerations for the study in relation to extant literature on research philosophies and methods. It focuses on pragmatic research strategies, along with justifications for their selection, including data collection techniques, ethical concerns, and data analysis. This study is designed according to Creswell's (2014) Explanatory Mixed-methods Design-Participant Selection Model (*see* Figure 7).

5.1. Research Process

Specific methodological considerations were adopted to comply with social science research and ethics guidelines. Saunders, Lewis, and Thornhill's (2019) visual description of the research process as an "onion" (*see* Figure 5) was used to go through the "layers" of research components (philosophical approach to theory development, methods, strategies, time horizon, and techniques and procedures for data collection and analysis) in order to advance the study rationally.

Figure 5: The Research Onion



Source: Saunders, Lewis and Thornhill (2019).

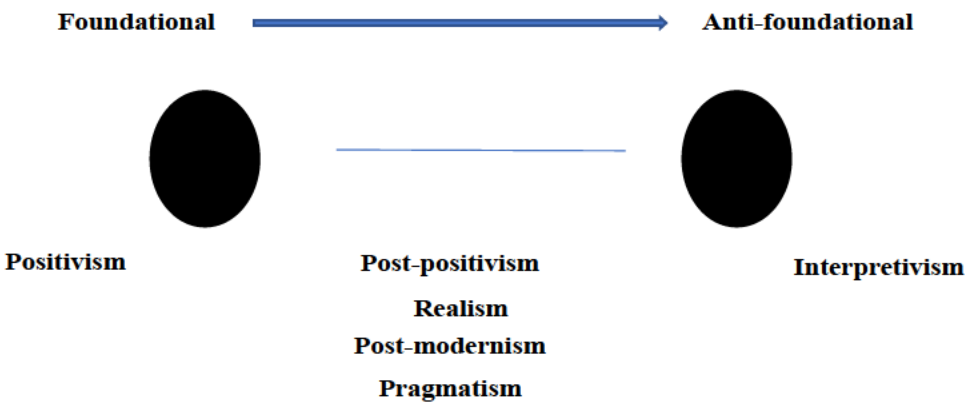
5.2. Research Philosophy

Research philosophy is a set of principles for gathering data, analysing, and applying evidence regarding an identified phenomenon (Creswell, 2014; Hughes and Sharrock, 1997; Russell, 2011). Knowledge, assumptions, and the nature of the investigation all play a role in research philosophy. Researchers may hold differing beliefs about the nature of knowledge and truth regarding a social phenomenon, and philosophy enables us to comprehend these diverse perspectives.

Before designing any research study, researchers must consider how the investigation fits into the broader context of the world and how to conduct it effectively (Dudovskiy, 2021; Lincoln and Guba, 2000). These considerations can be aligned in a philosophical spectrum of schools of thought/worldviews (pragmatism, post-modernism, interpretivism, critical realism, positivism, naturalism/humanism, rationalism/empiricism, relativism) (Rosenberg, 2016; Porta and Keating, 2008; *see* Figure 6). According to Grix (2010), these schools of thought about what constitutes reality and how knowledge about reality is constructed can be grouped into two philosophical frameworks: (a) foundationalism (concerned with the explanation of events) and (b) anti-foundationalism (concerned with understanding people's experiences).

Figure 6 below depicts the boundaries between methodological paradigms, where much "real-world" research is conducted. Where 'hard' proponents of one paradigm cross paths with 'soft' proponents of the other would be in the darkened areas. Depending on where a researcher falls on the continuum, there would likely be no consensus on what to examine, how to collect data about it, or which research techniques to use. Some research straddles both the anti-foundationalist concern with understanding and the foundationalist concern with explanation (*e.g.*, the works of Max Weber are challenging to categorise on such a dichotomous continuum).

Figure 6: Continuum of Key Philosophical Positions in Human and Social Sciences Research



Source: Grix (2010), The Foundations of Research.

Researchers operating at the spectrum's end are relatively simple to understand. Typically, positivist research aims to provide "predictive" findings, whereas interpretivist research seeks to comprehend the meanings and experiences of people as related through "life stories" (an informal, unstructured interview technique). Researchers approaching the foundationalist-anti-foundationalist division (on the periphery of post-positivism and interpretivism) are far more likely to share presumptions underpinning research and its methodology. A problem arises when research crosses the shaded area because of the underlying assumptions of foundationalism and anti-foundationalism. Contrary to popular belief, once a method crosses the line between the two, researchers must acknowledge and embrace the underlying presuppositions of the opposing approach. However, there should instead be an incremental shift toward an epistemological perspective based on a researcher's direction of travel (Grix, 2010).

According to Saunders, Lewis and Thornhill (2019; *see* Figure 5), an implicit component of a researcher's methodological perspectives in any given study is determined by the philosophical assumptions underpinned by ontological and epistemological approaches to research, the role of researchers' values (axiology) and approaches to theory development (deduction, abduction and induction). The term ontology refers to assumptions researchers make about the nature of *reality* and shapes how research objects (organisations, individuals, events, artefacts) are seen and studied. *Reality* can be assumed to be scientific, justified, objective, factual, subjective, contain multiple truths, facts that can be constructed by people (social construction), non-scientific, and dependent on the observer's viewpoint.

Epistemology refers to the philosophical study of knowledge, focusing on its nature, origins, and legitimacy (Crotty, 1998; Cohen, Manion and Morrison, 2018). In the context of research, it reflects the assumptions a researcher makes about what counts as valid knowledge and how such knowledge can be acquired. These assumptions shape how the research problem is approached, influencing methodological choices, which in turn affect how questions are framed, evidence is gathered, and findings are interpreted (Bryman, 2001). Recognising that knowledge can be both constructed through lived experience and measured through observable data, this study adopts a pragmatist and constructivist epistemological stance that values multiple ways of knowing (Guba and Lincoln, 1994).

Axiology explains how values and ethics influence the conduct of research (Gary, 2013). To assess the credibility of the study findings, it is essential to consider concerns regarding how researchers make decisions about their own values and the values of participants throughout the research process. All decisions made by people, including researchers, are driven by their values (Heron, 1996). Axiological abilities are displayed by researchers when they articulate their values and pass judgement

on the subject and methodology of their research. The fact that researchers chose one topic over another, for instance, shows that one topic is more important than the other. A researcher's choice of philosophy and data-gathering methods in each given research endeavour also reflects their ideals.

Concerning this study, *ontology* refers to the researcher's assumptions about the nature of mental illness recovery and the choices made regarding what to research in this area. The *epistemology* concerns what constitutes adequate, valid and legitimate knowledge about the phenomenon of mental illness recovery and how the researcher can communicate this knowledge to others. This study is grounded in a constructivist epistemology, which views knowledge as socially and culturally constructed rather than objective or value-free. It reflects the belief that understanding emerges through human interaction, lived experience, and contextual interpretation (Crotty, 1998; Cohen, Manion and Morrison, 2018). In line with this stance, the research assumes that the realities of caregivers and service users in Ghana are shaped by their cultural, relational, and spiritual contexts.

This stance aligns with a pragmatist approach. Pragmatism recognises that no single way of knowing is sufficient for understanding complex social phenomena and instead values the integration of multiple methods to generate more comprehensive insights (Creswell and Plano Clark, 2018). This stance allows the study to combine qualitative narratives, which capture the lived experiences of caregivers and service users, with quantitative measures that provide broader patterns and generalisability. By drawing on both subjective meaning-making and objective indicators, the research acknowledges the legitimacy of different knowledge forms, employing them in an explanatory sequential mixed-method design to address the research questions.

Privileging participants' voices and local knowledge systems, the study contributes to the decolonisation of mental health research and challenges the dominance of Western biomedical models.

It recognises that relational, communal, and spiritual dimensions are integral to understanding caregiving and recovery in the Ghanaian context. Thus, the choice in this study to employ constructivist and pragmatic philosophical stances and the employment of explanatory sequential mixed-methods approaches (survey and interviews) form the basis for making judgements about the research conduct and how to do it constitutes *axiology*. The researcher's *axiological* perspectives determined what was ethically appropriate given the mental health conditions of participants, their low educational background, inadequate use of technology and the researcher's logistics to conduct the study.

Understanding family caregiving and mental illness recovery in Ghana requires attention to both measurable patterns (quantitative) and nuanced, lived experiences (qualitative). The constructivist element of this research foregrounds participants' perspectives, values, and meaning-making processes, while the pragmatist lens justifies the integration of diverse data types to address real-world mental health challenges in a culturally grounded way. Methodologically, this informed the use of a sequential explanatory mixed-methods design, where quantitative findings from the adapted Social Provisions Scale were used to inform and deepen qualitative interviews with service users and caregivers. This design allowed for both breadth and depth of insight, supporting a comprehensive understanding of how social support functions within Ghanaian caregiving contexts.

The choice between research philosophies and methodologies, including quantitative and qualitative research methods, has historically been a contentious issue that has implications for data collection and practice (Sandelowski, 2000). Two extreme theories concerning reality and the nature and sources of knowledge—positivism and interpretivism—are mutually irreconcilable (Risjord, 2014). Nevertheless, it is also necessary for researchers to occasionally "change their philosophical assumptions throughout time and shift to a new location on the philosophical continuum," depending on the research

question (Collis and Hussey, 2014, pp. 54). Knowledge, as well as the methods used to acquire it, are never static but constantly evolving. There is a general propensity among social scientists to avoid thorough scrutiny and questioning of their own assumptions, even though all social science research is undertaken based on philosophical, including epistemological, premises (Isaeva *et al*., 2015; Tsoukas and Chia, 2011). However, whether researchers are aware of them or not, their epistemologies are closely related to other types of suppositions, including those regarding the nature of reality (ontology), the relationship between theory and practice (praxeology), and the researcher's role in the research process (axiology). Together, they form research philosophies with significant theoretical and methodological implications. Ultimately, epistemological presuppositions influence research goals, questions, approaches, data analyses, and the knowledge researchers add to their academic field.

5.2.1. Study's Philosophy: Pragmatic philosophical framework

The pragmatic philosophical model, formulated by Goldkuhl (2012), served as the study's framework and guided the researcher in making robust methodological choices. In this study, the researcher believes that reality does not exist by itself but is created by people. Consequently, the researcher is concerned with reality (*ontology*) in the form of applying concepts derived from study participants' perceptions and knowledge (*epistemology*) in the form of methods and procedures that effectively capture the experiences of MHSUs and their respective FCs. Instead of rigidly adhering to a philosophical position, pragmatic research encourages methods and strategies that are appropriate for obtaining information from the study population, especially in research involving vulnerable populations (Goldkuhl, 2012). This framework was chosen to balance the complexities of conducting research in Ghana, where technology is inadequate to engage with MHSUs during a pandemic like COVID-19. Employing and combining several data collection methods made it possible to gather and analyse

pertinent data in-person and remotely to find answers to the research questions (Adom, Osei, Adu-Agyem, 2021; Keshavan, 2020; Torous and Keshavan, 2020).

As Saunders, Lewis and Thornhill (2019) rightly remark, there are many different ways of interpreting the world and undertaking research. No single point of view can ever give the entire picture, and there may be multiple realities. Hence, a pragmatic research philosophy accepts concepts as relevant only if they support action. Regarding this study, the experiences and perceptions of MHSUs may or may not align with those of their FCs during the recovery trajectory and others in the social environment. Therefore, there was a need to combine and adopt methods that adequately capture the unique experiences of MHSUs and their FCs (participants) about their interactions and access to mental health services. The researcher and participants' subjective and objective views of the mental illness phenomenon in Ghana were balanced (using Goldkuhl's (2012) framework) to obtain accurate information using telephone and face-to-face (questionnaire and interviews) data collection approaches to advance the research in the best possible manner (Berg and Lune, 2012; Silverman, 2013; Gary, 2013).

In addition, the study employed an abductive technique to structure its theoretical framework (as far as possible within pragmatic approaches). This study's abductive technique entails going from data to theory and back to data. Therefore, the findings reflect the concepts of family inclusiveness, interpersonal relationships, caregiving, and support for recovery from mental illness from the perspectives of MHSUs and their FCs, identifying common themes that reflect the study's theoretical framework (*see* Chapters Four, Seven & Eight).

5.3. Methodological Choices

Saunders, Lewis, and Thornhill (2019, *see* Figure 5) propose several methodological designs, strategies, time horizons, techniques, and data collection and analysis procedures:

a. methods: mono-method quantitative, mono-method qualitative, multi-method quantitative, multi-method quantitative, multi-method qualitative, mixed-method simple and mixed-method complex.
b. strategies: survey, experiment, archival research, case study, ethnography, action research, grounded theory and narrative inquiry).
c. time horizon (duration for which data is collected): longitudinal (data collection with same sample/participants over the years) or cross-sectional study (data collection with a new or different sample/participants at a given point in time).
d. techniques and procedures for data collection: questionnaires, interviews (structured, semi-structured, and in-depth), which can be conducted face-to-face, in groups, or electronically.

Considering any methodological alternatives has implications for how data is analysed, how findings and results are reported, and how the evidence is drawn to warrant discussions and conclusions. Nonetheless, the best choices researchers make are invariably determined by the research question(s)/objectives of any given study or research project, study population and recruitment procedures/techniques, and logistics (including time, funding, data management software, the scale of the project (small/large), type of research project (student-based projects, organisations, national), the team of researchers). These factors largely influenced the researcher's methodological choices throughout the study.

5.3.1. Mixed-methods Research Design

The study employs a mixed-methods research (simple) design where primary data from surveys and semi-structured face-to-face interviews were collected at specific periods in time (cross-sectional). It also drew on extant literature (empirical, theoretical, and policy) to situate the findings within the current knowledge base.

Mixed-methods research design is defined as a research framework that combines the components of qualitative and quantitative research methods in the design and data collection approaches (Creswell and Clark, 2011; Cohen, Manion and Morrison, 2018; Palinkas *et al*., 2013; Schoonenboom and Johnson, 2017; *see* Figure 7). According to Creswell (2014), mixed methods research can be classified into four main designs: convergent, embedded, explanatory, and exploratory sequential designs. The best mixed-method model to adopt in any study depends on the design's suitability and ability to explore the research problem and answer the question(s) (Creswell *et al*., 2003; Molina-Azorin, 2012; Palinkas, 2014; Razafsha *et al*., 2015; Robins *et al*., 2008; Sandelowski, 2004; Saunders, Thornhill and Lewis, 2019; Wisdom and Creswell, 2013).

In the context of mental health research, mixed-methods research designs can be categorised in terms of their structure, function, and approach (process/strategy) (Schoonenboom and Johnson, 2017; Palinkas *et al*., 2011a; Palinkas *et al*., 2013; Teddlie and Tashakkori, 2003). In terms of structure, the combination of quantitative and qualitative methods is categorised as concurrent or sequential, with one method prioritised over the other (Schoonenboom and Johnson, 2017). However, equal weight can be given to both methods (Creswell, 2014; Yin *et al*., 2017; Palinkas, 2014). It also involves three distinct approaches (process/strategy) for combining qualitative and quantitative data sets:

1) merging or converging the two data sets by unifying them.

2) connecting the two data sets by having one build upon the other.

3) embedding one data set within the other so that one type of data provides a supportive role to the other data set.

According to Palinkas *et al*. (2013), the functions of mixed-method research designs are usually based on four strategies:

a. whether the two methods are used to answer the same question or to answer related questions concurrently. Thus, for comparison of results for sameness or differences, or for converting a data set from one type into another.

b. whether each set of methods is used to answer a related question or series of questions complementarily (viz, for evaluation or elaboration of treatment outcomes).

c. Expansion: using one type of research method to answer questions that the other type of research method will raise, for example, using qualitative methods to explain findings from an analysis of quantitative data.

d. Development/Explanatory: using one type of research method to answer questions that will enable the use of the other research method to answer different research questions, for instance, sampling: using one type of research method to define or identify the participant sample for collection and analysis of data representing the other type of research method—for example, using non-probabilistic sampling techniques to select participants for individual interviews based on their responses to a survey.

5.3.1. Mixed-methods techniques and rationale

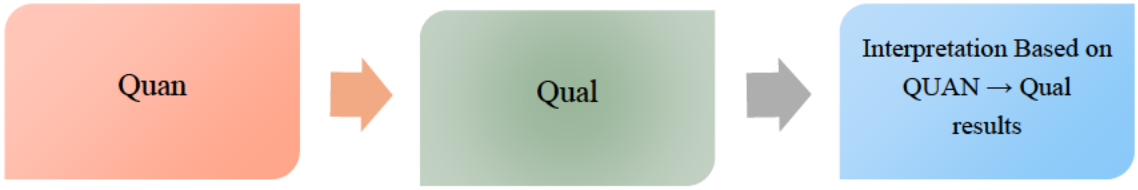
The study employs a sequential design within the categorisation of mixed-methods research designs. In this type of design, the data collection and analysis of the qualitative component occur after

the quantitative data collection and analysis. This design is similar to the explanatory mixed-methods design proposed by Creswell (2014). Creswell's (2014) explanatory design is a two-phase mixed-methods design, wherein qualitative data are employed to explain, develop, or build upon the initial quantitative results. It has two variants: the follow-up explanations model and the participant selection model (*see* Figure 7).

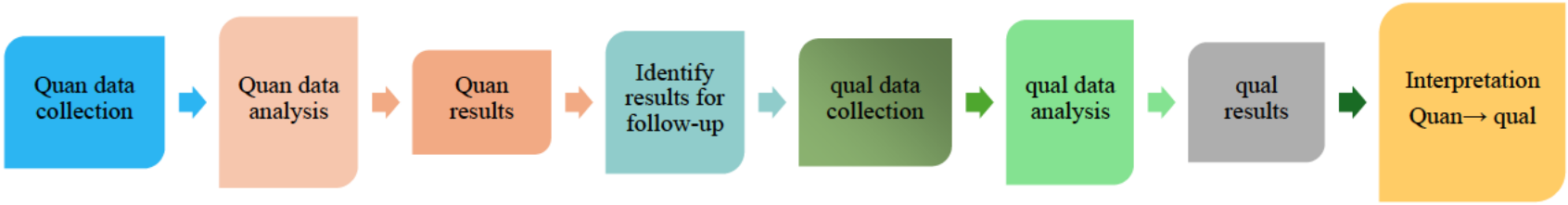
The follow-up explanatory model identifies specific quantitative findings that require additional explanation, such as unexpected results or outliers, in the initial phase. The second phase involves collecting qualitative data from specific participants to provide a deeper understanding of these findings. In this type of model, more emphasis is placed on the quantitative aspects of the study (Creswell, 2014; Palikans, 2014). In the participant selection model, the researcher collects the quantitative data first and uses the outcomes to identify and purposefully sample the qualitative participants for follow-up interviews (Creswell, 2014; Saunders, Lewis and Thornhill, 2019; Creswell and Clark, 2011; Palinkas *et al*., 2013; Palinkas, 2014; Schoonenboom and Johnson, 2017).

Figure 7: Creswell's (2014) Explanatory Mixed-methods Design

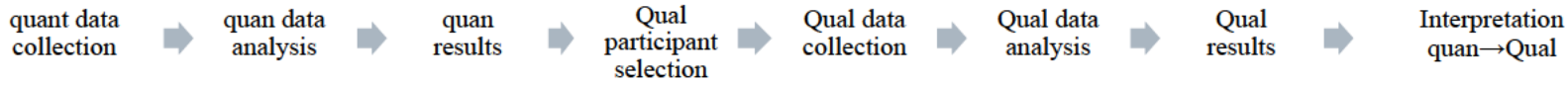
Explanatory Design



(A) ***Follow-up Explanatory Model***



(B) Participant Selection Model



Source: ***Creswell (2014) Quantitative, Qualitative & Mixed-methods Research Designs.***

In terms of design, the study adopted the participant selection model to select interviewees for the sequential qualitative phases (De Loo and Lowe, 2011; Sandelowski, 2000; Creswell, 2014; *see* Figure 7). Thus, the idea is to use the survey to obtain a broader picture from a larger number of MHSUs and select interviewees. The outcomes are then used to identify and choose purposively the participants for qualitative semi-structured interviews. The quantitative phase (questionnaire survey) was employed to inform research question one. Additionally, the qualitative phase sought to answer research questions one to four, respectively. The different data collection approaches (survey questionnaires and semi-structured interviews) are used to achieve completeness or exhaustive responses to the research questions, ensuring that the findings represent participants' actual views. This design is appropriate, considering that the study emphasises objectives and rationale for discovering and exploring flexible ideas and insights from a sample in a short time and in a relatively cost-effective way (Amponsah, 2019; Creswell, 2014; Kothari, 2004; Palinkas *et al*., 2011a; Sutton, 2010; Appiah, 2022; Teddlie and Tashakkori, 2009).

Herein, the development of the qualitative component, including data collection and analysis, may depend on the outcomes of the quantitative component (Palinkas *et al*., 2011b). Thus, the quantitative component was used to purposefully select participants for individual interviews based on their responses to a survey. Therefore, this design is reliable for obtaining large amounts of information and a rounded understanding of both MHSUs' and their FCs' experiences, with minimal effect on its robustness and validity (Regnault, Wilgoss and Barbic, 2018). The qualitative phase (interviews) provides more in-depth information from MHSUs and their FCs on similar issues explored in the quantitative phase. Findings can be generalised to determine the distribution of a phenomenon and explore experiences within a chosen population (Palinkas, 2014).

Similarly, this design is easy to describe, implement and report because the steps fall into separate stages. The survey results can be quickly and easily quantified by the researcher or SPSS data management software, which can then be developed into a strata/quota sample for the qualitative phase. When data has been quantified, it can be used to compare other research and to measure change across different settings (Tariq and Woodman, 2013). Additionally, it can be analysed more objectively than quantitative or qualitative approaches alone (Creswell and Clark, 2011). However, it requires more logistics and a substantial length of time to complete all data collection, given the two separate phases.

5.4. Data Collection Instruments

The study employed quantitative and qualitative data collection instruments structured according to its objectives and Creswell's (2014) explanatory mixed-methods research design, specifically the participant selection model. Findings from empirical studies on mental health in Ghana suggested several critical issues that are essential to explore with respondents/participants (*e.g.*, Gyamfi *et al*., 2020; Yaro *et al*., 2025; Coffey *et al*., 2019; Canavan *et al.*, 2016). In addition, feedback from Ghanaian mental health professionals on mental health research approaches was included to inform the development of appropriate questions for the data collection instruments (*see* Appendices C, F & G).

5.4.1. Quantitative Instrument- (SPS)

The study employs the SPS, designed by Cutrona and Russell (1987), which is based on Weiss's (1974) Social Provisions Theory (*see* Chapter Four). SPS is one of the few theory-based social support measures that assesses the degree to which an individual perceives their social relationships as providing various types of support towards recovery (Cutrona and Russell, 1987; Caron, 2013; Chiu, Motl, and Ditchman, 2016; Iapichino *et al*., 2016).

SPS contains 24 standardised items grouped into six subscales/pathways following Weiss's (1974) Social Provisions Theory: *attachment* refers to feelings of intimacy, peace, and security (similar to emotional support); *social integration* denotes a sense of belonging to a group with whom one shares common interests and social activities; *reassurance of worth* refers to having others validate one's competence and value; *reliable alliance* has to do with perceived access to assistance in times of need from others; *opportunity for nurturance* represents the support receiver providing care to others, such as children or senior family member and finally, *guidance* refers to having people available who can provide suggestions, solutions, and advice when needed. Each subscale comprises four items, two formulated positively and two negatively, for a total of 24 items.

Several studies have demonstrated that the SPS-24 items are flexible, modifiable, and adaptable to diverse contexts when measuring people's perceptions, feelings, and experiences of social support (Cutrona and Russell, 1987; Iapichino *et al*., 2016; Perera, 2016). Nonetheless, SPS-24 items have been used to a limited extent with people with disabilities, mental health problems, and chronic illnesses, especially in the Global South. Furthermore, the scale allows for wording modifications to investigate diverse social phenomena (Baron *et al*., 1990; Chui, Motl and Ditchman, 2016; Iapichino *et al*., 2016; Katsuki *et al*., 2020; Langeland and Wahl, 2009), which has been successfully employed in developed contexts (Norway, Italy, Canada, Japan), following the standards of back translation of scales (English to official/native languages to English). Therefore, adapting SPS-24 items to this study's rationale in a Ghanaian context is appropriate.

5.4.1.1. Social Provision Scale-10 Items

The shortened version of the SPS-24 items was instead employed in this study, which contains ten items proposed by Iapichino *et al*. (2016) to measure perceived levels of social support. The SPS-10

items retain five of the original six subscales of the SPS-24 items. It includes only positively worded items based on Weiss's (1974) social provisions theory. In line with Iapichino *et al*.'s (2016) recommendation, the subscale that measures the *opportunity for nurturance* was left out of the survey/questionnaire design and analysis because it measures the support given rather than the support received within the context of social provisions and because prior research has shown that it has a weaker correlation with mental health and social support than the other subscales (*e.g.*, Caron, 2013; Chiu, Motl, and Ditchman, 2016; Steigen and Bergh, 2019).

SPS-10 items are adopted because several studies have suggested that MHSUs may have a short attention span (*e.g.,* Akyeampong *et al*., 2015; Bee *et al*., 2015; Callaghan and Lovell, 2018). Additionally, they may rush to leave the hospital after their clinical appointments (Gyimah *et al*., 2019; Amponsah, 2019). The reliability and robustness of the SPS-10 items, compared to the original scale (SPS-24 items), have been demonstrated to be both internally and externally consistent and adaptive. For example, Cronbach's Alpha for the full scale is reported to be 0.88 when applied to Canada's general population (Caron, 2013) and 0.89 in a sample of mothers of patients with an eating disorder in Japan (Katsuki *et al*., 2020). Thus, SPSS factor approaches (psychometric properties) have reported good validity and reliability for this version of the scale's total score.

5.4.1.1.1. Modification of the SPS-10 Items

A content modification was made to the SPS-10 items to align with the Ghanaian cultural context in which the survey was administered, thereby supporting the study's first objective. The purpose was to prioritise the views and feelings of MHSUs about their FCs' supportive roles in their recovery journey. Hence, the wording of the items on the scale was prefixed with the phrase, *within my family…*,

For example, "I have close relationships that provide me with a sense of emotional security and wellbeing" was modified to read, "Within my family, I have close relationships that provide me with a sense of emotional security and wellbeing."

Each subscale has two positively worded items describing the presence of a type of support following Weiss's (1974) social provisions theory (*see* Table 2 below).

Table 2: Modified Version of SPS-10 Items Considering the Study's Aims

Subscales	SPS-10 items
Social Integration	***Item 1***
	• Within my family, I feel part of a group of people who share my attitudes and beliefs.
	Item 2
	• Within my family, there are people who enjoy the same social activities I do
Attachment (*emotional support*)	***Item 3***
	• Within my family I feel a strong emotional bond with at least one other person.
	Item 7
	• Within my family, I have close relationships that provide me with a sense of emotional security and wellbeing.
Reassurance of worth	***Item 8***
	• Within my family, I have relationships where my competence and skills are recognised.
	Item 9

	• Within my family, there are people who admire my talents and abilities.
Reliable alliance (material support)	***Item 4***
	• Within my family, I can depend on people to help me if I really need it.
	Item 6
	• Within my family, there are people I can count on in an emergency for my sustenance.
Guidance	***Item 5***
	• Within my family, there is someone I could talk to about important decisions in my life.
	Item 10
	• Within my family, there is a trustworthy person I could turn to for advice if I were having problems.

Source: *Researcher's Construct (Fieldwork, September 2021- February 2022).*

5.4.1.2. New Scaled Items

Two new items were added to the survey questionnaire (*see* Appendices C) to measure the importance of close (nuclear family relations) or extended/wider family members in MHSUs' day-to-day lives and any perceived feelings of shame due to MHSUs' mental illness, thereby adequately informing Research Question One. These items were self-developed after reviewing relevant literature and consulting mental health professionals and researchers in Ghana (*e.g.,* Anoakye, 2018; Dadson, Annor and Yendork, 2018; Gyimah *et al*., 2019; Quinn, 2007; Waller *et al*., 2018; Reupert *et al*., 2015). For convenience in managing the analysis in SPSS version 26.0, the two new items have been labelled as *"family involvement" and "stigmatisation,"* respectively (*see* Table 3 below). These were correlated

separately to identify statistical associations (test hypothesis) with the SPS-10 scores (*see* Chapter Seven).

Table 3: New Constructs

Self-developed construct(s)	Statement(s)
Stigmatisation	• I feel that members of my family (close or wider) are ashamed of me because of my mental illness.
Family involvement	• Family members (close or wider) such as parents, grandparents, aunts, uncles, and cousins are really important in my day-to-day life.

Source: *Researcher's Construct (Fieldwork, September 2021- February 2022).*

5.4.1.3. Survey Questionnaire Design

The survey questionnaire was designed using a Likert scale approach. According to Bryman (2016), a Likert scale questionnaire survey is convenient and easy to complete within the respondents' shortest possible time. The survey was grouped into two sections (*see* Appendices B-D). The introductory section provides brief information about the study, including details regarding survey consent. The survey consent form requests MHSUs' (respondents) contact details (name and telephone number) and whether family members consent to be contacted for a follow-up interview. This section was completed by the MHSUs and their respective FCs. The second section contains a questionnaire that seeks to gather the demographic characteristics of MHSUs and their SPS scores, using a 4-point Likert scale.

The 12 statements on the 4-point Likert scale, included on the survey questionnaire leaflet, were presented to MHSUs to identify those that applied to them. “Strongly Disagree” was coded as 1, “Disagree” as 2, “Agree” as 3, and “Strongly Agree” as 4. This was intended to measure the degree of sentiment towards support received from family in the recovery journey. Thus, the Likert scale questionnaire survey provides quantitative data about qualitative aspects, such as MHSUs’ attitudes (perceptions/feelings), likelihood/agreement with the statements on the SPS-10 and the two new constructs (*see* Appendices C). Following Creswell’s (2014) explanatory mixed-methods design-participant selection model, the Likert scale questionnaire survey provided data for the quantitative phase, which aimed to inform Research Question One — perceptions about FCs' supportive roles and inclusiveness in MHSUs' recovery — and determined the sample for the qualitative follow-up phases.

5.4.2. Qualitative Instruments (Semi-structured interview schedule(s)).

Semi-structured interview schedules were employed to obtain qualitative data from participants. Two sets of interview schedules were self-developed following the study’s literature and theoretical reviews (*see* Chapters Two to Four). The first (1) set was used in one-to-one interviews with MHSUs (*see* Appendices E). The second (2) set was employed in face-to-face/telephone interviews with their FCs (*see* Appendices F). The schedules’ design was guided by recommendations from the research methods literature on qualitative inquiries, Ghanaian researchers and medical staff of *Ayaresabea* (*e.g*., Adjieteh, Amponsah, and Amoanoo, 2017; Anokye, 2018; Kallio *et al*., 2016; Lincoln and Guba, 1985; Kvale, 1996; Saldaña, 2011; Shuy, 2003; Sturges and Hanrahan, 2004).

These schedules contain open-ended questions exploring sensitive issues in MHSUs' recovery journeys, including their socio-demographic details (*see* Appendices E & F). The main issues covered in the interview schedules were mirrored between FCs and MHSUs. It included needs (acceptance,

opportunities, empowerment, sources/forms of support), attitudes (supportive or stressful emotional relationships), expectations, and family as a 'secure base' from which to re-establish wider community engagement and challenges/burden of caregiving.

The overarching goal of using these schedules is to foster an open dialogue and an environment where FCs and MHSUs feel comfortable sharing their thoughts, feelings, and experiences around mental illness and the recovery journey. Thus, employing semi-structured interview schedules, the researcher was able to gather exploratory data that could be triangulated with the literature and theoretical reviews, validate findings via participants' feedback (DeJonckheere and Vaughn, 2019; Watkins, 2012; Bernard, 2000; *see* Chapter Eight), and provide additional clarification regarding quantitative phase results utilised to test hypotheses (*see* Chapter Seven).

5.4.3. Participants' Information Sheets and Consent Forms

Participants' information sheets and consent forms were developed to provide information about the study and to obtain participants' consent (*see* Appendices A, B & D). Considering participants' educational and health backgrounds, these data collection instruments were designed to be user-friendly (basic English language and emojis). For participants who were not conversant in English, the study's information was explained verbally in the Twi language (widely spoken in Ghana) during the data collection phases.

5.5. Recruitment of Participants

5.5.1. Target Population

Gary (2013) defines a population as an aggregate or totality of all objects, subjects or members that conform to a specification set. For ethical and compliance reasons, the name of the mental health

facility where the study was conducted has been obscured with the pseudonym *Ayaresabea* [Hospital in the Twi language]. Personal discussions with the head of the facility at *Ayaresabea* revealed that about 250 active cases are being reviewed within a month. These cases are adult mental health outpatients attending regular clinical reviews with their family members.

In this study, the population represents all adult mental health outpatients attending clinical reviews with their respective family members at *Ayaresabea* over the past six months. MHSUs attending regular clinical reviews are considered to have their symptoms managed and are actively recovering. MHSUs as respondents/participants in this study could understand the questions asked and provide answers. MHSUs could also exercise some form of self-control and make informed decisions throughout the data collection process.

5.5.2. Sampling Techniques

5.5.2.1. Quantitative Sampling Technique and Sample Size

A simple random sampling technique was used to collect quantitative data from MHSUs attending clinical reviews during the data collection period. This technique was adopted because it gave respondents an equal chance of being selected, making the data more generalisable to the target population (De Vaus, 2002). The specific characteristics that warrant random sampling are captured under the heading of *eligibility criteria*. This technique enabled the researcher to select a sample of active adult cases that were most suitable to provide the specific sources of information required to gain insight into the research study.

5.5.2.2. Qualitative Sampling Technique

A combination of quota and purposive sampling techniques was employed to select MHSUs for the semi-structured interviews, which were conducted face-to-face and on a one-to-one basis (Etikan,

Musa and Alkassim 2016; Gorard, 2013). This selective sampling technique was employed to deliberately identify a credible sample capable of providing the information necessary to address the study's research questions (Pope and Mays, 1995; Parahoo, 2014; Patton, 2015; Berg and Lune, 2012). The aim was to create a manageable yet diverse sample, avoiding the strict use of random sampling while ensuring analytic adequacy. Although generalisability is limited in qualitative research owing to its interpretive nature and the researcher's engagement with participants' meanings (Peters, 2010; Sharma, 2017; Opdenakker, 2006; Padgett, 2008; May, 2011), the study enhanced credibility and dependability through triangulation, member checking, and transparent documentation of analytic procedures (Silverman, 2013; Leitz and Zayas, 2010; Marshall and Rossman, 2016). The rationale for adopting quota sampling and the development of analytical categories is discussed below.

5.5.2.2.1. Quota Sampling Technique

Quota sampling is a purposive, non-probability sampling technique that divides a population into key strata (such as gender, age, caregiving role, support level) and fills preset quotas to ensure that each subgroup is adequately represented (Creswell and Plano Clark, 2011). This approach is instrumental when the aim is analytic or interpretive adequacy across relevant categories rather than statistical inference, and where sampling frames are incomplete or difficult to construct, as is often the case in community and mental-health research (Bryman, 2016; Marshall and Rossman, 2016; Teddlie and Yu, 2007; Onwuegbuzie and Collins, 2007). Classic methodological literature likewise recognises quota sampling as a pragmatic design for securing subgroup coverage when probability sampling is infeasible (Kalton, 1983; Henry, 1990). According to Etikan (2017), there are two primary techniques of quota sampling:

- Proportional quota sampling, in which subgroup representation mirrors their distribution in the population; and
- Non-proportional quota sampling, in which subgroup sizes are deliberately adjusted, often equalised, to ensure sufficient representation of smaller or underrepresented groups for analytic comparative purposes.

Given the study's focus on capturing the full range of perceived family-support experiences, the non-proportional approach was adopted. The quantitative phase revealed that most participants reported high levels of support, while comparatively few indicated low or moderate levels. Reproducing this pattern proportionally would have yielded an unbalanced qualitative sample and limited insight into less common but analytically important cases. The non-proportional strategy therefore prioritised conceptual depth and inclusive representation over statistical proportionality, consistent with the pragmatic logic of mixed-methods research (Teddlie and Yu, 2007; Onwuegbuzie and Collins, 2007).

This study employed an explanatory sequential mixed-methods design (participant-selection model), in which the quantitative phase informed the qualitative phase (Creswell and Plano Clark, 2018; *see* Figure 8). Within this framework, the modified Social Provisions Scale (SPS-10) provided a robust and theoretically grounded measure of perceived family support among MHSUs. Using SPS-10 scores as the criterion for quota construction ensured that participant selection was explicitly tied to the study's central construct, *family support in recovery*, rather than to indirect demographic variables such as age, gender, or education.

This decision was both analytically coherent and ethically considered. Analytically, it enabled systematic comparison of recovery experiences across different levels of family support—low, moderate,

and high (*see* Table 19, Chapter Seven). Ethically, it ensured that participants reporting limited or strained support, who are often overlooked in research, were deliberately included. This approach aligns with the mixed-methods principle of purposeful selection for conceptual depth (Patton, 2015; Teddlie and Yu, 2007) and with social work commitments to equity and voice (Dominelli, 2017; Tew, 2006).

Inspection of the aggregated SPS-10 scores using a histogram (*see* Figure 11, Chapter Seven) showed a right-skewed distribution with a long lower tail, indicating that while most respondents reported high family support, a smaller subset experienced limited support. Guided by this pattern, three pragmatic analytical categories were established to maintain balance and interpretive clarity:

- High support (41–48): consistently strong endorsement of family support
- Moderate support (32–40): mixed or conditional experiences
- Low support (≤ 31): limited or strained family involvement.

These thresholds were selected pragmatically, taking account of the skewness and long tail of the distribution and the researcher's interaction with participants. They were not statistically determined by sudden frequency drops but chosen to create analytically meaningful strata for purposive recruitment, ensuring that each support level was sufficiently represented for qualitative comparison (*see* Table 19 & Figure 11, Chapter Seven). The three-tier approach, widely applied in social research (McLean *et al.*, 2022; Petersen, Madsen and Holstein, 2023; Santos *et al.*, 2015), provided an effective balance between capturing diversity and maintaining coherence. A simple high/low division would have masked mid-range variation, while four or more categories would have fragmented the sample and added little interpretive value.

Alternative grouping strategies were carefully evaluated to ensure methodological robustness and analytical coherence. A quartile-based approach would have further fragmented the already small low-

support subgroup, potentially resulting in very few or no eligible participants for qualitative follow-up. Conversely, treating the modified SPS-10 scores as a continuous variable, while statistically precise, would have undermined the practicality of recruitment and analysis, as it would not provide discrete cut-off points to guide participant selection or facilitate systematic cross-group comparison. The adopted three-category model, comprising low, moderate, and high support, therefore offered a pragmatic balance between statistical integrity and qualitative feasibility, ensuring both clarity of interpretation and alignment with prior studies employing similar classification structures (McLean *et al.*, 2022; Petersen, Madsen and Holstein, 2023; Santos *et al.*, 2015).

This pragmatic categorisation aligns with Weiss's (1974) Social Provisions Theory, which conceptualises social support as a continuum encompassing attachment, reliable alliance, guidance, social integration, and reassurance of worth. Grouping participants into low, moderate, and high support levels reflects this continuum and captures differences in access to supportive resources. Complementarily, Tew *et al.*'s (2012) concept of social recovery capital positions family and community relationships as resources that can either enable or constrain recovery, depending on their distribution and quality.

Integrating these frameworks justified differentiating levels of family support: families offering high support typically provide stronger relational and material resources that facilitate recovery, whereas MHSUs experiencing moderate support from families may have conditional experiences, and low-support families may restrict such access, heightening isolation and stigma. Including all three levels ensured that the qualitative phase could examine these dynamics systematically. Empirical evidence further supports this rationale: higher family involvement has been linked with improved treatment adherence, reduced relapse, and enhanced wellbeing (Caqueo-Urízar *et al.*, 2014; Ae-Ngibise *et al.*,

2015; Santos *et al.*, 2015), whereas limited or strained support is associated with isolation and poorer outcomes (Corrigan and Phelan, 2004; Addo *et al.*, 2018). Accordingly, using SPS-10 scores as the quota criterion ensured that participant selection was both conceptually and empirically aligned with the study's research questions.

Although quota sampling strategies introduce potential selection bias and lack the randomness of probability methods, these limitations were recognised and carefully accounted for in interpreting the findings. Transparency and transferability were enhanced through standardised screening procedures, which applied consistent inclusion criteria and SPS-10 scoring thresholds, as well as detailed documentation of recruitment flows (Kalton, 1983; Henry, 1990; Bornstein, Jäger and Putnick, 2013). Standardised screening ensured that all potential participants were evaluated using the same eligibility criteria and scoring process, minimising researcher bias and promoting methodological consistency. This process also strengthened the auditability of the study by making participant selection replicable and by providing a clear record of how each quota category was filled.

The non-proportional sampling approach adopted in this study was not only methodologically justified but also ethically informed. Ensuring balanced representation across the three levels of perceived family support, particularly including participants from low-support contexts, was guided by principles of equity, justice, and voice, which underpin both social work values and the ethics of qualitative research. The deliberate use of non-proportional quota sampling sought to prevent the marginalisation of families whose experiences might otherwise remain unseen, thereby promoting inclusive knowledge production and respect for participant diversity. These ethical considerations informed every stage of the research process, from recruitment and consent to data collection and interpretation, and are discussed further in the section on Ethical Considerations (*see* Section 5.7).

In summary, the quantitative phase established a pragmatic, conceptually grounded, and ethically informed framework for participant selection for the qualitative phase. The categorisation of low, moderate, and high support levels reflected both observed data patterns and theoretical understandings of social provisions, ensuring that the qualitative phase could systematically explore recovery experiences across the continuum of family support.

5.6. Data Collection

5.6.1. Survey and Interviews Process

A more significant part of the data was gathered after the restriction on social life had been mildly relaxed in line with measures (vaccination, social distancing, wearing of face masks) to prevent the spread of COVID-19 in Ghana. All data from participants were collected during this period. Thus, the fieldwork was conducted over six months (*i.e.*, September-February 2021). Data collection instruments were employed in three stages:

a. pilot study
b. surveys with MHSUs
c. semi-structured interviews with MHSUs and FCs.

5.6.1.1. Stage 1: Pilot study

The researcher began preparing for fieldwork two weeks after arriving in Ghana (11th September 2021). A two-phase pilot study was conducted before the main research (mid-September to October 3, 2021). The first phase assessed the external validity, trustworthiness, and reliability of the data collection instruments among Ghana's mental health professionals and researchers. This comprised five experts: two clinical psychologists (Ghana Mental Health Authority) and three senior social work lecturers from a Ghanaian University, providing their professional views and research expertise concerning the data

collection instruments. This process enabled the researcher to better understand the appropriate questions and their suitability in the Ghanaian context.

In the second piloting phase, the researcher contacted a private residential care institution where the researcher had completed her undergraduate field placement to negotiate access for the pilot study. This pilot study was conducted on Saturdays & Sundays (25th - 26th September & 2nd - 3rd October 2021), the visitation days for MHSUs and their FCs. Eight MHSUs voluntarily consented to complete the survey after their wellness to participate was determined by the residential nurse. Out of these eight respondents, three MHSUs and their respective FCs were interviewed after gaining their consent. The pilot study assessed participants' understanding of the data collection instruments. No shortfalls were identified within the study's design, and the instruments were found to be reliable.

5.6.1.1.1 Survey Reliability Test of the Pilot Study

A reliability test was conducted for the quantitative aspect of the pilot study. A sample of five (5) survey questionnaires from the pilot study was input into SPSS data management software version 26.0 to test the questionnaire's reliability. A Cronbach's Alpha score (α) of 0.896 was obtained, indicating that the quantitative data collection instrument is authentic, valid, and exhibits good internal consistency. This statistical function was then employed for the main data collection for the study (*see* Chapter 7.3.2). Reliability function in SPSS, version 26.0, measures the internal consistency of the study's constructs.

A construct is reliable if the Alpha value (α) is within a range of $0.8 \geq \alpha \geq 0.7$ (Cronbach, 1951; Hair *et al*., 2013; Cowan, 1998; Salkind, 2015; Agresti and Finlay, 2013; Tavakol and Dennick, 2011; Roberts and Priest, 2006; Taber, 2017). The α-value of the SPS-10 subscales is within the acceptable range of validity, as reported in other studies adopting the scale (Caron, 2013; Katsuki *et al*., 2020; Perera, 2016; Baron *et al*., 1990; Chiu, Motl and Ditchman, 2016; Iapichino *et al*., 2016; Katsuki *et al*., 2020;

Langeland and Wahl, 2009). Therefore, the higher α-scores indicate that the items on the scale have good internal validity and reflect the ability of MHSUs (respondents) to understand, interpret questions, and provide accurate responses. It should also be noted that while a high value for Cronbach's alpha indicates good internal consistency of the items in the scale, it does not mean that the scale is unidimensional. Factor analysis is a method used to determine the dimensionality of a scale; however, it is beyond the scope of this study.

Qualitative descriptions for alpha values used in various science-based studies, according to Taber (2017), include excellent (0.93–0.94), strong (0.91-0.93), reliable (0.84–0.90), robust (0.81), fairly high (0.76–0.95), high (0.73–0.95), good (0.71–0.91), relatively high (0.70–0.77), slightly low (0.68), reasonable (0.67–0.87), adequate (0.64–0.85), moderate (0.61–0.65), satisfactory (0.58–0.97), acceptable (0.45–0.98), sufficient (0.45–0.96), not satisfactory (0.4–0.55), low (0.11). Nonetheless, Kamis and Lynch (2020, pp. 31) provide the following rules of thumb: " ≥ 0.9 – Excellent, ≥ 0.8 – Good, ≥ 0.7 – Acceptable, ≥ 0 .6 – Questionable, ≥ 0.5 – Poor, and ≤ 0.5 – Unacceptable" in social science research. Internal consistency of the scale items increases when Cronbach's alpha coefficient approaches 1.0.

5.6.1.1.2 Credibility and Trustworthiness Interviews for the Pilot Study

A consolidated criterion for reporting qualitative research, COREQ, a 32-item checklist (peer debriefing and member checking) for interviews developed by Tong, Sainsbury and Craig (2007), was adapted to underpin all interviews (qualitative phase). It is a robust scientific evaluation of credibility and trustworthiness in qualitative data collection. This checklist was employed to assess, as far as possible, whether the study's findings result from the experiences and ideas of the piloted participants, informing the main data collection strategies (Lincoln and Guba, 1985; Shenton, 2004). After gaining feedback from experts and piloting the data collection instruments, the researcher made no adjustments

to the interview schedule (*see* Appendices F & G). These instruments were suitable for addressing the research questions and emphasising crucial information. The main data collection employed the credibility approaches described above, indicating the dependability, confirmability, and transferability of the interview schedules.

5.6.2 Stage 2: Survey/Quantitative Phase I (MHSUs only)

Before any data was collected, the researcher met the head of the facility at *Ayaresabea* (4th October 2021) to discuss the data collection processes and logistics. The discussion centred on screening participants in the conference room and remuneration for the time and effort of both participants and medical staff involved in the study. It was agreed that data collection be conducted on Wednesdays & Thursdays from 8:00 am to 4:00 pm, from 11th October 2021 to February 2022, in the conference room to ensure confidentiality and privacy. A doctor and a nurse were assigned to assist with screening MHSUs. The purpose of the screening was to assess MHSUs' capacity and wellness to participate, considering that their health may fluctuate during the study. Subsistence for staff and MHSUs was provided throughout the data collection period.

5.6.2.1 Eligibility Criteria

MHSUs and FCs (respondents/participants) for the study were selected based on the following inclusion criterion:

a. MHSUs must be 18-65 years old and be receiving support from at least one member of a nuclear (close) or extended (wider) family.
b. MHSUs should currently be attending outpatient clinical reviews at *Ayaresabea* on a regular basis (for over six months). They should be deemed well enough by their responsible clinician to

consent to and participate in the proposed research. Persons with all mental health diagnoses are to be included, except severe cases of dementia.

c. Family members must be primary caregivers to the MHSU. This may include nuclear or extended family members who are 18 years old or older.

5.6.2.2 Survey Sample Size

The sample comprised 140 MHSUs who attended the outpatient clinic from the first day of survey recruitment (11th October- 11th November 2021), met the selection criteria, and provided consent. During the survey recruitment period (Phase 1), no sampled respondents (MHSUs) refused to participate. The researcher employed Agresti and Finlay's (2013) mathematical formula for estimating sample sizes from the target population, ensuring the validity of using both descriptive and inferential statistics to minimise bias in the study's sample selection. This mathematical formula helps to predetermine a study's sample size:

n: $\frac{N}{1+\mathrm{N}(d^2)}$ Where n = sample size, N = study's sample frame drawn from the target population (250 outpatients): 216, and d = margin of error, given as 0.05, at a confidence level of 95%.
$\frac{216}{1+216(0.05^2)}$ $\mathrm{n} \approx 140$ outpatients.

5.6.2.3 Procedure for Phase I Data Collection (Surveys)

The recruitment of participants (MHSUs and FCs) and data collection survey began on 11th October-11th November 2021. The assigned nurse and doctor introduced the researcher and the study to the participants who had been seated in the OPD/waiting area since 5:00 am. It appears to be a practice that individuals usually come early to queue with their appointment cards to avoid spending their entire day at the *Ayaresabea*. *Ayaresabea* is generally crowded during the clinical review (check-up) days. Hence, medical service provision is on a first-come, first-served basis.

The researcher explained the study and the approach to data collection, including the location, time, and duration of the entire data collection process, to individuals at the OPD. These individuals raised questions about the study and expressed concerns about not participating. For instance, during recruitment, some participants expressed concerns about whether their decision to participate or to refuse might impact the medical care they received from staff or the support they relied on from family members. The researcher reassured individuals at the OPD about their concerns and emphasised the voluntary nature of participation. The information sheet was provided to all MHSUs and their FCs who expressed interest and were willing to participate. This technique enabled MHSUs and their FCs to read and understand the study's requirements, ask questions, and have sufficient time to decide whether to participate and provide consent.

Although the researcher provided information sheets and clear verbal explanations emphasising the voluntary nature of participation, it is significant that no individuals explicitly declined to take part. This absence of decliners raises important ethical considerations. These concerns raised by participants suggest that refusal could be perceived as socially undesirable or even disadvantageous, reflecting broader cultural and relational dynamics in the Ghanaian context, where hierarchical relationships with medical staff and the central role of family decision-making can influence individual choices (Molyneux, Peshu and Marsh, 2005; Kass *et al.*, 2011; Ae-Ngibise *et al.*, 2010). The researcher explained the study in detail to individuals at the OPD, including the location, timing, and duration of data collection.

Participants were given information sheets to read, consider, and ask questions before deciding whether to participate. Despite these safeguards, the fact that some individuals raised questions about "not participating" indicates an underlying pressure to comply, perhaps linked to limited exposure to research participation and the perception that involvement might yield indirect negative consequences

on their family relationships and jeopardise family support provisions. While informed consent procedures were rigorously followed, the absence of decliners highlights how cultural expectations, power imbalances, and dependency on healthcare and family support may have subtly constrained participants' freedom of choice. This underscores the need for ongoing ethical reflexivity in similar studies, particularly when working with vulnerable populations such as people with mental health problems and their caregivers.

Participants' usual clinical review was scheduled at 8:00 am, and the researcher began the survey at 9:00 am. However, the researcher reported to the Unit at 7:00 am as advised by the head of the facility to have informal discussions with MHSUs and their FCs before any official introductions. Respondents were chaperoned to the conference room while observing *Ayaresabea's* COVID-19 protocols. Additionally, sign posters were created to provide directions for all individuals who voluntarily participated in the study, both before and after their medical review. The researcher also provided respondents with COVID-19 materials, including two-piece nose masks, hand gloves, pocket-size hand wipes, and pens. In addition, the researcher placed a hand sanitiser station at the conference room entrance, in addition to the handwashing station mounted by *Ayaresabea*.

Communication with MHSUs (respondents) was conducted in both English and Twi. Although it is acknowledged that the survey questionnaire was in English, respondents who requested an explanation in the Twi language were given verbal assistance in completing the survey (20 MHSUs). Each respondent was screened and deemed fit by the assigned medical staff before participating in the survey. Respondents were first briefed about the study, given consent forms to sign and handed a survey questionnaire to complete.

On average, it took approximately 20 minutes to complete each survey form, resulting in 140 questionnaires being completed between 11th October and 11th November 2021; *see* Table 4 below. The questionnaire was used to assess the socially valuable activities, family support provisions, family interpersonal relationships and care of MHSUs reliably and validly. A copy of the signed and dated survey consent form, along with the participant information sheet, was given to each respondent and retained by the researcher for secure storage on file. The consent form and survey questionnaire were cross-labelled for easy identification (especially when respondents wished to withdraw within five weeks of data collection) and to facilitate data input in SPSS.

Table 4: Survey Recruitment of MHSU

Recruitment	Duration (Wednesdays & Thursdays, 8:00 am -4:00 pm)	Number of Participants recruited per day
Day 1	13th October 2021	15 service users
Day 2	14th October 2021	20 service users
Day 3	20th October 2021	20 service users
Day 4	21st October 2021	15 service users
Day 5	27th October 2021	10 service users
Day 6	28th October 2021	15 service users
Day 7	3rd November 2021	10 service users
Day 8	4th November 2021	15 service users
Day 9	10th November 2021	10 service users
Day 10	11th November 2021	10 service users
Total		**140 participants**
Duration for withdrawal	**16th December 2021**	

Source: Researcher's Construct (Fieldwork September 2021- February 2022).

5.6.3 Stage 3: Qualitative Phase II - Participant Selection

The survey data were populated into SPSS as soon as each day's data collection schedule was completed. This approach made it quicker and easier to construct the interview data sample. The thesis supervisors and the researcher discussed the likely number of 10-12 interviews. By December 16, 2021, no respondents (MHSUs) from the survey (Phase 1) had requested to withdraw from the study.

5.6.3.1 Qualitative Sample Size

Based on the survey questionnaire responses, 12 participants were selected for the qualitative follow-up phases using quota and purposive sampling techniques (*see* Section 5.5.2.2). The qualitative sample comprises two MHSUs drawn from the 'high response group', two MHSUs drawn from the 'moderate response group', and two MHSUs drawn from the 'low response group', plus their respective FCs. The resulting data has been summarised in Table 5 below.

Table 5 illustrates how the questionnaire responses were used to construct smaller stratified samples of MHSU experiencing high, low, and moderate levels of family support, where additional consent was given to include family members in the research and where they were interviewed. In applying the quota and purposive sampling techniques, MHSUs were categorised into three groups based on their Family Support Scores (*see* Phase 1 survey). High, moderate, and low family support groups were then extracted from a proportional sample for each stratum.

Table 5: Qualitative Sample Size and Interview Process

Service user(s)	Date	Time	Type of interview and venue	Family caregiver(s)	Date	Time	Type of interview and venue
High category	17th December 2021	10:00 am-12pm	face-to-face in *Ayaresabea*'s conference room	**High category**	17th December 2021	1:00 pm-3:00 pm	face-to-face in *Ayaresabea*'s conference room
High category	21st December 2021	11:00 pm- 1:00 pm	face-to-face in *Ayaresabea*'s conference room	**High category**	21st December 2021	2:00 pm-4:00 pm	face-to-face in *Ayaresabea*'s conference room
Moderate category	5th January 2022	9:00 am-11:00 am	face-to-face in *Ayaresabea*'s conference room	**Moderate category**	5th January 2022	12:00 pm-2:00 pm	face-to-face in *Ayaresabea*'s conference room
Moderate category	14th January 2022	11:00 pm-1:00 pm	face-to-face in *Ayaresabea*'s conference room	**Moderate category**	14th January 2022	2:00 pm-4:00 pm	face-to-face in *Ayaresabea*'s conference room
Low category	21st January 2022	11:00 am - 1:00 pm	face-to-face in *Ayaresabea*'s conference room	**Low category**	3rd February 2022	2:00 - 4:00 pm	Phone/WhatsApp interviews
Low category	31st January 2022	1:30 pm-3:30 pm-	face-to-face in *Ayaresabea*'s conference room	**Low category**	17th February 2022	10:00 am-12 pm	Phone/WhatsApp interviews

Source: *Researcher's Construct (Fieldwork, September 2021- February 2022).*

Thus, MHSUs scoring 41-48 were categorised as having high levels of support (55%). MHSU scoring 32-40 were grouped as experiencing moderate levels of support from their family (35%), and MHSU scoring 31 ≤ were placed in the low levels of support category (10%), *see* Chapter Seven. Similarly, MHSUs with the highest score in each stratum were given priority over those with a lower score. A pattern-matching process was used to select family members of the respective MHSU recruited.

5.6.3.2. Procedure for Phase II Data Collection/Fieldwork (Interviews)

Preparation for Stage 3/Phase 2 (semi-structured interviews) commenced on November 12, 2021, and continued until February 17, 2022, contingent upon participants' availability (*see* Table 5). Selected participants were initially contacted by phone (12th November -16th December 2021) to schedule the day and time for the interviews in *Ayaresabea*'s conference room. The brief phone interviews allowed participants to decide whether to participate and provided an opportunity for them to give their consent willingly. In addition, MHSUs provided further verbal consent for their wellness to participate, which was to be determined by medical staff (nurse/doctor) during the interviews. All participants contacted by phone accepted the invitation and provided their informed consent. Through WhatsApp, text messages, and phone calls, participants were reminded every two days of the agreed-upon schedule.

Before conducting the interviews with selected MHSUs, the researcher shared participants' names and time schedules with the medical staff assigned to the study. These professionals (a nurse or a doctor) screened and checked selected MHSUs per their consent throughout the interviews. The purpose of the screening was to ascertain participants' capacity or wellness to participate, considering that their health may fluctuate during the study.

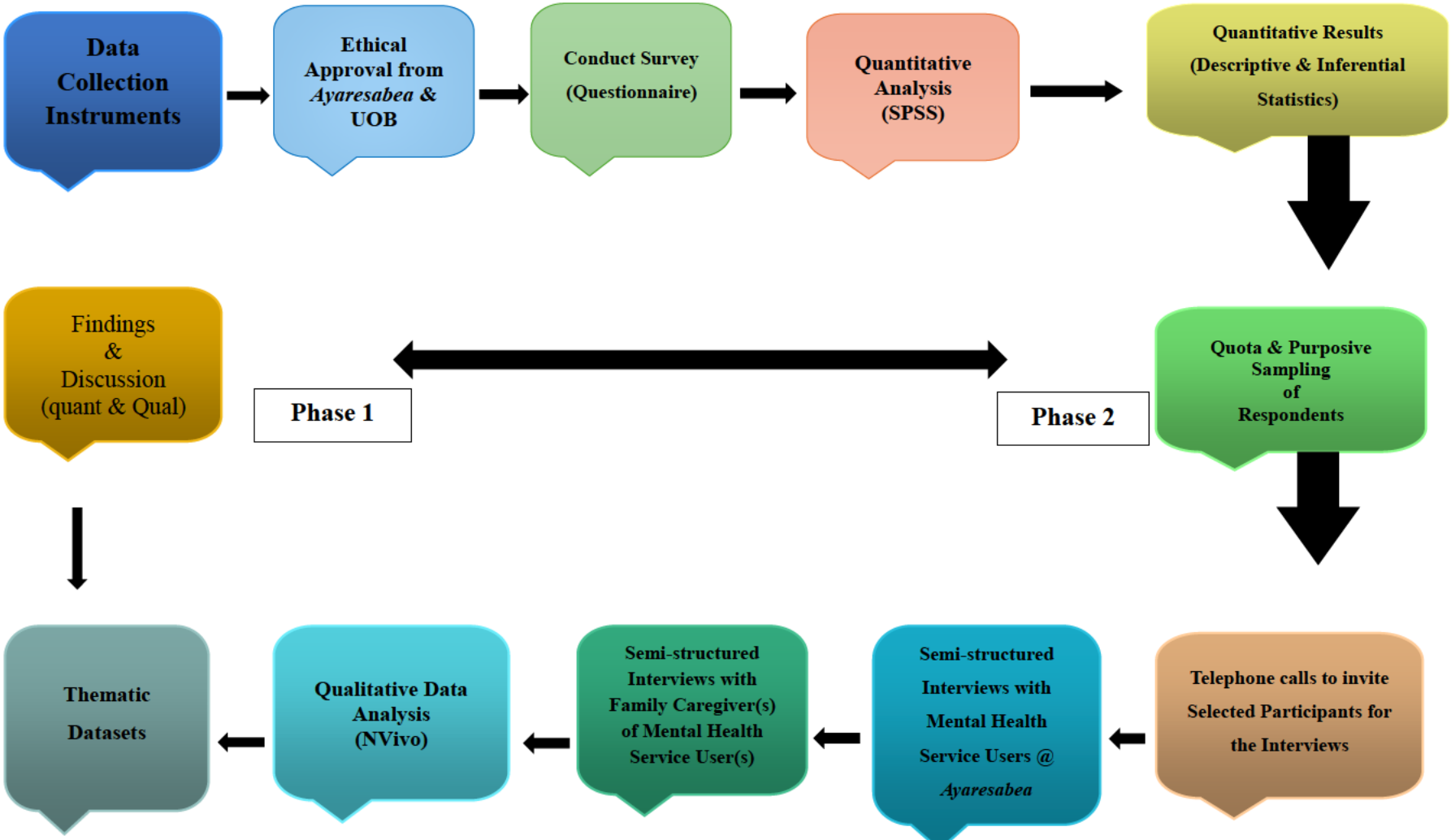
Ten face-to-face interviews (adhering to COVID-19 protocols) were conducted sequentially for MHSUs and their FCs at *Ayaresabea*'s conference room to ensure privacy and avoid third-party

interferences. Consent for interviews to be audio-recorded was obtained in writing and verbally. Each participant was given GH₵ 80 / £8.00 as incentives (for food and transportation) for participating in the study. A copy of the signed and dated interview consent form was provided to each participant, and the original was retained securely on file.

Nonetheless, two interviews were conducted via telephone solely for two FCs in the low social support category who consistently could not honour the agreed interview dates (*see* Table 5). Consent to participate and be audio-recorded was obtained verbally, and their incentives were sent via mobile money. A portion of their audio-recorder interviews, which provided consent to participate and outlined the duration for data withdrawal, was sent to them electronically and retained electronically in accordance with the University of Birmingham (UOB) ethics guidelines and data management plan. Participants were given five weeks from the time of the interviews to declare their wish to have all or part of their data withdrawn.

Each interview lasted 80 minutes on average. The interview series has opened several connections for the researcher to receive immense support and interest from most of the study's participants. The entire data collection procedure is depicted in the diagram below (*see* Figure 8)

Figure 8: Data Collection Processes



Source: *Researcher's Construct (Fieldwork, September 2021- February 2022*

5.7. Ethical Considerations

The research was ethically approved and conducted in accordance with the guidelines of *Ayaresabea* and UOB's Humanities and Social Science Ethics Committee (HASSEC) (https://intranet.birmingham.ac.uk/finance/rss/ethics-and-governance/research-ethics/index.aspx), in conjunction with the Government of Ghana's COVID-19 protocols, in September 2021.

Before completing these ethics applications, all ethical considerations and data collection instruments were developed and discussed with the researcher's thesis supervisors and gatekeepers. The ethics approval for the fieldwork took a dual approach: *Ayaresabea*'s approved ethics application (June 2021) was used to apply for UOB's ethics (August 2021). Regarding *Ayaresabea*'s ethics application, the researcher paid $100.00, and that of UOB was free. Upon approval, the researcher obtained introductory letters from the School of Social Policy & Society and the Department of Social Work and Social Care, UOB, to the study's gatekeepers to formalise the research process (*see* Appendices I & J).

The study's ethical practice was guided by the Belmont Report (National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research (NCPHSBBR), 1979) and the World Medical Association's (WMA) Declaration of Helsinki (2013) frameworks. These frameworks provided internationally recognised principles of *respect for persons*, *beneficence*, and *justice*, as well as standards for voluntary, *informed consent*, which were applied sensitively to the Ghanaian cultural and caregiving context to ensure relevance and appropriateness.

Participants were fully informed about the purpose, scope, and voluntary nature of the study. No participants explicitly declined to take part. This can be explained by the recruitment process, in which gatekeepers (mental health professionals) introduced the study and approached individuals already

considered eligible and interested. As trusted intermediaries, gatekeepers created an environment of established trust, which reduced the likelihood of refusals. Participants were nevertheless provided with information sheets, verbal explanations, and assurances that participation was voluntary, and withdrawal was possible at any stage. The absence of decliners, therefore, reflects the cultural and relational context of recruitment rather than coercion. At the same time, the reliance on gatekeepers may have influenced willingness to decline and should be acknowledged as a methodological consideration when interpreting the findings.

Because the MHSUs were accessed through *Ayaresabea*, their wellness to participate in the study was risk-assessed through discussions with the medical staff assigned to the study as enumerators. Additionally, a thorough explanation was provided to each participant regarding the ethical issue of voluntary participation. Participants may feel that they should participate in the research once they have given their consent. However, the researcher reminded participants of their right to withdraw from the study at any time during data collection and highlighted this in the information sheets (*see* Appendices A). In line with this, each participant could refuse to participate (without giving any reasons) at any point without consequences from *Ayaresabea*. Participants were to do so within five weeks after each data collection. The completed consent forms were stored in a locked filing cabinet at the Department of Social Work and Social Care at UOB and were destroyed when no longer needed.

Verbal or written informed consent was obtained from all participants before their involvement. *Ayaresabea*'s medical staff (mental health professionals assigned to the study as enumerators) were asked to witness all verbal consents given by participants. Similarly, participants who could not read or write were assisted in completing the questionnaires (surveys) upon their full consent. Participants were allowed to skip questions they deemed personal and inappropriate based on their own intuition.

All measures were undertaken to ensure data protection. Participants' identities, including names and contact numbers, remained confidential throughout the research process to protect their privacy. However, these details were not anonymous to the researcher and the study's assigned medical staff. Pseudonyms were used to code participants' names, people or places that could be traced to them and for easy identification, analysis and reporting of findings. Additionally, their contact details (names and telephone numbers) were compiled and stored separately on a master sheet, secured on the UOB storage platform (OneDrive & Bear Research Data Store). These files were destroyed along with the consent forms when they were no longer needed. Hence, no recognisable personal data were included in the write-up without participants' consent or with their permission, even if they are identifiable. As additional safeguards to ensure participant anonymity, they and the hospital have been assigned pseudonyms, and all details related to the service agency and the study location have been removed.

Furthermore, participants were assured that their data would be stored securely at UOB for a minimum period of Ten years, as per the provisions of the Data Protection Act 1998. Participants' information was accessed only by authorised personnel involved in the project (UOB's supervisors) for audit purposes. In this regard, the SPSS files (questionnaires) and anonymised transcripts were transferred to a secure BEAR Archive platform for future use. The original audio recordings are securely destroyed after the degree is awarded. However, participants were later provided transcripts for discussion, review and amendments (member-checking) upon request (*see* Appendices A). No request was received from participants after the duration of this provision had expired.

Due to the study's sensitive nature, there was a risk that the researcher's questions might upset or emotionally distress participants when discussing a challenging time or experience in their lives. Whenever they felt this way, the process was halted entirely and only resumed if they wanted to. In line

with participants' approval, medical staff (Doctors or Nurses) on duty at the clinic were asked to join the session. The researcher observed two MHSUs becoming agitated during the data collection process. The process was immediately halted, and the researcher did not ask these MHSUs any more questions. In line with participants' wishes, the researcher destroyed the information they had already shared. As a partial response to this study's duty of care responsibility, the researcher checked in with participants the following day(s)/after the research interviews and contacted *Ayaresabea* twice to offer medical and emotional support to these participants, where necessary. Some of the participants' discussions were emotionally upsetting for the researcher, requiring her to seek additional support from thesis supervisors who sign-posted her to use the wellbeing services available at UoB and *Ayaresabea*.

Concerning the management of COVID-19 risk in Ghana, where the fieldwork took place, the country was not under lockdown (September 2021). The researcher carefully monitored and adhered to all directives from UOB and the Ghanaian government regarding policies on social distancing and regional lockdowns. During the fieldwork, the researcher ensured that all COVID-19 protocols and *Ayaresabea's* policies and procedures were followed to keep the researchers and participants safe. The researcher also provided participants with hand sanitisers and nose masks and ensured these were used throughout the data collection process. Also, interviews through WhatsApp video/audio calls were adopted (twice) as a backup plan for non-face-to-face data collection (*see* Table 5 & Section 5.6.3.2). Medical staff at *Ayaresabea* assisted in coordinating these WhatsApp video and audio calls, with the full consent of the participants. The researcher consulted with the thesis supervisors to discuss any critical developments that arose during the fieldwork.

Ten participants involved in the interview phases were also offered COVID-19 kits, plus transportation costs, to recognise their time in the study (*see* Section 5.6.3.2). This amounted to GH₵ 80

/ £8.00 per participant. An encrypted link to the study's fieldwork write-up was provided to *Ayaresabea* as per their ethics application guidelines. A copy of the thesis and any resulting research publications is provided upon the participants' request.

5.8. Data Analytical Approaches

The findings and analysis of the study are discussed in two distinct Chapters (Chapters Seven & Eight). Chapter Seven presents the results and discussions based on the quantitative data. The subsequent Chapter provides a thematic analysis and interpretation of qualitative data.

5.8.1. Quantitative Data Analysis and Presentations of Results.

- Descriptive and Nonparametric Inferential Data Analysis using SPSS, version 26.0.

In fulfilment of this study's quantitative phase, frequency tables, a histogram, and a scatter plot diagram were constructed to summarise, organise, and discuss the results and findings from the survey data (*see* Chapter Seven). In addition, a nonparametric inferential statistical analytical approach, namely the Chi-square test for association and Spearman's rank correlation, was employed to identify the relationships, patterns, and associations in the study's variables, considering that Likert data are ordinal, discrete, and have a limited range (Bryman, 2016; Creswell, 2014; Daniel, 2011; Greener, 2011; Miller and Brewer, 2003; Frost, 2020a; Rose and Sullivan, 1996). Thus, this nonparametric correlation analysis is not intended to identify cause and effect or provide information about causal relationships, but rather to determine the association, relationship, or pattern between the variables. There is no intention to characterise one variable as dependent and the other as independent, which requires a specific research design, such as experimental and quasi-experimental research designs with larger sample sizes (Tsoukas,

2009; Krejcie and Morgan, 1970). Adopting this quantitative analytical approach aims to achieve the sample's representativeness of the target population.

As Cowan (1998) rightly asserts, correlation does not equal causation. Confounding variables cannot be controlled or determined in a nonparametric data set (categorical variables/ordinal data). Therefore, the relationships identified using Spearman's rank order correlation should be interpreted for what they are: associations, not causal relationships. The correlation coefficients do not indicate whether one variable moves in response to another (*i.e.*, linear relationships). These psychometric properties of nonparametric data sets violate the assumptions of most parametric tests (Agresti and Finlay, 2013; Frost, 2024).

Considering that the study's data set is *not normally distributed*, a nonparametric inferential statistical test was employed to ensure that the study's quantitative research methods were appropriate, the results were accurate, the conclusions were valid, and to show how the study's variables are related and likely to be present in the broader population. Given the study's sample size and the use of a Likert scale questionnaire, comprehending the distribution of the quantitative data was essential. This understanding helped avoid the application of inappropriate statistical tests that could lead to inaccurate conclusions (Frost, 2020b). Consequently, a normality test was performed to confirm that the sample results accurately represent the overall data set and facilitate more informed decisions during the quantitative inferential data analysis phase, in line with Creswell's (2014) explanatory mixed-methods design participant selection model. The quantitative data analysis process is summarised in the following steps:

1. Each questionnaire was given a numerical code.
2. Responses to the questionnaires were entered into the SPSS software.
3. The data was cleaned manually, and its distribution was identified following a normality test.

4. A descriptive and nonparametric inferential analysis was run to produce output data.

5. The output data was transferred to Microsoft Word for data presentation and further analysis.

5.8.2. Qualitative Data Analysis

- Thematic Analysis

The qualitative datasets were analysed thematically, following Braun and Clarke's (2006) procedure (*see* Figure 9). The thematic analysis involves identifying, classifying, and reporting common patterns of ideas within the datasets (Boyatzis, 1998; Nowell *et al.*, 2017; Terry *et al.*, 2017; Maguire and Delahunt, 2017). This type of qualitative analysis is well-suited for this study because it enables the derivation of core ideas (themes) from the experiences shared by participants.

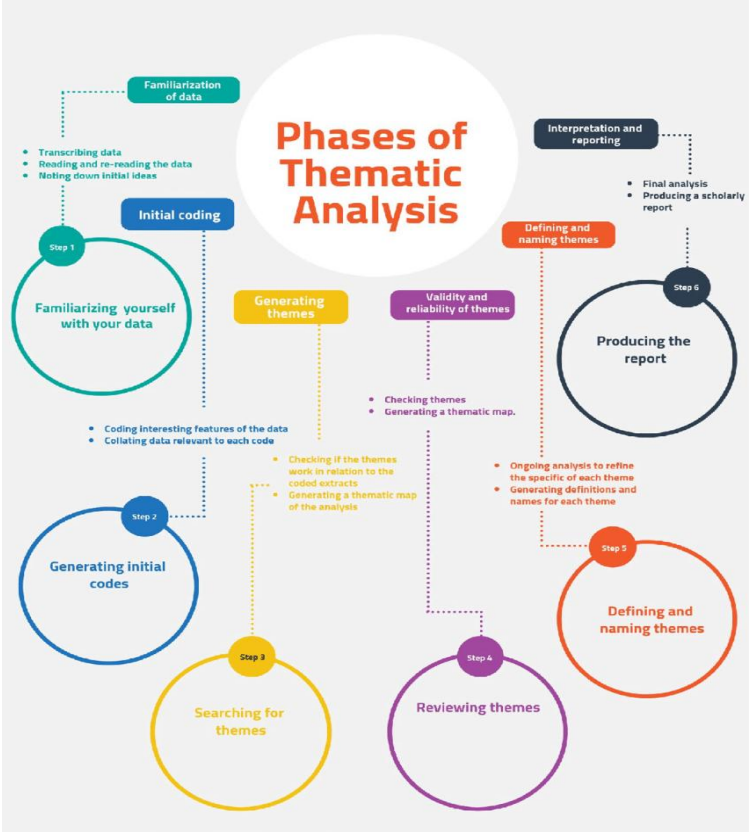
In conducting the thematic analysis, the recorded audio interviews were transcribed verbatim (cleaning the data) to help understand the specific meaning of participants' narratives in a readable format. By cleaning the data, the researcher gained insight into how participants used limited Twi language and diction to express their perspectives on mental illness recovery, family caregiving, and roles and interactions in the recovery journey. The researcher continued to familiarise with the datasets by reading them several times (data immersion) to develop initial ideas (open coding) through a pencil-and-sheet procedure. This way, initial ideas were discerned from the transcripts based on their common appearance in the data related to participants' self-reported experiences. The initial ideas were discussed with the researcher's supervisors to ensure accuracy.

These ideas were then grouped into codes and transferred to NVivo data management software to develop main themes/sub-themes and collate excerpts (quotations from the transcripts). This approach is more manageable than manual data management, considering the enormous amount of data obtained from MHSUs and their FCs. These excerpts were provided to participants (upon request) to verify

whether the assigned meanings and descriptions aligned with their experiences. This process, O'Brien *et al.* (2014) term as member checking. No significant changes were made to these excerpts, and the researcher used them to produce the final description of findings, representing the common essence of participants' experiences (*see* Chapter Eight).

On a methodological level, the analysis process was not aimed at constructing themes through a process of generalisation, but rather at understanding the dynamic of the sense-making process. The study's thematic approach is illustrated in Figure 9 below, adapted from Sendze (2019), which is derived from Braun and Clarke (2006), to depict the intricate and iterative processes involved in qualitative data analysis.

Figure 9: Illustrates the Study's Thematic Analysis Approach for Developing Themes.



Source: *Sendze (2019)'s Adaptation of* ***Braun and Clarke's (2006)*** *Thematic Analytical Process.*

5.9. Summary

This Chapter has thoroughly discussed the study's methodological choices using Saunders, Lewis and Thornhill's (2019) research onion. It has proven to be a helpful tool for progressing the study sequentially and steadily, coordinating the flow of processes, and considering the study's mixed-method approach to data collection in line with Creswell's (2014) explanatory mixed-method design-participant selection model.

Reflections about the research ethics/risks, strategies and techniques, and data analytical approaches adopted were also explored to understand the researcher's considerations and choices made throughout the research process (a key feature of a pragmatic philosophical framework). These methodological approaches were adopted to increase the extent to which the study's findings could be generalised. While it must be acknowledged that the study's mixed-methods approach has certain limitations (*e.g.*, cost and time), it enabled the collection of rich data from participants from diverse geographical areas (urban and rural) attending clinical reviews at *Ayaresabea*.

The next chapter presents fieldwork reflexivity. It is pertinent to discuss fieldwork experiences in addressing the dearth of literature on fieldwork lessons drawn from mixed-method data collection with MHSUs and their FCs, especially from the Global South.

CHAPTER SIX

FIELDWORK EXPERIENCES

6.0. Introduction

Chapter Six provides a reflective account of fieldwork experiences (data collection) with MHSUs and their FCs. It is based on a mixed-methods research design, incorporating both a survey and semi-structured interviews (*see* Chapter Five). Chapter Six begins by laying out the situational factors and actions taken by the researcher to ensure the success of data collection. This includes how the researcher negotiated access to the research site, as well as the gatekeepers and the recruitment of MHSUs and their FCs (respondents/participants). It further examines the complexities of handling mixed-methods data collection with MHSUs and their FCs, as well as the ethical issues and challenges associated with this approach. The final part concludes with the researcher's views on exiting the field and afterwards. This Chapter, therefore, focuses on reporting selective fieldwork experiences regarding MHSUs and their FCs' participation in this study's exploration of family systems and support towards mental illness recovery.

6.1. Fieldwork Situational Issues and Actions for Recruiting Study Participants

Gathering data from MHSUs and their FCs presents a multifaceted challenge, but ultimately a fulfilling endeavour. It necessitates that researchers approach ethical dilemmas, emotional nuances, sensitivities, and practical barriers with care and self-awareness (Gary, 2013). The researcher learned that utilising insights from literature and personal experience, and embracing a person-focused, inclusive, flexible, and adaptable data collection approach, enhances the richness of the data while respecting the dignity and independence of all participants. By cultivating trust and cooperation, the researcher can guarantee that the perspectives of MHSUs and FCs significantly influence the progress of mental health research in Ghana.

Nevertheless, MHSUs' factors, including their poor mental health phases, lack of insight, or verbal ability, can hinder effective data collection. Reflections from researchers in this field revealed that data regarding MHSUs' expressed views of mental illness symptoms, support, and treatment needs in the recovery journey are often incomplete or inaccurate (*e.g.*, Kirwan, 2017; 2020; Beresford, 2007; 2012; Read and Doku, 2012; Murphy *et al*., 2015; Street and Millay, 2001). To ensure this does not occur in this study, the researcher formed partnerships by consulting *Ayaresabea's* medical staff and other peer researchers, and piloting the study to inform and shape the data collection instruments (see Appendices A, C, F, & G). This approach yielded 140 participants for the survey phase, from which a quota sample of 12 participants was selected for the interview phase, in line with the research design employed in this study (*see* Chapter Five).

The researcher employed the following strategies during the fieldwork to ensure rigour and reliability in the data collection phases:

a. Credibility: Member checking and prolonged engagement with participants to ensure that findings accurately represent their experiences.
b. Dependability: Maintaining a detailed audit trail documenting research decisions and processes to allow replication or evaluation by others.
c. Confirmability: Minimising researcher bias through reflexivity, peer debriefing, and transparent documentation of survey data, interview phases and analysis.
d. Transferability: Providing rich contextual descriptions to help readers assess applicability to other settings.
e. Data saturation: Collecting data until no new themes emerge, ensuring comprehensive coverage of participants' experiences.

These strategies not only empowered the researcher but also enhanced the authenticity of the findings, reflecting the value of rigour and shared ownership in research (Lincoln and Guba, 1985; Bryman, 2016).

The stories shared by participants in this study revealed the frequently uncomfortable contrast between their perceptions of reality concerning their experiences of mental distress and the influential framework of professional diagnosis and the health-seeking actions and interactions of close (nuclear) and wider (extended) family members in their recovery journey. Listening to participants' stories highlights the importance of empathy, inclusivity, and reflexivity, which ensures that the data collection process respects participants' rights and wellbeing. This experience reinforced the importance of trauma-informed approaches, which emphasise sensitivity to participants' past experiences and current needs. Literature supports this, noting that researchers should anticipate emotional risks and provide appropriate support, such as signposting participants to relevant mental health services (Brewin, 2020).

Reflexivity was critical in understanding how the researcher's perspectives and assumptions may influence the research process. During the interview phase, it was realised that the phrasing of a question unintentionally reflected a clinical perspective, potentially limiting the participant's response. Adjusting this approach of questioning to align with the participant's lived experience not only enriched the data but also highlighted the value of self-awareness in research. Documenting such moments in a reflective journal helped analyse the researcher's positionality and critically adjust adopted methods. Reflexivity, as emphasised by Finlay (2002), is a dynamic process that enhances both the researcher's understanding and the authenticity of the findings. Reflecting on the study's methodological choices, the data collection strategies adopted (*see* Chapter Five) included transparency and gatekeepers, which fostered trust and encouraged participants to share openly, emphasising the importance of ethical rigour in building relationships.

MHSUs often come from vulnerable populations who may have experienced stigma, discrimination and trauma. Researchers must prioritise informed consent, ensuring participants fully understand the study's purpose, risks, and benefits. Obtaining consent was an ongoing dialogue between the researcher and participants rather than a one-time event, particularly in mental health contexts where conditions may fluctuate. This resulted in the absence of recorded decliners, which raises questions about the authenticity of voluntary participation. Although participants were provided with detailed information and reassured that their decision would not affect their care, some voiced concerns that refusing might jeopardise their medical treatment or family support (*see* Chapter Five). This highlights how cultural expectations, dependency on healthcare providers, and family hierarchies may have subtly constrained participants' freedom to refuse. Recognising this, future studies in similar contexts could adopt strategies such as recruiting through neutral facilitators not directly associated with clinical staff, offering private or anonymous refusal options, and engaging in community sensitisation to reinforce the right to decline without consequence. Such measures would help strengthen ethical safeguards and ensure that informed consent is not only obtained but genuinely exercised.

The study's mixed-method data collection approach (*see* Chapter Five) was employed to strike a balance between obtaining valid data and minimising potential distress. While structured tools, such as questionnaires, can ensure consistency, qualitative approaches, like interviews, provide richer insights into personal experiences (Braun and Clarke, 2013; 2016). Although this data collection approach allowed flexibility and depth, it was observed that specific questions on family interactions and agency triggered emotional responses for which the researcher provided emotional support (signposting to medical staff assigned to the study) and reaffirmed participants' right to withdraw an approach aligned with trauma-informed research principles (Brewin, 2020). The regular

check-ins ensured participants remained comfortable and engaged throughout the data collection process.

A notable difficulty during the fieldwork was balancing the responsibilities of being both a researcher and a compassionate listener. While striving for objectivity, ignoring the emotional weight of participants' stories became impossible. This experience underscored the importance of debriefing with colleagues and seeking supervision and guidance to navigate these issues. On the other hand, this approach also offered opportunities to learn about resilience and the diverse ways participants navigate mental health challenges and recovery journeys. These insights were invaluable for the researcher's growth and understanding of mental health care in Ghana.

6.1.1. Negotiating Access

Negotiating access is an iterative and incremental process that occurs from the beginning until exiting the field and sometimes beyond, as rapport with gatekeepers needs to be maintained for a lifetime (Gummesson, 2000; Okumus, Altinay, and Roper, 2007; Marshall and Rossman, 2016). Success in obtaining traditional access for the fieldwork, including physical, continuing, and cognitive levels of access, results from multiple factors, including MHSUs' involvement in several research activities over the years, researcher's cultural background, knowledge of local context and issues, and the cognitive benefits of years of fieldwork experience as a social worker. Similarly, the researcher's role as an internal (local) or participant researcher determined the extent to which the feasibility and sufficiency of the fieldwork could be achieved. These factors altogether facilitated access, trust, and cooperation with participants.

Gaining access requires deep contextual and local knowledge about combining formal and informal networks and processes (Jauregui, 2016; Porta and Keating, 2008). Building rapport can sometimes manifest in a kind of negotiation that resembles the art of seeking access without faking

friendship (Duncombe and Jessop, 2002). Rapport is thus needed to create appropriate trust between *Ayaresabea's* staff, the researcher and the study's participants. For instance, in negotiating access to the research site, it became evident that there were subtle elements of reciprocity and trust in seeking access. Previous experience as a social work intern established the researcher as an "insider", potentially affecting how staff and participants engaged with the research. While this familiarity encouraged trust and openness, it also carried the risk of creating expectations of loyalty, blurring professional boundaries, or exerting subtle pressure to participate in specific ways.

This circumstance reflects broader discussions within the methodological literature on insider/outsider research. Existing scholarship highlights that insider status can strengthen rapport and contextual understanding, but it also raises concerns regarding bias and boundary management (Mercer, 2007; Asselin, 2003). In this case, the researcher's position can be described as an example of dual positionality (Dwyer and Buckle, 2009), situated simultaneously as an insider through prior placement and relationships and as an outsider through the independent status of a doctoral researcher. Such a dual identity required a reflexive approach to ensure that the benefits of insider familiarity did not compromise ethical safeguards or neutrality.

Strategies to mitigate these risks included adherence to established ethical protocols, securing independent institutional approvals, and maintaining a reflexive diary to document potential biases and decisions during fieldwork. This approach aligns with Finlay's (2002) assertion that reflexivity is essential for ensuring ethical rigour in empirical research, as it demands critical attention to how positionality shapes access, recruitment, and interpretation. In balancing the practical advantages of insider access with the responsibility to uphold autonomy, consent, and impartiality, the study demonstrated the value of sustained reflexivity in ethically complex research contexts. Several discussions were held via emails and WhatsApp with the medical and non-medical staff of *Ayaresabea* (gatekeepers), considering the study's methodology and ethics. This proved helpful in

designing the data collection instruments and completing *Ayaresabea*'s ethics application. The researcher obtained introductory letters from the School of Social Policy & Society and the Department of Social Work and Social Care, UOB, to the study's gatekeepers to formalise the research process (*see* Appendices I & J).

There is also the issue of who introduces the researcher to participants. This seemingly insignificant observation can have a potentially debilitating effect on access. Gatekeepers are required to facilitate potential participants' smooth access and cooperation (Given, 2008; Farrimond, 2013). Without the gatekeepers' support and approval, fieldwork at *Ayaresabea* could be jeopardised. For instance, they could suggest to participants not to cooperate with the researcher, and their influence can carry weight. Some participants even inquired whether the approval of *Ayaresabea* had been obtained before approaching them. Thus, initial permission from the medical staff helped facilitate access to the participants. Initial contact with MHSUs and their FCs was at the OPD/waiting room. The researcher was introduced (verbally) by the assigned medical staff (a nurse and a doctor) to MHSUs and their FCs, patiently waiting to be seen. MHSUs who showed interest and voluntarily declared their participation were chaperoned to *Ayaresabea's* conference room to be screened and complete the survey (Phase 1). This ensured their privacy and managed COVID-19 risks.

Saunders, Lewis and Thornhill (2019) provide helpful information on the types, levels and issues of negotiating traditional access. These researchers argue that the interview site has a telling effect on participants' responses, with homes being more likely to disrupt the power dynamics between researchers and participants. Holding interviews in the conference room not only establishes a sense of equilibrium among MHSUs, FCs and the researcher but also diminishes the fear of losing familial support. This setting fosters an atmosphere of trust and safety, encouraging MHSUs to candidly share their concerns about the support they receive and the role of family involvement in their recovery journey. Knowing that their openness will not compromise familial support allows

MHSUs to engage more genuinely in discussions, fostering a collaborative environment essential for healing and growth.

Interactions with *Ayaresabea's* Ethics Department confirmed that all research could be conducted in safe spaces/conference rooms (designated for data collection) to promote adherence to ethical principles and avoid insurance issues for a non-clinical research study. Without this, all researchers cannot be allowed access to participants (*see* Appendices G). The study's sensitivity and the vulnerability of participants (due to their mental capacity) further warrant using a designated room for research to ensure privacy and confidentiality (Elwood and Martin, 2000; Simons and Usher, 2000). Given that the study aims include exploring the interpersonal relationships between MHSUs and their FCs and their impact (positive/negative) on their recovery journey, it was best to interact with each participant independently. This measure ensured that MHSUs did not lose any assistance/help from their family members or further worsen any relationship between them (McDowell, 2001; Sin, 2003).

Having demonstrated above how traditional access (physical access, gatekeepers and access to participants) was negotiated, it is now necessary to describe in greater detail the course of actions and observations throughout the interactions with MHSUs and their FCs as participants/respondents in this study.

6.1.2. Collecting Data

Field notes are essential for documenting fieldwork experiences and promoting reflexivity (Creswell, 2013; Reeves, 2010; Nadin and Cassell, 2006; May and Perry, 2011). However, mental notes and mental 'videos' were the most effective means of keeping records in this context. Such encounters provided an excellent opportunity to observe and understand the views of different participants, including their focus, posture, requests for breaks when questions seemed sensitive,

mannerisms, voice pitch and tone, and body language (Bryman, 2016). These observations were recorded in a diary at the end of each day, discussing how meetings were scheduled (either in person or over the phone), potential problem areas, and new approaches to take. It includes the recruitment process (how possible participants were identified), nonverbal cues, remarks from the medical professionals assigned to the study, expectations following the conclusion of the interviews or surveys, and schedules for the days ahead (fieldwork activities). All of these provided valuable insights into the research process, including research reflexivity and discussion of results and findings.

Each survey or interview began with a researcher's introduction and a request for participants' verbal and written agreement. The request for consent was based on Western ideals and principles, so the researcher wasn't sure if all the participants understood and valued it. This reignites an old debate about 'consent' in non-Western societies, which have different socio-legal and cultural philosophies. A flexible data collection instrument (user-friendly) was employed because flexibility is vital in research with vulnerable populations (*see* Appendices A-F). Bryman (2001, pp. 487) suggests that 'flexibility in such areas as varying the order of the questions, following leads, and clearing up inconsistencies in answers' is essential to successful data collection. During the interview phase, probing and paraphrasing techniques were employed to enable participants to describe their experiences in depth. For instance, there were times when participants took a long detour and spoke at length about issues unrelated to the study, which sometimes served as a form of therapeutic effect or catharsis for these participants. Under such situations, the participants controlled the interview's focus, priority, and trajectory. At times, the researcher did not interrupt participants but listened to them all the way through and gradually brought them back to answer key questions, without being insensitive to their immediate concerns and the primary focus of attention. These diversions provided

valuable insights, although they disrupted the day's schedule. With time, planned interviews were spaced adequately to accommodate such contingencies.

6.1.3. Researcher Positionality

Experience in the fieldwork shows that how a gatekeeper is perceived in the research site, particularly by potential participants, may sometimes facilitate or inhibit access to the research process. Similarly, the reputation of the gatekeepers who introduce a researcher may affect how the researcher is perceived. According to Saunders, Lewis, and Thornhill (2019), researchers may carry some of the benefits and liabilities of participants and gatekeepers, at least initially, during the fieldwork process. Thus, a researcher's already existing subjective identities interact with newly ascribed perceptions in the field. For instance, some participants may see a researcher as privileged and ignorant about reality. This view may precipitate and create visible and invisible tensions, such as how FCs perceived and responded to the researchers' presence and lines of inquiry, together with many others. Such issues can affect access and time spent in the field.

Consequently, the shifting subjective identities in the field affect the positionality of a researcher, which has implications for access (Bolderston, 2016). Therefore, it is up to the researcher to be mindful of such shifting identities among different people and, where necessary, respond, repackage, and realign one's identity and association. From experiences of using social work interviewing skills (empathy, patience, compassion, active listening, tone control, questions' sensitivity), the reputation of the gatekeepers and researcher (social worker) might, in some instances, significantly affect how the gates of communication are either opened or shut and for how long. For example, constantly conscious of being wrongly tagged, misconceptions at the onset and offset of each interview session were resolved. When participants did not respond to the initial invitation, the researcher shared their contact information with the medical staff responsible for follow-up calls. Some participants perceived that non-cooperation might jeopardise their access to services at

Ayaresabea, raising concerns that their engagement in the study may have been influenced by pressure rather than free choice. This underscores the importance of safeguarding consent integrity, understood here as ensuring that participants' decisions to engage are fully voluntary, informed, and free from perceived coercion, so that their participation does not compromise their rights or wellbeing.

Furthermore, the researcher was mindful of the possible challenges one could face in *Ayaresabea* and how to tactfully (re)negotiate and craft positionalities in the course of the fieldwork (Merriam *et al*., 2001; Stone, 2003). The reason was that the researcher's gender and educational status would not be inhibitive. Herein 'to craft positionalities', the researcher does not mean 'deceive or not to deceive' (Saunders, Lewis and Thornhill, 2019, pp. 5) but rather how researchers could (re)package themselves in response to wrong notions within ethically appropriate boundaries. Without faking friendship, the craft of identity performance presents significant ethical dilemmas. For example, the researcher was mindful of patriarchal norms and decided to use deference in interactions with male and/or older participants. According to Jourdan, Durand, and Thornton (2017), deference is a strategic behaviour aimed at establishing and maintaining relationships with others who are reluctant to do so. Specifically, deference seeks to 'convince the recipient that the message sender is yielding, appeasing and honouring the recipient's position in the rank order' (Fragale *et al*., 2012, pp. 374).

Although the researcher is a PhD student, she also had multiple identities, which came with some expectations, values, and norms. Does it mean that once researcher(s) are in the field, other identities (female, age, human, social worker) and values become irrelevant and non-existent? If so, what does that portray for rapport, reflexivity, and future cooperation? Will a researcher be seen as insensitive and self-centred, only interested in data collection? Should a researcher numb their locally/culturally acquired conscience to observe the situated meaning of a phenomenon? – struggled

with these dilemmas. Perhaps being a Ghanaian researcher reduces expectations, invoking the debate about the benefits and drawbacks of being either a local researcher or a foreign researcher.

Additionally, the researcher took the stance from the beginning not to provide information that the participants did not need while still being careful not to withhold crucial information on the research and positionality. To help participants feel at ease, comfortable and settled, the researcher frequently used the local language and name (*Mayakua*: names in Ghana denote the day of birth, tribe and ethnic group to which a person belongs). As a result, participants appeared pleasant and welcoming throughout the data collection process. Contrary to other studies (Arendell, 1997), the researcher did not find any observable traits that suggest that the researcher's status as a PhD student from the UK (*abrokyere*) or as a young, educated and middle-class woman was a barrier to reaching out to MHSUs and their families. There was no display of intermediary behaviours, such as participants becoming overly friendly or shy. Participants warmly welcomed and engaged in lively conversations. Participants and the researcher could dissent in instances where they had different views on the matter—indicating some level of agency and self-confidence, which generally challenges the old orthodox that the researcher (almost invariably) holds more power over participants and could likely exploit them due to their vulnerabilities (Vähäsantanen and Saarinen, 2013; Brinkmann and Kvale, 2015; Kvale, 2006; 2007). For instance, in the OPD/waiting room, participants were the first to approach the researcher and were eager to declare their interest. When the researcher had not yet attended to them, participants expressed their dissatisfaction.

It is equally important to stress that how good or bad an individual's reputation is conceived and articulated is context-specific (Mann, 2016). Fieldwork experiences demonstrate that awareness of people's reputations can help researchers position themselves to utilise the social capital, networks, and other benefits that strategic association with gatekeepers offers (Saunders, Lewis, and Thornhill, 2019). At the same time, an appreciation of the likely effect of a gatekeeper's reputation can help

researchers avoid nasty tags that may ruin the chances of getting access to potential participants and, by extension, rich data.

Some FCs regarded consultations with different religious/traditional leaders as vital in making informed decisions on critical personal and sensitive issues to avoid stigmatisation. Religious and spiritual activities in Ghana are often seen as essential to their overall wellbeing. Therefore, prospective researchers need to be aware of traditional/religion's role in fieldwork in specific contexts. Similarly, FCs in the *low category* (interview Phase II) consistently rescheduled the agreed appointment because they had to attend church, family and work engagements. Sometimes, the researcher had already travelled to the *Ayaresabea* to wait for them. They did not show up or hardly called to reschedule the appointment. Some also reported late, which has become a widely known norm as 'Ghana man time'. Most people in Ghana tend not to report on time for events based on their own personal reasons. From experience, one needs much flexibility in the schedule for this kind of fieldwork because disruptions and unexpected opportunities often occur, requiring corresponding changes in etiquette and ethics. Therefore, researchers must be sensitive and adjust ethical principles and protocols accordingly. In this case, such sensitivities went a long way in building excellent rapport. It partly indicated to the participants that the researcher was not self-centred and just interested in the data but cared about them as well.

The study's objectives were to explore how interpersonal relationships, family support and the subjective experiences of MHSUs and their FCs in the recovery journey. Participants (especially FCs in the *high* and *moderate* categories) seemingly had their own views about the confines of the discussions and what could and could not be discussed. The participants' expectations were not always in sync with the objectives. Therefore, as the interviews unfolded, the researcher exercised a great deal of flexibility with time, the focus of the discussion, and time spent on specific issues as well as 'tangential' matters. Sticking strictly to the interview guide and being mindful of planned

schedules would have meant insensitivity and selfishness. It would also have prevented the researcher from making unexpected findings through occasional long diversionary discussions.

6.1.3.1. Dealing with Ethical Dilemmas

Ethical issues constantly arise at different phases in most social science research, including data collection in the field, analysis and dissemination of quantitative and qualitative reports (Creswell, 2013). These ethical issues cannot be predicted (Palmer *et al*., 2014), and 'in real-world research, ethics are not fixed' (Armstrong, Gelsthorpe and Crewe, 2014, pp. 1). Based on lessons from the field, the researcher essentially shares the views of De Laine (2000, pp. 29) that 'researchers should seek ways to move beyond harm minimisation as a standard for ethical research and recognise an obligation to design and conduct research projects that aim to bring about reciprocal benefits'. Also, adhering to ethical research practice is an ongoing process with 'iterative models of consent' (Mackenzie, McDowell and Pittaway, 2007, pp. 307). It has been argued that ethical standards should go beyond rule-based approaches and instead give more experienced researchers some space to make appropriate decisions on unpredictable ethical matters to become ethical thinkers or virtuous investigators (Downes, Kelly and Westmarland, 2014).

Beyond this, ethical issues that arise also tend to vary depending on the kind of study, location, and culture, among others – in other words, its holistic context. Nevertheless, what may be seen as sensitive questions or topics by a researcher and *Ayaresabea*'s medical staff and Ethics Department may not always be regarded in that light by some participants. Such realities challenge the underlying principles, purpose, and philosophies of most prescriptive ethical guidelines and requirements, which in turn question their relevance in the field. Moreover, the researcher learned that making mistakes, poor judgements, and other embarrassing episodes are all part of the learning curve.

6.2. Fieldwork Challenges

Fieldwork presents unexpected opportunities, confusion, and challenges, each of which calls for the right ethical decisions. As Buchanan, Boddy and McCalman (2013, pp. 53–54) write:

> Fieldwork is permeated by the conflict between what is theoretically desirable on the one hand and what is practically possible on the other. It is desirable to ensure representativeness in the sample, uniformity of interview procedures, and adequate data collection across the range of topics to be explored… Nevertheless, the members of organisations block access to information and constrain the time allowed for interviews... The possible always wins in the conflict between the desirable and the probable.

This quotation reveals how negotiating access is unlikely to be straightforward, requiring persistence and emotional resilience (Peticca-Harris, deGama and Elias, 2016). However, the researcher could anticipate and hopefully overcome problems during fieldwork with careful planning.

6.2.1. Excessive Bureaucracy

It is worth noting that being aware of the power constellations at *Ayaresabea* can help progress the study. However, the process of ethics approval is not straightforward (McAreavey and Muir, 2011; Greene, 2014; Yacob-Haliso, 2019; Sowatey *et al*., 2021). Firstly, all research must be registered online and then wait for approval within three months. The final stage is paying the ethics cost to obtain a registration certificate (*see* Appendices G) and formally notifying the security department about the study's schedule. Unfortunately, the researcher was not aware of key decision-makers in the security department, leading to potential challenges during data collection. To enhance future research endeavours, it would be beneficial for researchers to receive comprehensive briefings on these key figures, ideally during initial discussions.

6.2.2. *Ayaresabe's* Security/Police Interruption

Upon the usual security checks in the wards, the security guards chanced on the information sheet left behind by some participants. They were directed to the researcher for interrogation concerning the authorisation of the study and demanded the immediate end of the survey. Their demeanour was very unpleasant, and their mood and tone were authoritative and argumentative. The researcher's phone, survey documents, and audio recorder were seized right in front of participants and amid the crowded reception area, resulting in a bit of commotion. The medical staff assigned to the study intervened but to no resolution. The researcher presented all documentation to the security men, who seemed unsatisfied. The security men presumed the researcher was a news reporter or a spy (speaking aside in the Twi language). It took the intervention of the head of the medical staff to calm the tempest down. This commotion lasted more than 30 minutes. The head of securities claimed researcher(s) should always seek further permission from them for security reasons.

This incident would not have occurred in the first place if *Ayaresabea's* Ethics Department had indicated security registration as a requirement in the guidelines for all researchers to follow. The mental health facility itself is not aware of such security policies. In truth, such visits did not only create 'ethically important moments' (Guillemin and Gillam, 2004, pp. 265) but also engendered confidentially sensitive moments. People, better still, gatekeepers, can feel disrespected if they are not consulted. In most cases, there are different constituents in a research site, and a researcher can pretend to be oblivious to these divisions or hide under the cloak of being a naive external (foreign) researcher who is unaware of these divisions and makes amends when attention is drawn to them. In other words, being a foreign researcher offers some respite for making some mistakes and provides a defence mechanism to deploy within ethically appropriate contexts. However, this is not an honest way to handle mistakes. For example, reconciling with faction A (who may have felt disrespected for not being consulted at the inception) may make faction B (participants) distrust the researcher. As a

result, when mistakes are made, lessons must be learned. As in the case illustrated above, the researcher looked out for signs of error over time and found ways to adapt and remedy wrongs. The researcher visited *Ayaresabea's* security office, presented an official letter, and completed some paperwork before beginning the second phase (interviews). Indeed, fieldwork can be complex and thus demands experience, diplomacy, and tact.

6.2.3. Language/Translation Issues

Ghana is a West African country with over 80 ethnic groups, each speaking its own language (Dakubu, 2015). Akan is most extensively spoken in three dialects (Asante Twi, Fante, and Akuapem Twi), the most popular of which is Asante Twi, which nearly everyone speaks in Ghana. With English as Ghana's official language, organisations such as the health system publish health information in English, and services are frequently offered orally in the local language. This might be because a higher percentage of the population uses their mother tongue in everyday life, or it could be because the cultural milieu is defined as one that relies heavily on oral communication.

Data collection was primarily conducted in the Twi language, while a few participants tended to mix both the English and Twi languages (*see* Chapter Five). Participants' Twi language expressions were very descriptive, which helped them recount a scene or event that had occurred. However, finding its exact meaning in the English language could be challenging. Words such as health and wellbeing were quite tricky to translate because the same word normally refers to them in the study context: "*apomoden*", "*ahoto)"*- comfort/ wellbeing, "*ayaresa*" -healing/recovery. Besides, participants' choice of words may appear to be derogatory. For example, mental health persons translate as "*abodamfo)"* meaning mad persons. Researchers in the process of translating participants' accounts could focus on the semantical meaning, not just its literal meaning. Several researchers (*e.g.*, Boateng *et al*., 2020; Chen and Boore, 2009; Chidlow, Plakoyiannaki, Welch, 2014; Dzokoto, 2010; Dzokoto, Opare-Henaku and Kpobi, 2013; Dzokoto *et al*., 2018; Gobo, 2011) have discussed the

limitations of using the English language to describe healthcare processes in the native language of MHSUs. This may lead to misinterpretation or misrepresentation of participants' accounts (Steyaert and Janssens, 2013; Müller, 2007). Foreign researchers conducting studies with participants in such contexts (especially without a mastery of the local languages) can hire professional translators.

6.3. Exiting the Field

How a researcher exits the field is a crucial part of fieldwork and holds several implications, including ethics, analysis, validation, and future studies. Ironically, not enough attention is given to this area. Even the few studies that share insightful fieldwork experiences do not adequately cover this. During the fieldwork, new acquaintances were formed, and personal and touching stories were heard. Some of these revelations were not directly connected to the study. However, the researcher had to listen and, in some cases, sympathise. Some participants expressed that they considered the researcher a new friend they could turn to for advice in areas where help was needed, such as their children's education. The researcher felt honoured and had a sense of duty to those participants who sought to keep this friendship.

In keeping with the cultural context, the researcher sometimes sends them text/WhatsApp messages or phones them just to say hello and check on them. Even months after the fieldwork, these occasional calls or text messages to participants are usually appreciated and perceived as an expression of interest in their lives. By default, the researcher has subsequently learned more about participants during such 'post' fieldwork engagements, making these experiences an integral part of the knowledge acquisition process. This represents a significant difference between an external researcher who interviews and leaves the research site and a participant researcher or an internal researcher who has further opportunities to return. This is not to suggest that all external researchers abandon their participants or that all internal researchers are willing or able to return to research sites. Moreover, in an era of social media and various communication channels, the influence of distance

is somewhat reduced, providing additional opportunities for researchers to maintain professional contact with participants. Nevertheless, the difference in the exit experiences of external/participant researchers and the ethical issues it invokes must be examined in more detail.

Based on prior fieldwork experience, it was anticipated that ethical issues would emerge at the point of exiting the field, particularly a sense of obligation towards participants. Many individuals shared stories of extreme hardship, including the loss of life savings or the sale of family property to cover the cost of medical treatment. Others spoke of being unable to afford medication, provide three meals a day, or secure employment, while some families described being trapped in debt after taking loans they could not repay.

In most instances, the researcher could only express sympathy. At times, this created a moral tension, particularly after hearing moving accounts, around the possibility of making promises of financial assistance that could not realistically be honoured. For example, several weeks after data collection had ended, some participants contacted the researcher in the UK, requesting money for treatment or daily needs. During these encounters, participants were gently reminded that the purpose of the study was to explore their experiences and perspectives, rather than to provide financial or material support. Offering this clarification was not always easy, as it often followed the sharing of difficult and moving personal stories, and the researcher felt a strong emotional pull to respond more directly by providing financial help. Nonetheless, the researcher recognised that offering false assurances or commitments would be unsustainable. Ultimately, the decision was taken not to do so. It was therefore decided that maintaining honesty, however uncomfortable it may be in the moment, was ethically essential. Misleading participants could not only damage their trust in this project but also create negative consequences for future researchers, since participants might perceive all researchers as part of the same community.

Foreign researchers may share similar views, but for local researchers, seeing participants daily at *Ayaresabea* creates a different kind of post-fieldwork feeling of obligation. This becomes more likely when a researcher becomes aware of or shares some challenges facing participants. During this fieldwork, the researcher sometimes felt uneasy that participants might feel exploited when their calls went unanswered at awkward times. Participants had personal tasks to accomplish when they offered the researcher an interview opportunity. Participants sacrificed their time and knowledge to tell personal stories. *Does the researcher owe them some ethical obligations in return*? The ethical challenge, therefore, lay in balancing compassion with professional responsibility.

Boundaries were drawn by limiting direct support to actions that were feasible and sustainable. This included maintaining respectful relationships after data collection, following up with some participants to clarify transcription issues, and signposting them to resources available through the Ghana Mental Health Authority. In certain cases, the researcher also shared information on educational and career opportunities that could benefit participants or their families. These actions were intended as ethically appropriate ways of "giving back" that avoided creating dependency or making promises that could not be fulfilled. By adopting this approach, participants were engaged not as research subjects but as people deserving of respect, reciprocity, and honesty beyond the immediate boundaries of the study.

This approach is consistent with widely recognised ethical principles in research. By resisting the temptation to promise financial assistance, the researcher upheld the principle of non-maleficence, ensuring that participants were not harmed through the creation of false expectations (Beauchamp and Childress, 2013). The decision also reflected the importance of avoiding undue inducement, as highlighted in research ethics guidance such as the ESRC Framework for Research Ethics (2021), which cautions against offers that may compromise the voluntariness of consent. At the same time, the choice to provide limited but meaningful support through signposting and information-sharing

reflected a commitment to reciprocity, acknowledging participants' contributions without creating dependency (Ellis, 2007). Taken together, these actions illustrate how ethical boundaries were drawn in ways that balanced compassion with professional responsibility, while also safeguarding trust in future research.

A summary of the fieldwork report was provided to Ayaresabea in accordance with their ethical guidelines for concluding data collection. The researcher then sent thank-you messages to participants via text/WhatsApp and also sent thank-you cards to gatekeepers. Remuneration was paid to the medical staff involved in the study, along with the electricity charges for using the conference room during data collection. To conclude this section, it is important to note that the rules governing a local researcher's departure from the field differ significantly from those for a foreign researcher in certain aspects. Some leave with a psychological burden, as accurately described by Dickson-Swift *et al*. (2007, pp. 328), who state, 'researchers undertaking quantitative and/or qualitative research on sensitive topics need to be able to assess the impact of the research on both the participants and themselves'. How do researchers view the individuals they interview, assuming that the nature of the interview and the disclosures made will not affect future interactions, discussions, and expectations? As an African proverb says, *a leopard cannot change its spots*. Any researcher, whether foreign or local, cannot entirely shed their native identities and adopt a completely new persona as a researcher disconnected from their previous self.

6.4. Summary

This Chapter has explored fieldwork experiences with MHSUs and their FCs in Ghana. It detailed fieldwork situational issues by examining the complexities of negotiating access and researcher positionality, as well as the strategies employed in mixed-method data collection. Fieldwork within the social sciences constitutes a rite of passage and an exercise that bestows

authority and legitimacy on academics. For researchers interested in fieldwork in Ghana or Africa, challenges in the field can be more complicated and pronounced.

While fieldwork can be fraught with difficulties, it presents opportunities to extend the frontiers of knowledge. The researcher, as the principal investigator, originated from Ghana and possessed social and capital qualities prior to the study. These qualities were leveraged in addition to the participants' cooperation and willingness, resulting in what the researcher described as 'successful fieldwork'. The experiences shared in the field could benefit others both theoretically and practically in appreciating the multifaceted connection between family caregiving, support for MHSUs, and interpersonal relationships that facilitate or hinder recovery. The following Chapters (Seven, Eight, and Nine) analyse, discuss, and synthesise the survey results and findings from the semi-structured interviews conducted during the fieldwork.

CHAPTER SEVEN

PRESENTATION OF QUANTITATIVE DATA & DISCUSSION OF RESULTS

7.0. Introduction

This chapter presents the quantitative phase of the study, conducted in accordance with Creswell's (2014) Explanatory Sequential Mixed-Methods Design – Participant-Selection Model, which was applied to MHSUs and informed the subsequent selection of their FCs. The quantitative phase served a dual purpose: first, to generate an empirical understanding of perceived family support and its relationship to recovery-related indicators; and second, to produce the data-informed quota categories that structured participant selection for the qualitative phase. In fulfilling both roles, the quantitative analysis made an independent empirical contribution while also providing the methodological and conceptual foundation for the mixed-methods integration.

The analysis examined the distribution and patterns of perceived family support, as measured by the modified SPS-10, revealing significant variations that informed the three analytically derived categories of *low*, *moderate*, and *high* support. These categories captured meaningful differences in the relational quality and intensity of family involvement in recovery, thereby offering a rigorous framework for exploring these dynamics in greater depth during the qualitative phase. The dataset was managed using SPSS (version 26.0), with findings presented through frequency tables and a scatter plot to test additional constructs introduced in the modified SPS-10. Reliability analyses and non-parametric tests were employed to assess internal consistency, correlations, and proportional differences across key socio-demographic and caregiving variables, demonstrating patterns consistent with and extant literature on family caregiving and social support.

The chapter is organised into four main sections. The first two present descriptive statistics and associations between variables, while the third examines the modified SPS-10 results, capturing the scope and nature of family support and its contribution to recovery. The final section reports the

levels of family support that underpinned the quota sample (*see* Table 19 and Figure 11), providing the pragmatic basis for the non-proportional quota framework. A histogram complements this table, illustrating both the distribution pattern of SPS-10 scores and the practical and analytic cut-offs that informed the three support categories, as explained in Chapter Five.

Together, these quantitative findings demonstrate that the phase contributed not merely as a preparatory step but as an essential empirical component of the study. The results illuminate the statistical landscape of family support in mental illness recovery and directly inform the purposive design of the qualitative phase. Collectively, they establish a transparent methodological and theoretical bridge between the quantitative survey analysis and the in-depth qualitative exploration of recovery experiences presented in Chapter Eight, which are further interpreted and synthesised in Chapter Nine.

7.1. Quantitative Data Results

7.1.1. Socio-Demographic Characteristics of MHSUs (Respondents).

This section discusses the socio-demographic details of respondents involved in the quantitative phase of the study. It includes details such as *gender*, *age*, *education*, *marital status*, *employment status* and *place of residence*. These details are analysed using basic descriptive statistics to represent the distribution in the study's sample (Respondents, n = 140). Table 6 provides an overview of the socio-demographic profile of MHSUs.

Table 6: Socio-Demographic Profile of MHSUs (Respondents)

Variable (s)	Frequency n =140	Percentage (%)
Gender		
Male	66	47.10
Female	74	52.90

Age (years)		
18-25	14	10.00
26-35	50	35.70
36-45	40	28.60
46+ years	36	25.70
Education status		
Primary	12	8.6
Junior	42	30
Senior	46	32.90
Tertiary	40	28.60
Marital status		
Married	35	25.00
Divorced	12	8.60
Never married	84	60.0
Separated	5	3.60
Widowed	4	2.90
Religious status		
Christian	126	90.00
Muslim	11	7.90
Traditionalist	1	0.70
Others	2	1.40
Employment status		
Formal employment	29	20.70
Self-employed	36	25.70
Unemployed	75	53.60
Place of residence		
Urban	87	62.14
Rural	49	35.00
Other parts of Ghana	4	2.86

NB: The extracted socio-demographic details were assigned numerical codes and entered into the Statistical Package for Social Sciences (SPSS version 26.0) to compute frequencies and percentages. Considering that the survey data set is non-parametric, all independent variables were treated as categorical variables for convenience and to make it more manageable to analyse.

Source: ***Researcher's Construct (Fieldwork, September 2021- February 2022).***

7.1.1.1. *Gender*

Respondents' preferred sex identity was coded as 1"male" and 2 "female". The sample comprised 66 (47.10%) male and 74 (52.90%) female respondents. It can be seen from the data in Table 6 that females reported significantly (5.80%) more than male respondents. This assertion corroborates several empirical studies reporting on the trends and gender differences of MHSUs and

their health-seeking behaviours (*e.g.*, Zhang *et al*., 2015; Lindinger, 2014; Sagar *et al*., 2019; Farkas *et al.*, 2005; Sipsma *et al*., 2013; Tansella *et al*., 1998; Kim and Kim, 2017; Asafo, 2021; Ofori-Atta *et al*., 2010). This hypothesis, in conjunction with other relevant socio-demographic variables that precipitate mental health issues, is tested in this study (*see* Section 7.2). A more detailed bivariate gender analysis is presented in Section 7.3.3.4 (*see* Table 18).

7.1.1.2. *Age*

Usually, a *continuous variable* was measured as a categorical variable (ordinal), as were the rest of our socio-demographic variables. It was coded as 1 "18-25 years", 2 "26-35 years", 3 "36-45 years", 4 "46+ years". In the data sample, the highest age was 65, and the lowest was 18. 10.00% (14) of the sample are in the range of 18- 25 years, 35.71% (50) are between 26-35 years, 28.57% (40) are between 36-45 years, and 25.71% (36) are 46 years and above. It can be inferred from the data that most respondents (90.00%) in this study were between 26 and 65 years old. These results are similar to empirical statistical data on Ghana's socio-demographic profiles of MHSUs (*e.g.*, Sipsma *et al*., 2013), indicating that most MHSUs are within the youthful age bracket.

7.1.1.3. *Education status*

Respondents' *educational status* was coded as follows: 1 for "Primary school", 2 for "Junior high school", 3 for "Senior high school", and 4 for "Tertiary". The resulting data show that 8.57% have attended Primary school, 30.00% have attended Junior high school, 32.86% have attended Senior high school, and 28.57% have pursued Tertiary education. This indicates that MHSUs' have attained some level of education but may have dropped out, discontinued or failed to progress to a higher educational level due to the severity of symptoms, economic challenges, stigma and lack of educational resources to support their learning and vocation, as Daliri *et al*. (2024) found in their study.

7.1.1.4. *Marital status*

This variable was coded as 1, 2, 3, 4 & 5 for variables indicating whether the respondent is "married", "divorced", "never married", "separated", and "widowed", respectively. From Table 6, 25.00% (35) were married, 8.60% (12) divorced, 60.00% (84) never married, 3.60% (5) separated, and 2.90% (4) widowed. Therefore, it can be deduced from the data that more respondents (105/75.00%) were single (divorced, never married, separated, or widowed) than their married counterparts (35/25.00%). Data show that MHSUs are likely never to marry or remain single for the rest of their lives, corroborating Sipsma *et al*.'s (2013) national-level study findings that 63% of MHSUs were single.

7.1.1.5. *Religious status*

Respondents' affiliation to a religious group was measured by a question that asked respondents, "*Which religion did they belong to"?* Where 1 was coded as "*Christian*", 2 "*Muslim*", 3 "*Traditionalist*", 4 "*Other*". From the data (Table 6), there were more Christians (126) than the other religious associations reported by respondents. This indicates that the respondents in this study were predominantly Christian (90.00%). Christianity and other religious bodies have been cited in numerous Ghanaian literatures concerning the health-seeking behaviours and treatment of MHSUs as the source of hope and faith for a cure, providing meaning to MHSUs' predicaments and the means to their coping capacity and resilience throughout the recovery journey. It is, without doubt, the reason for the numerous religious and traditional healing centres across Ghana (Ae-Ngibise *et al*., 2010; Mensah, 2021; Read and Doku, 2012; Osei, Asare and Roberts, 2021b; Bartlett, 2016).

7.1.1.6. *Employment status*

MHSUs' economic engagement was measured with the question "*what is your current employment status*?", where "formal *employment*" was coded as 1, "self-employed" 2 and "*unemployed*" coded as 3". 29 (20.70%) respondents reported that they were in formal employment,

36 (25.70%) were self-employed, 75 (53.60%) were unemployed. It could be inferred that there were more unemployed respondents (53.60%) than those who were in some kind of employment (*formal* or *self-employment*). This result is not surprising as the Ghanaian socio-economic context is known for its hostility to MHSUs. Several Ghanaian researchers (*e.g.*, Tawiah, Adongo, and Aikins, 2015; Dadson, Annor, and Yendork, 2018; Kyei *et al.*, 2014; Opoku-Boateng *et al*., 2017) have noted that MHSUs face secondary stigmatisation, resulting in a loss of economic opportunities for them. They are less likely to be hired into formal employment, and any self-employment enterprise they engage in may not be widely patronised or economically viable. Additionally, the government has created fewer avenues for employment or vocational training to facilitate their inclusion in nation-building (Mensah, 2021; Read *et al.*, 2023; Daliri *et al.*, 2024; Yaro, Teg-Nefaah, and Asampong, 2025). It is not surprising that most Ghanaian MHSUs live impoverished lifestyles due to their socio-economic difficulties in their recovery journey.

7.1.1.7. *Place of residence*

This variable was surveyed with three items, where 1 was coded and relabelled as "*Urban Areas*", 2 as "*Rural Areas"*, and 3 as "*Other parts of Ghana*". The respondents' place of residence has been relabelled for ethical reasons, as discussed in Chapter Five. From Table 6 above, 62.10% of respondents lived in urban areas, 35.00% lived in rural areas, and 2.90% lived in other parts of Ghana. The data shows that most respondents (97.10%) were from urban and rural areas compared to other parts of Ghana. Respondents from rural areas were 27.10% less than those from urban areas. These findings confirm Sipsma *et al*.'s (2013) national-level study, which found that one-third of MHSUs reside in urban areas with FCs, and most of them have unstable housing arrangements (Ofosu-Oti *et al.,* 2025; Dzator, 2013). Opoku-Boateng *et al*. (2017) found that due to stigma by association, most landlords or rental companies in urban areas of Ghana are less likely to approve leasing an apartment

to MHSUs and their families; this may compel MHSUs and their families to relocate to rural areas to settle with extended family members in their traditional family homes (*abusufie*).

Having discussed the variables constituting the socio-demographics of respondents, the subsequent section analyses associations to determine any statistical significance. *Gender, age, marital status, religion, education* and *employment* have been consistently cited in the literature as factors determining the mental health of MHSUs (*e.g.*, Amu *et al*., 2021; Sipsma *et al*., 2013; Gureje *et al*., 2006; Ovuga, Boardman and Wasserman, 2005; Aidoo and Harpham, 2001; Nair and Pillay, 1997; Rosenfield and Smith, 2012; Kessler *et al.*, 1992; Damodaran and Paul, 2016; Abel and Newbigging, 2018). These factors were examined in the study's survey data, as shown in Table 7.

7.2. Chi-square test of Independence or Association and Effect Size.

7.2.1. Chi-square test of association of respondents' socio-demographics.

The Chi-square statistical test for independence was employed to analyse associations of respondents' socio-demographics and to identify their significant statistics @ 95% confidence interval under the following null and alternative hypotheses, H_0 and H_1:

H_0: Independent (no association)
H_1: Not independent (association)

The Chi-square test of independence or association identifies whether the proportions of one variable (either nominal/or categorical) are different for different values of the other variable in large data sets ($N \geq 100$) (McDonald, 2014; Bewick, Cheek and Ball, 2004). Table 7 below presents the results of these associations. It was revealed that gender, age, marital status, education, and employment were statistically significant, with $p < 0.05$ @ 95% confidence interval, whereas the religious status of MHSUs turned out to be statistically insignificant. What is interesting about the data in this table is that variables with $p < 0.001$* and $p < 0.05$ show that the null hypothesis (H_0) was rejected in favour of the alternative hypothesis (H_1), indicating a significant association between the variables.

Table 7: Chi-Square Statistical Test Matrix on Respondents' Socio-Demographics

Socio-demographic of respondents	*Gender*	*Age*	*Education*	*Religion*	*Marital Status*	*Employment*	*Place of residence*
Gender	-						
Age	0.723	-					
Education	0.334	0.210	-				
Religion	0.676	0.502	0.103	-			
Marital status	0.001*	0.001*	0.477	0.238	-		
Employment	0.008*	0.001*	0.006*	0.103	0.373	-	
Place of Residence	0.344	0.644	0.795	0.378	0.225	0.121	-

NB: Significant statistics = p<0.001*, p<0.05 @ 95%, * indicates that the categorical variables are not independent (there is an association between the variables).

Source: Researcher's Construct (Fieldwork, September 2021- February 2022).

7.2.2. Effect Size

In identifying the effect size of the positive statistical association between *gender, age, marital status, education and employment*, the two SPSS functions employed in the study were Pearson Chi-Square denoted as (x^2) or $^{(a)}$ when N (sample size) > 20, but expected cell count is 0, or greater is < than 20% of cells and Likelihood ratio denoted as $^{(R)}$ when N > 20, but expected cell count is 1, or

greater is > than 20% of cells. In principle, McHugh (2013) and Cohen (1988) propose that the measurement of effect size/magnitude (Φ/φ or Φc/φc) between two or more categorical variables is interpreted as ≤ 0.10 = small effect, ≥ 0.30 < 50 = moderate or medium effect, and large effect ≥ 0.50. However, Agresti (2007) suggests that Φ/φ or Φc/φc may be viewed as the association between variables in the form of a percentage of their maximum possible variation. The different effect sizes for these tested variables are highlighted in Tables 8, 9, 10, 11 & 12 crosstabulations.

Table 8: Gender * Employment Crosstabulation

Employment Status	Gender		Total	Pearson Chi-Square Value[(a)]
	Male % (n)	*Female* % (n)	% (n)	*P-value** Cramer's $V(\varphi_c)$
Formal Employment	30.3% (20)	12.2% (9)	20.7% (29)	9.738[a]
Self-employed	28.8% (19)	23.0% (17)	25.7% (36)	0.008*
Unemployed	40.9% (27)	64.9% (48)	53.6% (75)	*0.264(φ_c)*

a. **0 cells (.0%) have an expected count of less than 5. The minimum expected count is 13.67.**

Significant Statistics = p<0.001/p<0.05* @ 95% Confidence Interval, [a] = *Pearson Chi-Square Value* (N > 20, but expected cell counts is 0 or greater is < than 20% of cells), Cramer's $V(\varphi_c)$= Effect size.

(x^2 =9.738[a] , *df* = 2, *p* = 0.008, which is < 0.05) $\varphi_{c=}$ 0.264/26.40%

Source: Researcher's Construct (Fieldwork, September 2021- February 2022).

Table 9: Gender * Marital Status Crosstabulation

Marital Status	Gender		Total	Likelihood Ratio$^{(R)}$
	Male	*Female*		*P-value**
	% (n)	% (n)	% (n)	Cramer's $V(\varphi_c)$
Married	16.70% (11)	32.40% (24)	25.0% (35)	19.310
Divorced	9.10% (6)	8.10% (6)	8.60% (12)	
Single	74.20% (49)	47.30% (35)	60.0% (84)	0.001*
Separated	0.00% (0)	6.80% (5)	3.60% (5)	
Widowed	0.00 % (0)	5.40% (4)	2.90% (4)	*0.335(φ_c)*

a. **4 cells (40.0%) have an expected count of less than 5. The minimum expected count is 1.89.**

b. **The standardised statistic is -.767.**

Significant statistics = p<0.001/p<0.05* @ 95% Confidence Interval, $^{(R)}$= Likelihood Ratio (N > 20, but expected cell counts is 1 or greater is > than 20% of cells), Cramer's $V(\varphi_c)$= Effect size.

Source: Researcher's Construct (Fieldwork, September 2021- February 2022)

Table 10: Age of respondents * Marital Status Crosstabulation

Age of respondents	Marital Status					Total	Likelihood Ratio$^{(R)}$
	Married	*Divorced*	*Single*	*Separated*	*Widowed*	% (n)	*P-value**
	% (n)	% (n)	% (n)	% (n)	% (n)		Cramer's $V(\varphi_c)$
18-25 years	2.90% (1)	0.00% (0)	15.50% (13)	00.00% (0)	00.00% (0)	10.00% (14)	34.270
26-35 years	22.90% (8)	25.00% (3)	45.20% (38)	00.00% (0)	25.00% (1)	35.70% (50)	
36-45 years	31.40% (11)	41.70% (5)	26.20% (22)	40.00% (2)	00.00% (0)	28.60% (40)	0.001*
46+ years	42.90% (15)	33.30% (4)	13.10% (11)	60.00% (3)	75.00% (3)	25.70% (36)	*0.269 (φ_c)*

a. 13 cells (65.0%) have an expected count of less than 5. The minimum expected count is .40.

b. The standardised statistic is -2.171.

Significant Statistics = p<0.001/ p<0.05* @ 95% Confidence Interval, $^{(R)}$= Likelihood Ratio (N > 20, but expected cell counts is 1 or greater is > than 20% of cells), Cramer's $V(\varphi_c)$= Effect size.

Source: Researcher's Construct (Fieldwork, September 2021- February 2022).

Table 11: Age of respondents * Employment status Crosstabulation

Employment status	Age of Respondents				Total	Pearson Chi-Square Value[(a)]
	18-25 years % (n)	*26-35 years* % (n)	*36-45 years* % (n)	*46+ years* % (n)	% (n)	*P-value** Cramer's $V(\varphi_c)$
Formal employment	0.00% (0)	28.00% (14)	17.50% (7)	22.20% (8)	20.70% (29)	21.505[a]
Self-employed	7.10% (1)	12.00% (6)	42.50% (17)	33.30% (12)	25.70% (36)	.001*
Unemployed	92.90% (13)	60.00% (30)	40.00% (16)	44.40% (16)	53.60% (75)	$0.277_{(\varphi_c)}$

a. **2 cells (16.7%) have an expected count of less than 5. The minimum expected count is 2.90.**

b. **The standardised statistic is -2.221.**

Significant Statistics = p<0.001/ p<0.05* @ 95% Confidence Interval, ([a]) = Pearson Chi-Square (N > 20, but expected cell counts is 0 or greater is < than 20% of cells), Cramer's $V(\varphi_c)$= Effect size.

($x^2 = 21.505^a$, $df = 6$, $p = 0.001$, which is < 0.05) $\varphi_{c=}$ 0.277/27.7%

Source: Researcher's Construct (Fieldwork, September 2021- February 2022).

Table 12: Level of Education * Employment Status Crosstabulation

Employment Status	Level of Education				Total	Pearson Chi-Square Value[(a)] *P-value** Cramer's $V(\varphi_c)$
	Primary % (n)	*Junior High School* % (n)	*Senior High School* % (n)	*Tertiary* % (n)	% (n)	
Formal employment	0.00% (0)	7.10% (3)	30.40% (14)	30.00% (12)	20.70% (29)	17.895[a]
Self-employed	50.00% (6)	35.70% (15)	21.70% (10)	12.50% (5)	25.70% (36)	0.006*
Unemployed	50.00% (6)	57.10% (24)	47.80% (22)	57.50% (23)	53.60% (75)	*0.253(φ_c)*

a. **2 cells (16.7%) have an expected count of less than 5. The minimum expected count is 2.90.**

b. **The standardised statistic is -2.221.**

Significant Statistics = p<0.001/ p<0.05* @ 95% Confidence Interval, ([a]) = Pearson Chi-Square (N > 20, but expected cell counts is 0 or greater is < than 20% of cells), Cramer's $V(\varphi_c)$ = Effect size.

(x^2 =17.895[a], df = 6, p = 0.006, which is < 0.05) φ_c= 0.253/25.30%

Source: Researcher's Construct (Fieldwork, September 2021- February 2022).

Closer inspection of the tables above shows that there are moderate or medium positive significant effects between the variables at varying standard deviations *(df)*: $\varphi_{c=}$ 33.5% @ 1 *df*, 26.4% @ 2 *df*, 27.7% @ 6 *df*, 26.9% @ 1 *df* and 25.3% @ 6 *df*. The effect sizes for the tested variables were statistically significant @ 95% Confidence Interval. This provides strong evidence of the association of the variables, confirming the rejection of the H_0 hypothesis. This implies that there is a positive statistical association between *gender, age, marital status, education and employment* in conformation of empirical studies identifying precipitating factors for mental health (Sipsma *et al*., 2013; Gureje *et al*., 2006; Ovuga, Boardman and Wasserman, 2005; Aidoo and Harpham, 2001; Nair and Pillay, 1997; Rosenfield and Smith, 2012; Kessler *et al.*, 1992; Damodaran and Paul, 2016; Abel and Newbigging, 2018; Wilson and Somhlaba, 2018).

So far, the sections above have presented and discussed the findings of MHSUs' socio-demographic results in relation to the reviewed literature. It is now necessary to examine the measure for support (using the modified SPS-10) received by MHSUs from their FC in the recovery journey.

7.3. Presentation of the Social Provision Scale (SPS-10) Results and Hypothesis Testing

7.3.1. Social Provision Scale (SPS-10) Results

The SPS-10 was employed to assess the degree to which MHSUs perceive their family relationships as yielding various dimensions of social support during their recovery journey. As previously covered extensively in Chapters Four and Five, SPS-10 is based on the social provisions theory put forward by Weiss (1974). A content modification of the scale was made to suit the study's context, and its reliability was assessed. In addition to the scale, two new constructs were self-developed (*see* Chapter Five) to measure the importance of family in respondents' day-to-day lives and any perceived feelings of shame due to respondents' mental illness, further exploring Research

Question One. For convenience in managing the analysis in SPSS version 26.0, the two new constructs have been labelled as *"family involvement"* and *"stigmatisation,"* respectively.

The modified SPS-10 and the two new constructs (comprising the survey questions) were presented to respondents to identify those that applied to them on a 4-point Likert scale (*see* Appendices C), with "Strongly Disagree" coded as 1, 2 "Disagree", 3 "Agree" and 4 "Strongly Agree". The new constructs were correlated separately to find any statistical associations. The reliability of the new constructs was not determined as Cronbach's alpha does not provide reliability estimates for individual items. By the end of the survey period, data had been collected from 140 MHSUs. Simple statistical analysis summarises the type of support (social provisions) MHSUs receive from their families (*see* Table 13). Responses to the two new constructs are set out in Table 14.

Table 13: Summary of Respondents' Ratings on the Modified SPS

Social Provisions 10 Scaled items		**Likert Scale**	**Frequency n =140**	**Percentage (%)**
Social Integration (SI)				
Item 1	Within my family, I feel part of a group of people who share my attitudes and beliefs.	*Strongly Disagree*	8	5.70
		Disagree	5	3.60
		Agree	47	33.60
		Strongly Agree	80	57.10
Item 2	Within my family, there are people who enjoy the same social activities I do.	*Strongly Disagree*	9	6.40
		Disagree	9	6.40
		Agree	58	41.40
		Strongly Agree	64	45.70
Attachment (*emotional support*) (AT)				

Item 3 Within my family I feel a strong emotional bond with at least one other person.	*Strongly Disagree*	7	5.00
	Disagree	8	5.70
	Agree	61	43.60
	Strongly Agree	64	45.70
Item 7 Within my family, I have close relationships that provide me with a sense of emotional security and wellbeing.	*Strongly Disagree*	3	2.10
	Disagree	7	5.00
	Agree	55	39.30
	Strongly Agree	75	53.60
Reliable alliance (material support) (REA)			
Item 4 Within my family, I can depend on people to help me if I really need it.	*Strongly Disagree*	3	2.10
	Disagree	10	7.10
	Agree	49	35.00
	Strongly Agree	78	55.70
Item 6 Within my family, there are people I can count on in an emergency for my sustenance.	*Strongly Disagree*	NR	NR
	Disagree	9	6.40
	Agree	49	35.00
	Strongly Agree	82	58.60
Reassurance of worth (RWORTH)			
Item 8 Within my family, I have relationships where my competence and skills are recognised.	*Strongly Disagree*	4	2.90
	Disagree	15	10.70
	Agree	55	39.30
	Strongly Agree	66	47.10
Item 9 Within my family, there are people who admire my talents.	*Strongly Disagree*	4	2.90
	Disagree	12	8.60

	Agree	57	40.70
	Strongly Agree	67	47.90
Guidance (GUIDE)			
Item 5 Within my family, there is someone I could talk to about important decisions in my life.	*Strongly Disagree*	8	5.70
	Disagree	19	13.60
	Agree	56	40.00
	Strongly Agree	57	40.70
Item 10 Within my family, there is a trustworthy person I could turn to for advice if I were having problems.	*Strongly Disagree*	5	3.60
	Disagree	12	8.60
	Agree	54	38.60
	Strongly Agree	69	49.30

Source: Researcher's construct (fieldwork, September 2021- February 2022).

Table 14: Summary of Respondents' Ratings for the New Constructs

Self-developed construct(s)	Likert Scale	Frequency n = 140	Percentage (%)
Stigmatisation			
I feel that members of my family (close or wider) are ashamed of me because of my mental illness.	Strongly Disagree	13	9.30
	Disagree	8	5.70
	Agree	28	20.00
	Strongly Agree	91	65.00
Family Involvement			
Family members (such as parents, grandparents, aunts, uncles, cousins) are really important in my day-to-day life.	Strongly Disagree	15	10.70
	Disagree	24	17.10
	Agree	62	44.30
	Strongly Agree	39	27.90

Source: Researcher's construct (fieldwork, September 2021- February 2022).

The results obtained from the preliminary simple statistical analysis in Tables 13 & 14 indicate that most of the MHSUs surveyed felt that within their family, they receive some type of support (social provision) which is essential in their recovery journey. While a minority of respondents *disagree* or *strongly disagree* with the statements on the SPS-10. When MHSUs were asked about the importance of family in their recovery journey, over 70% reported that family members play a significant role in their day-to-day lives. It can be deduced from the data that most MHSUs perceive that support from family helps them to rebuild their competencies and coping skills, relearn daily living skills, find their place and position in the family and society and validate their identities in making sense of their mental health problems and the recovery journey. These findings corroborate the various empirical studies on families' caregiving roles and support harnessing the recovery journey of MHSUs within their social contexts (*e.g.*, Dadson, Annor and Yendork, 2018; Read, 2013; Read and Nyame, 2019; Opoku-Boateng *et al*., 2017).

Nonetheless, there is considerable evidence from the data that MHSUs experience stigmatisation within their families despite support received from family members. As seen in Table 14 above, 85 % (119) of respondents reported experiencing stigmatisation within their family. The data imply that MHSUs *agree* and *strongly agree* that members of their family (close or wider) were ashamed of them because of their mental illness. 15% of the sample *disagree* and *strongly disagree* with this item on the survey. This result is rather a disappointing outcome as the African communal home is noted as the hub for MHSUs' recovery (Van der Geest, Dapaah and Kwansa, 2019; Akyeampong, 2015; Ukpong, 2006; Mensah, 2021; Chineyemba, 2023). Further analysis of the correlation between *family involvement* and *stigmatisation* is discussed in section 7.3.3.2.

7.3.2. Reliability Statistics

Construct reliability statistics were assessed using SPSS version 26.0 Cronbach's Alpha function using the equation $\alpha = rk / [1 + (k - 1)r]$, α-value is affected by both the scale's total number of items and its mean inter-item correlations, where k represents the number of items considered and r represents the average of those correlations. The results revealed that the modified SPS-10 subscales, with five items (α = 0.821), were found to be reliable and robust. Reliability results are summarised in Table 15 below:

Table 15: Reliability Statistics from SPSS Output

	No. of items	**Mean**	**Variance**	**Standardised Deviation(*df*)**		**No. of Respondent(s)**
Statistics for Scale	5	16.76	6.656	2.580		140
	Mean	**Maximum**	**Minimum**	**Range**	**Max/Min**	**Variance**
Item Means	3.353	3.246	3.482	.236	1.073	.007
Item Variances	.456	.322	.534	.213	1.661	.010
Inter-Item Correlations	.481	.349	.595	.246	1.706	.005
Item Total statistics	**Scale mean if item deleted**	**Scale variance if item deleted**	**Corrected item total correlation**	**Squared multiple correlation**		**Alpha if item deleted**
Social Integration	13.42	4.152	.673	.482		.768
Attachment	13.39	4.575	.655	.457		.777
Reliable Alliance	13.28	5.019	.518	.300		.812
Reassurance of Worth	13.44	4.295	.604	.388		.790
Guidance	13.52	4.210	.637	.408		.780
Reliability Coefficients for items	Alpha (α)			Standardised item alpha		
	0.821			**0.823**		

Source: Researcher's Construct (Fieldwork, September 2021- February 2022).

The reliability statistics were conducted to identify the robustness and trustworthiness of modified SPS-10 items. The overall reliability statistics (α = 0.821) indicate a common degree of shared variance with at least some other items in the instrument (*see* Table 15). It also reflects the extent to which different subsets of items produce similar measures and reports how much the test score depends on the total number of participants in the study, rather than item-specific factors (Gardner, 1995; George and Mallery, 2003). The modified SPS-10 is robust enough that even when any two or three subscales considered difficult for respondents were removed from the scale, the Cronbach's alpha reliability did not drop below the acceptable value of 0.70. Therefore, omitting items on the subscale would not lead to unacceptable α-values.

An inspection of the items included in the survey shows that varied types of family support are being analysed, and also that the scale consists of multiple items to elicit experiences of MHSUs (respondents) about specific concepts of family relationship, support and involvement in their recovery journey (within the perspectives of Weiss's social provisions theory; *see* Chapter 4.3.2). As expected, the inter-item correlation (*see* Table 15) revealed that individual items shared variance with other items when the survey was administered to MHSUs, providing the basis for a high alpha value across the overall instrument. Hence, reporting the items of the scale allows the reader to identify pairs of items that might be expected to elicit similar response patterns to MHSUs' knowledge.

According to Taber (2018), detailing a scale's items and finding its reliability statistics within research reports supports readers in interpreting and evaluating the robustness of those reports. Cronbach's alpha offers an accurate value for reliability by providing a lower bound or suitable proxy for identifying the average degree of interrelatedness of the items provided that there are no negative covariances and there are more than two items in the subscales (Sijtsma, 2009; Schmitt, 1996; Gliem and Gliem, 2003).

7.3.3. Statistical Tests

7.3.3.1. Goodness-of-fit test

Before conducting any statistical tests on a given scale, it is good practice to determine whether the data set is parametric or nonparametric, thereby ascertaining which statistical test method to employ. Data were analysed using SPSS version 26.0 to identify the appropriate test for analysing the respondents' responses to the SPS-10. The goodness-of-fit test was performed to determine whether the modified SPS-10 is parametric or nonparametric (normally or not normally distributed). In addition, the statistical significance of the two self-developed constructs (*family involvement* and *stigmatisation*) was examined.

Considering that the total number of respondents was more than 100 (n = 140), Kolmogorov-Smirnov$^{\alpha}$ and Log_10 goodness-of-fit tests were used to determine the distribution of the data (normality tests) and to identify its statistical significance as well as any relationship between the variables (Sullivan and Artino, 2013; Agresti and Finlay, 2013; Evans, Hastings and Peacock, 2000; Chakravarti, Laha and Roy, 1967; Obumneke, 2021; NIST, 2022). Table 16 below shows that the *p-value* was less than 0.05 ($p < 0.05$), indicating that the data is not normally distributed @ 95% confidence interval.

Table 16: Test for Normality of Data Set

SPS-10 Construct(s)	*Kolmogorov-Smirnov[a] Goodness-of-Fit-Test*			*Log 10 Goodness-of-Fit-Test*		
	Statistic	**N**	**Significance**	**Statistic**	**N**	***Significance***
Social Integration	.196	140	<.001	.282	140	*<.001*
Attachment	.212	140	<.001	.231	140	*<.001*
Reliable Alliance	.269	140	<.001	.255	140	*<.001*
Reassurance of Worth	.224	140	<.001	.261	140	*<.001*
Guidance	.193	140	<.001	.230	140	*<.001*
Stigmatisation	.382	140	<.001	.357	140	*<.001*
Family Involvement	.267	140	<.001	.324	140	*<.001*

a. Lilliefors Significance Correction, p < .001, (p < 0.05), data is not normally distributed, but statistically significant).

Source: Researcher's construct (fieldwork, September 2021- February 2022).

The test results above prove that the data is not normally distributed. Hence, a nonparametric method was a suitable fit for identifying any significant associations, relationships, or patterns within or between the modified SPS-10 and the two self-developed items. Namely, Spearman's rank order correlation and Pearson chi-square test for independence/association using crosstabulations (contingency bivariate tables), as the quantitative data set consists of only categorical variables/ordinal data.

7.3.3.2. Spearman's rank order correlation test for nonparametric data set.

Spearman's rank order correlation (test) measures the strength and direction of a monotonic association/relationship between two variables not normally distributed (Agresti and Finlay, 2013). A sample's Spearman correlation coefficient is usually denoted as $-1 \leq rs \leq 1$. However, SPSS (version 26.00) denotes Spearman's correlation coefficient as *rho*. Spearman's rank-order correlation

test was computed to determine the associations between the types of support experienced by MHSUs within their families. The test investigates whether there is less than a 1% or 5% chance that the strength of the relationship found (r_s /*rho* coefficient) occurred by chance if the null hypothesis were true. The Spearman's correlation coefficients (scores) determine the magnitude of the relationship, and the positive (+) or (–) sign of the correlation coefficient determines the direction of the relationship. By a rule of thumb 0.00-0.19 "very weak", 0.20-0.39 "weak", 0.40-0.59 "moderate", 0.60-0.79 "strong", 0.80-1.0 "very strong" (NIST, 2022).

The results of Spearman's (r_s /*rho*) correlational analysis for the SPS-10 are set out in Table 17 below. A construct measuring family involvement and stigmatisation was included to identify any significant associations. The social provisions explored are associated and statistically significant @ 0.001 or 0.05 confidence level. This implies that these relationships/associations identified confidently exist between MHSUs and their families (target population).

Table 17: Spearman's Correlation Matrix (r_s/*rho*)

Social Integration	1						
Attachment	.607**	1					
Reliable Alliance	.382**	.498**	1				
Reassurance of Worth	.483**	.434**	.368**	1			
Guidance	.398**	.425**	.475**	.431**	1		
Family Involvement	.213*	.162	.304**	.309**	.257**	1	
Stigmatisation	.469**	.367**	.237**	.319**	.150	.210*	1

a. ****. Correlation is significant at the 0.01 level (2-tailed).**

b. ***. Correlation is significant at the 0.05 level (2-tailed).**

c. **± indicates the strength and direction of the monotonic relationship. 00-.19 "very weak" , .20-.39 "weak" .40-.59 "moderate", .60-.79 "strong", .80-1.0 "very strong".**

Source: Researcher's Construct (Fieldwork, September 2021- February 2022).

The Spearman's correlation coefficients (r_s /*rho*) show very weak to strong positive associations/relationships between the variables ($+ 0.15 \leq r_s$ /*rho* $\leq +6.07$), and most are statistically significant ($p < 0.001$) at a 95% confidence interval. The closer r_s/*rho* is to ±1, the stronger the association/relationship. This indicates that a unit increase or decrease in one variable should lead to a corresponding increase or decrease in the other variable (the values of X increase, while Y increases, or X decreases, while Y decreases). Nevertheless, the correlation of these variables does not establish causation or a linear relationship/regression, as the ordinal data does not meet the conditions for simple distribution or parametric data.

The Spearman's correlations result (*see* Table 17) replicates previous findings of the positive associations between the SPS subscales in diverse contexts, investigating different social phenomena (*e.g.*, Cutrona and Russell, 1987; Caron, 2013; Chiu, Motl, and Ditchman, 2016; Iapichino *et al*., 2016). It extends these findings in determining the magnitude of SPS associations with family involvement in the recovery journey of MHSUs and their experiences of stigmatisation within the family. Similar to findings reported in existing studies (*e.g.*, Chronister, 2009; Cutrona and Russell, 1987; Jaracz *et al*., 2010; Motl, Snook and McAuley, 2007), the results indicate that the modified SPS have moderate to high correlations with mental and psychosocial health indicators and small to moderate correlations with physical health measures.

As can be seen from Table 17 (above), the data showed no correlation between *family involvement* and *attachment* (emotional) support*, stigmatisation* and *guidance support.* This is an unexpected and disappointing outcome. It can be inferred from the correlation results that, although over 70% of MHSUs perceive that their family members are essential to their recovery journey, they do not feel a strong emotional bond with their family members and lack close relationships that provide them with a sense of emotional security and wellbeing. Similarly, it can be implied from the 85% of MHSUs perceiving that their family members are ashamed of them because of their mental

illness, that there is nobody within their family they could talk to about critical life decisions. There is no trustworthy person to turn to for advice when facing difficulties. These findings corroborate Van der Gesst, Dapaah and Kwansa's (2019) investigations into the changing virtues (intimacy, solidarity and reciprocity) fundamental to family caregiving in Ghana.

Nonetheless, for people with mental illness, support from family has been linked to improved coping with illness-related challenges, better physical and mental health development, and increased quality of life and wellbeing towards recovery (Read and Nyame, 2019; Dsane, 2009; Chronister *et al*., 2008; Chronister, 2009; Haber *et al*., 2007; Mitchell *et al*., 2006; Stuifbergen, Seraphine and Roberts, 2000; Van der Geest, 2002). Consequently, families' inadequate agencies to provide MHSUs with material support, to re-establish attachment and social integration with others, are associated with the likely recurrence and progression of mental health problems (Awenva *et al.*, 2010; Lakey and Cohen, 2000; Akyeampong, 2015; Tew, 2013).

In Ghana and many African countries, MHSUs receive various types of support throughout their recovery journey from their nuclear (close/immediate) and extended families. For instance, Van der Geest (2016) reported that the way families mobilise and provide support reflects how they cope with stressful life events, such as mental illness. Therefore, social provisions from the family play a significant role in fostering positive recovery outcomes for MHSUs and their families (Aldersley and Whitley, 2015; Waller *et al*., 2018). In addition, support within the family increases MHSUs' self-esteem and self-efficacy, which are critical components for living a positive, healthy, and productive life with mental illness (Bandura, 1982; Cobb, 1976; Cutrona and Russell, 1987; Waller *et al*., 2018).

Reliable alliances and *attachment* (material and emotional support), especially with close and extended family members, form a core social tie representing a basic social need, regardless of the type of mental health problem and severity of symptoms. In addition, the uncertainty of mental health

problems and unpredictability of flare-ups may lead MHSUs to seek support to manage the condition despite symptom severity. When MHSUs relapse, they may need tangible or material support to meet their immediate needs, including food, clothing, housing arrangements, money for medical bills and transportation.

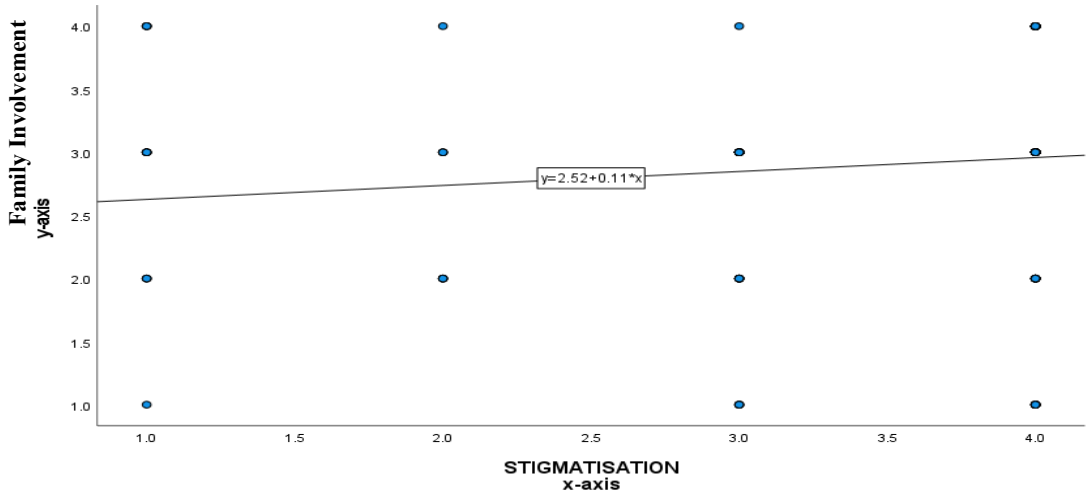
7.3.3.3. Hypothesis Testing

Of key importance to Research Question One, simple scatter plots/graphs (scattergrams), and Spearman's rank-order correlation test explored the significant associations between MHSUs' experience of *family involvement* and *stigmatisation* experienced within their family during the recovery journey under the following null and alternative hypotheses, H_0 and H_1, respectively.

> H_0: There is no (monotonic) association between MHSUs' experience of stigmatisation within their family and family involvement in their recovery journey.
>
> H_1: There is a (monotonic) association between MHSUs' experience of stigmatisation within their family and family involvement in their recovery journey.

The simple scattergram (*see* Figure 10) below shows MHSUs' experience of stigmatisation within their families due to their mental health problems and the importance of family involvement in their day-to-day life. The scattergram shows a weak correlation between the variables measuring *family involvement* and *stigmatisation*. However, the direction of the relationship is positive and statistically significant @ 0.001 or 0.05 confidence level (r_s = 210*, n = 140, p < .001).

Figure 10: MHSUs' Experiences of Stigmatisation within their Families



Source: Researcher's Construct (Fieldwork, September 2021- February 2022).

Figure 10 above shows that most data points fall above the fit/trend line and do not connect any of the scores to establish a linear relationship. The line of fit at the total/trend line (Y = 2.52 + 0.11*X) shows that Y also increases as the values of X increase. For instance, if X= 1.0, Y= 2.52+ (0.11×1.0)= 2.53, X= 2.0, Y=2.52+ (0.11×2.00) = 2.74 etc. The relationship between the two variables is monotonic; thus, as the values of *family involvement* increase, so does *stigmatisation*. This implies that MHSUs experience stigmatisation within their families, whether wider/close family relations, despite family members' involvement in their recovery journey. Therefore, evidence from the data supports this association with the broader population; consequently, the null hypothesis is rejected in favour of the alternative hypothesis (H_1 is accepted and H_0 rejected).

This result is somewhat counterintuitive, considering that literature on stigmatisation primarily focuses on social exclusionary factors in the broader socio-economic contexts with little concern for stigmatising issues (including expressed and unexpressed emotions) within the family contexts, exacerbating mental distress. This study, therefore, contributes to the literature by identifying factors that precipitate MHSUs' recovery from an ecological perspective. The correlation

between family and stigmatisation is further explored in semi-structured interviews with MHSUs and their FCs in Chapter Eight.

7.3.3.4. Pearson Chi-squared Statistical Test by Gender

Bivariate summary statistics were computed in SPSS version 26.0 (cross-tab function) to identify gender proportional differences and patterns in the study's quantitative sample. For each sex, computed descriptive statistics (frequencies & percentages), significant statistical p-values, and effect sizes for their socio-demographics, modified SPS-10, two self-developed constructs and levels of family are included in Table 18 below.

Table 18: Bivariate Summary Statistics of Gender Differences in the Quantitative Sample.

Gender	***Male*** **% (n)**	***Female*** **% (n)**	***Total*** **% (n)**	***P-Value**** **&** ***Cramer's V (φc)***
Age				0.723
18-25 years	10.60% (7)	9.50% (7)	10.00% (14)	
26-35 years	37.90% (25)	33.80% (25)	35.70% (50)	
36-45 years	30.30% (20)	27.00% (20)	28.60% (40)	
46+ years	21.20% (14)	29.70% (22)	25.70% (36)	
Religion				0.334
Christian	89.40% (59)	90.50% (67)	90.00% (126)	
Muslim	9.10% (6)	6.80% (5)	7.90% (11)	
Traditionalist	0% (0)	1.40% (1)	0.70% (1)	
Other	1.50% (1)	1.40% (1)	1.40% (2)	

Employment				
Formal Employment	30.30% (20)	12.20% (9)	20.70% (29)	
Self-employed	28.80% (19)	23.00% (17)	25.70% (36)	
Unemployed	40.90% (27)	64.90% (48)	53.60% (75)	0.676
Education				0.001*
Primary school	4.50% (3)	12.20% (9)	8.60% (12)	
Junior high school	30.30% (20)	29.70% (22)	30.00% (42)	
Senior high school	31.80% (21)	33.80% (25)	32.90% (46)	
Tertiary	33.30% (22)	24.30% (18)	28.60% (40)	
Marital Status				0.008*
Married	16.70% (11)	32.40% (24)	25.00% (35)	
Divorced	9.10% (6)	8.10% (6)	8.60% (12)	
Single	74.20% (49)	47.30% (35)	60.00% (84)	
Separated	0.00% (0)	6.80% (5)	3.60% (5)	
Widowed	0.00 % (0)	5.40% (4)	2.90% (4)	
Place of residence				0.344
Urban areas	68.20% (45)	56.80% (42)	62.10% (87)	
Rural areas	28.80% (19)	40.50% (30)	35.00% (49)	
Other parts of Ghana	3.00% (2)	2.70% (2)	2.90% (4)	

Bivariate Summary Statistics of Gender Differences * SPS-10

Social Integration				
Item 1				
Strongly Disagree				
Disagree	3.00% (2)	8.10% (6)	5.70% (8)	
Agree	3.00% (2)	4.10% (3)	3.60% (5)	
Strongly Agree	28.80% (19)	37.80% (28)	33.60% (47)	0.259
	65.20% (43)	50.00% (37)	57.10% (80)	
Item 2				
Strongly Disagree	6.10% (4)	6.80% (5)	6.40% (9)	
Disagree	9.10% (6)	4.10% (3)	6.40% (9)	0.627
Agree	42.40% (28)	40.50% (30)	41.40% (58)	
Strongly Agree	42.40% (28)	48.60% 36	45.70% (64)	
Attachment				
Item 3				
Strongly Disagree	6.10% (4)	4.10% (3)	5.00% (7)	
Disagree	7.60% (5)	4.10% (3)	5.70% (8)	0.001*
Agree	59.10% (39)	29.70% (22)	43.60% (61)	*0.351 (φ_c)*
Strongly Agree	27.30% (18)	62.20% (46)	45.70% (64)	
Item 7				0.846
Strongly Disagree	3.00% (2)	1.40% (1)	2.10% (3)	
Disagree	6.10% (4)	4.10% (3)	5.00% (7)	
Agree	37.90% (25)	40.50% (30)	39.30% (55)	

Strongly Agree	53.00% (35)	54.10% (40)	53.60% (75)	
Realiable Alliance				
Item 4				
Strongly Disagree	3.00% (2)	1.40% (1)	2.10% (3)	
Disagree	7.60% (5)	6.80% (5)	7.10% (10)	0.913
Agree	34.80% (23)	35.10% (26)	35.00% (49)	
Strongly Agree	54.50% (36)	56.80% (42)	55.70% (78)	
Item 6				
Strongly Disagree				
Disagree	NR	NR	NR	
Agree	7.60% (5)	5.40% (4)	6.40% (9)	0.703
Strongly Agree	31.80% (21)	37.80% (28)	35.00% (49)	
	60.60% (40)	56.80% (42)	58.60% (82)	
Reassurance of Worth				
Item 8				
Strongly Disagree	3.00% (2)	2.70% (2)	2.90% (4)	0.202
Disagree	9.10% (6)	12.20% (9)	10.70% (15)	
Agree	48.50% (32)	31.10% (23)	39.30% (55)	
Strongly Agree	39.40% (26)	54.10% (40)	47.10% (66)	
Item 9				0.990

Strongly Disagree				
Disagree	3.00% (2)	2.70% (2)	2.90% (4)	
Agree	9.10% (6)	8.10% (6)	8.60% (12)	
Strongly Agree	39.40% (26)	41.90% (31)	40.70% (57)	
	48.50% (32)	47.30% (35)	47.90% (67)	
Guidance				0.439
Item 5	7.60% (5)	4.10% (3)	5.70% (8)	
Strongly Disagree	15.20% (10)	12.20% (9)	13.60% (19)	
Disagree	33.30% (22)	45.90% (34)	40.00% (56)	
Agree	43.90% (29)	37.80% (28)	40.70% (57)	
Strongly Agree				
Item 10				0.831
Strongly Disagree	3.00% (2)	4.10% (3)	3.60% (5)	
Disagree	10.60% (7)	6.80% (5)	8.60% (12)	
Agree	36.40% (24)	40.50% (30)	38.60% (54)	
Strongly Agree	50.00% (33)	48.60% (36)	49.30% (69)	
Bivariate Summary Statistics of Gender Differences * the Two Self-developed Constructs				
Stigmatisation				0.096
Strongly Disagree	7.60% (5)	10.80% (8)	9.30% (13)	
Disagree	10.60% (7)	1.40% (1)	5.70% (8)	
Agree	19.70% (13)	20.30% (15)	20.00% (28)	
Strongly Agree	62.10% (41)	67.60% (50)	65.00% (91)	

Family Involvement				0.791
Strongly Disagree	10.60% (7)	10.80% (8)	10.70% (15)	
Disagree	16.70% (11)	17.60% (13)	17.10% (24)	
Agree	40.90% (27)	47.30% (35)	44.30% (62)	
Strongly Agree	31.80% (21)	24.30% (18)	27.90% (39)	
Bivariate Summary Statistics of Gender Differences* Levels of Family Support				
Levels of support				0.757
High	49.40% (38)	50.60% (39)	55.00% (77)	
Moderate	42.90% (21)	57.10% (28)	35.00% (49)	
Low	50.00% (7)	50.00% (7)	10.00% (14)	
Significant statistics = p<0.001/p<0.05* @ 95% Confidence Interval, * indicates that the categorical variables are not independent (association), Cramer's V (φ_c) = Effect size. NB: NR (Not Reported).				

Source: Researcher's Construct (Fieldwork, September 2021- February 2022).

The summarised data in Table 18 shows that the female group reported more responses on the survey than the male group. This gender difference is not surprising as large-scale epidemiological studies globally show that there are no differences overall in men's and women's rates of mental health problems (*e.g.*, McManus *et al*., 2016; Remes *et al*., 2016; ONS, 2019; APA, 2000, Demler, Kessler and Merikangas, 2005; Damodaran and Paul, 2016; Abel and Newbigging, 2018). The gender differences rather lie in the types of psychiatric disorders. WHO (2002) reports that the sexes differ in the kinds of psychological problems they tend to exhibit. Women exceed men in internalising difficulties of anxiety, phobias and depression (mild and severe forms), in which problematic feelings

are turned inwards against the self, resulting in feelings of profound sadness, loss of energy (motivation and interest in life) and negative self-concept (guilt, self-reproach and blame). This can leave them feeling hopeless and helpless in their ability to improve their circumstances. Coupled with difficulties in concentration, sleep, appetite and more likely to experience significant free-floating anxiety states that may associate themselves with seemingly random thoughts and situations.

Men, on the other hand, are more likely to exhibit externalising problems, including substance misuse and antisocial conduct. Blackouts and hallucinations are serious physical effects of heavy alcohol and drug use, which are more common among men. Problems at home, in the classroom, or at work can all stem from substance misuse. Addiction is more common in men; thus, they have to use more of the substance to have the same impact. Attempts to stop could have devastating emotional and physical effects on them as well. Men also tend to exhibit more antisocial behaviour, and disruptive disorders such as oppositional defiant disorder (ODD), obsessive-compulsive disorder (OCD), and attention deficit hyperactivity disorder (ADHD) are more common in children and teenagers. Men can acquire antisocial personality disorder as adults, which manifests itself in a variety of violent and antisocial behaviours, including lying, stealing, attacking people or animals, and damaging property. Some men may find it challenging to develop meaningful connections that last due to this (McGinty, 2023; Wilson and Somhlaba, 2018).

It is, therefore, clear that neither gender is worse off than the other in mental health, but instead experiences very different kinds of problems. Rosenfield and Smith (2012) consider various explanations for these differences by focusing on the gender conceptions and divisions between men and women in power, socio-economic responsibilities (different role positions) and personal characteristics relevant to mental health. Evidence reveals that while men are more likely to report feeling overwhelmed by work and family responsibilities, women report lower wages, less autonomy in their employment, and more instances of experiencing overload overall. Stronger social bonds

provide more support but also more opportunities for unpleasant encounters. Overall, women tend to be less confident and competent than men, and they rely heavily on others for emotional support, whereas men are more likely to be self-reliant. Self-salience—beliefs regarding the worth of one's own self relative to that of other people in social interactions—varies across the sexes: Internalising difficulties are more common among women because they prioritise the needs of others, but externalising problems are more common among men because they incline to prioritise themselves more strongly (Rosenfield and Smith, 2012; Vogel *et al*., 2011; Ofori-Attah *et al.*, 2010).

The findings from Pearson's chi-squared statistical test provide additional evidence to support Rosenfield and Smith's (2012) explanations for the differences observed in men's and women's mental health. While most of the inter-term correlation for the modified SPS-10 plus the two self-developed constructs were statistically significant @ 95% confidence interval, its chi-squared test showed statistically insignificant associations by gender differences, except for *Attachment-item 3, education and marital status.* The *p-value* for determining the significant association between *Attachment-item 3* of the SPS-10, *education* and *marital status* by *gender* is 0.001, 0.008 and 0.001, which is also < 0.05 @ 95% confidence interval. The distribution of the sample shows a 35.10% statistically significant moderate effect (Cramer's V (φ_c) = 0.351, $p < 0.001$) for *gender* and *Attachment-item 3.* This implies that there is evidence to support a statistical relationship between men and women and their emotional attachment to at least one other person within their family. This relationship can also be observed in the target/wider population.

The data also shows that more women (15.7%) are in a marital relationship as compared to their male counterparts. Similarly, men appear to be more self-salient than their female counterparts. 83.30% of men were discovered to be single or unmarried as compared to their female counterparts (67.70%). It is not surprising that men had the highest score (74.20%) for being single. In the Ghanaian and many African contexts, it is the man who seeks the hand of a woman in marriage, and

it takes a family to marry, not an individual, as contended by Nukunya (2016). Many families view good health as a prerequisite for marital stability (Van der Geest, 2016; Ukpong, 2006). An individual experiencing mental distress may not have the opportunity to form a loving and socially acceptable relationship. Those already in a heterosexual relationship may face challenges, such as family intrusion, financial strain, and unemployment, in maintaining the relationship over time, which can result in divorce or separation. Anthropological and ethnographic studies with MHSUs and FCs in Ghana indicate that family custodians/leaders (*abusupanyin*) often seek to preserve a 'clean' lineage identity within their communities and have been conscientious in the marital screening and evaluation of suitable heterosexual spouses (Dsane, 2009; Read, 2009; Mensah, 2021; Lovell, Read and Lang, 2019; White *et al.*, 2017; Murphy *et al.*, 2015). This may contribute to MHSUs' experiences of loneliness and difficulty in forming and sustaining heterosexual relationships in this context. For LGBTQ+ MHSUs, relationships can be compounded by societal prejudices and double stigma, consistent with minority stress theory (Meyer, 2003; Sowatey, 2021; APA, 2012), which highlights how stigma, bigotry, and discrimination create a hostile social environment that adversely affects mental health.

In Ghana, every citizen has the right to basic education, which is also enjoyed by MHSUs in this study (Read, 2020a, 2020b; Opoku *et al*., 2015). Nonetheless, the proportion of women (MHSUs) educated is eight percentage points higher than that of men (MHSUs), and the association is statistically significant @ 95% confidence interval (p-value = 0.001). This revelation is not surprising, as Sipsma *et al. (2013)* reported in their national-level study that female MHSUs are more likely to be educated than their male counterparts. This could be attributed to the government's educational campaigns promoting girls' education nationwide (Adu-Gyamfi, Donkoh, and Addo, 2016; Arkorful *et al*., 2019). However, this does not translate into women's employment status in this dataset. It

appears that more men (23.9%) are engaged in some form of economic activity (employed by others or self-employed) compared to their female counterparts (*see* Tables 18 and 8).

Research has shown that there is an intercorrelation between education and employment (formal or informal) (Mensah, 2021; Daliri *et al*., 2024; Opoku-Boateng *et al*., 2017; Sipsma *et al*., 2013; Adomako *et al*., 2020). Although informal employment may not require an educational certification, formal employment typically requires that an individual has attained some level of education, and in Ghana, the minimum is senior high school (Alua, Agalga, and Akamba, 2022; Adomako, Zhou, and Amarteifio, 2023). Data from the Ghana Living Standards Survey also shows gender disparities in women's employment in the formal sector compared to men (GSS, 2018). Consequently, it is not surprising that women experiencing mental health problems are the least considered in Ghana's economic sector, as revealed in Awortwe *et al*. (2024) systematic review of the social determinants of anxiety and depression among Ghanaian adults.

As can be seen from Table 18 (above), none of the respondents strongly disagreed with the statement, "*within my family, there are people I can count on in an emergency for my sustenance*", item *6* (*reliable alliance*/*material support*). Both men and women (93.60%) *agree* to some extent that they receive some form of material support from their family members during emergencies and therefore perceive their family as a reliable source of emotional and material support. While this is a remarkable revelation, the chi-squared test showed a statistically insignificant association by gender @ 95% confidence interval.

It can be inferred from the data (*see* Table 18) that men in the higher category appear to be experiencing 1.20% less family support during their recovery journey than *women* in this category. Similarly, men in the moderate category seem to be experiencing 14.20% less family support towards their recovery as compared to women of that same category. Interestingly, men and women in the

low category are experiencing equal levels of support within their families towards their recovery. It is apparent from this table that there are not many proportional differences in the levels of support for men and women in the low category. The chi-squared test showed a statistically insignificant association by gender @ 95% confidence interval.

7.4. Levels of Perceived Family Support

In adherence to Creswell's (2014) Explanatory Mixed-Methods Sequential Design, Participant Selection Model (*see* Figure 7(B)), the total score for each questionnaire response was computed using SPSS (version 26.0) to construct smaller, quota-stratified analytical samples of respondents experiencing varying levels of perceived family support for the qualitative phase. Levels of perceived support as reported by MHSUs are summarised in Table 19, showing that 55% of respondents experienced high support, 35% moderate support, and 10% low support. The quantitative distribution, summarised in Table 19, is further illustrated in Figure 11, which provides a visual presentation of the frequency distribution of total family-support scores derived from the modified SPS-10.

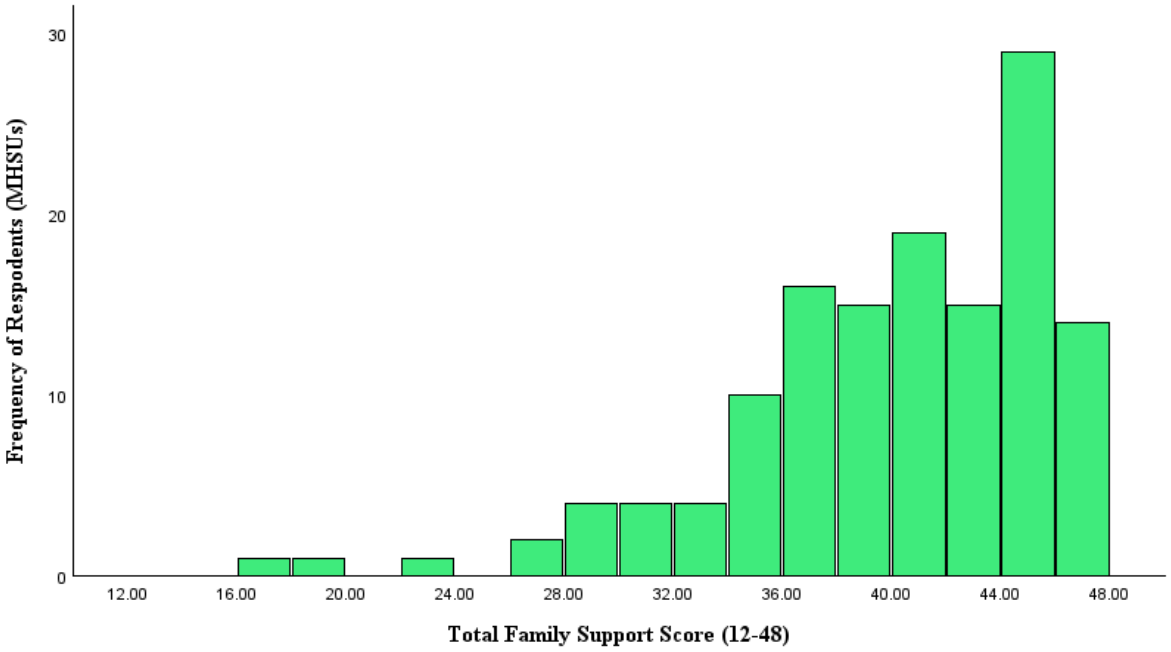
Table 19: Levels of Perceived Family Support

Respondent(s)	Frequency n =140	Percentage (%)
High support	77	55.0
Moderate support	49	35.0
Low support	14	10.0

Source: Researcher's Construct (Fieldwork, September 2021- February 2022).

Figure 11 below (histogram) illustrates a right-skewed pattern with a long lower tail, confirming that most respondents reported high levels of perceived family support, with progressively fewer reporting moderate or low support. This visual representation provides the descriptive and informs the pragmatic basis for applying pragmatic cut-off points (≤ 31, 32–40, ≥ 41) to construct three analytical categories of *low*, *moderate*, and *high* perceived levels of family support (as discussed in Section 5.5.2.2.1).

Figure 11: Distribution of Perceived Levels of Family Support Scores (N = 140)



Source: Researcher's Construct (Fieldwork, September 2021- February 2022).

As shown in Figure 11, the distribution pattern, concentrated toward the higher end of the scale, demonstrates how the quantitative findings informed the use of non-proportional quota sampling in the qualitative phase. These analytical categories enabled purposive selection across the full spectrum of perceived family support, ensuring balanced inclusion and adequate analytic coverage of contrasting experiences within the qualitative phase. Rather than defining statistically distinct groups, this approach established pragmatic thresholds in the absence of psychometric norms, providing a

meaningful basis and purposeful boundaries for cross-group comparison. Consequently, applying these pragmatic thresholds within the explanatory sequential design ensured that the qualitative phase was theoretically, ethically, and methodologically grounded, as well as contextually representative of the lived realities of caregiving in Ghana (*see* Section 5.5.2.2.1). This approach is consistent with Creswell and Plano Clark's (2018) view that explanatory sequential designs purposefully connect the quantitative phase's empirical breadth with the qualitative phase's interpretive depth, thereby generating a more comprehensive understanding of complex social processes—such as family support, caregiving, and recovery from mental illness—addressed by the study's research questions.

7.5. Summary

In summary, the quantitative analysis provided a substantive empirical contribution to the study by identifying meaningful variations in perceived family support among MHSUs and demonstrating statistically significant associations between the quality of interpersonal relationships and the consistency of support received. The findings established clear patterns of how family relationships influence recovery outcomes, showing that close or wider family remains a key source of affiliation, emotional security, and mutual responsibility. Such relational commitments often enhance wellbeing and continuity of care, while disrupted family ties or stigma within family contexts were shown to constrain recovery and heighten vulnerability.

Beyond these empirical insights, the quantitative analysis also fulfilled a strategic role within the explanatory sequential mixed-methods design by providing the analytical and conceptual foundation for the qualitative phase. The three-tier categorisation of *low*, *moderate*, and *high* family support, derived from the SPS-10 data, served as both an empirical and pragmatic framework for examining differences in recovery experiences. This categorisation informed the non-proportional quota sampling strategy, ensuring that the qualitative phase purposefully included participants across the full spectrum of family support and caregiving experiences.

Accordingly, the quantitative strand did not operate in isolation; it advanced empirical understanding of family support dynamics and guided participant selection, thematic focus, and interpretive framing in the qualitative phase. This integration exemplifies the participant-selection logic of the explanatory sequential mixed-methods design, whereby statistical patterns from the survey directly inform and are subsequently interpreted through qualitative exploration (Creswell and Plano Clark, 2018; Teddlie and Yu, 2007). The patterns identified, such as strong familial bonds, relational disruption, and the persistence of stigma, form the basis for the qualitative analysis in Chapter Eight, which contextualises these findings within MHSUs' lived experiences of family support and caregiving in the journey towards mental illness recovery.

CHAPTER EIGHT

QUALITATIVE DATA ANALYSIS

8.0. Introduction

This chapter builds on the quantitative phase presented in Chapter Seven to explore in greater depth how MHSUs and their FCs experience, interpret, and negotiate family support within the context of recovery, following the logic of the Explanatory Sequential Mixed-Methods Design – Participant Selection Model (Creswell, 2014). The quantitative findings identified three distinct levels of perceived family support—low, moderate, and high—which informed participant selection and structured the qualitative analysis. This design ensured a purposeful exploration of the diverse forms and meanings of family support as experienced across different caregiving and recovery contexts.

Whereas the quantitative phase mapped patterns and statistical relationships, the qualitative phase captures the lived realities and subjective interpretations underlying those patterns. Through participants' narratives, this chapter provides nuanced insights into how support is expressed, constrained, or transformed in everyday family life, illuminating the social processes that underpin recovery among MHSUs in Ghana. By integrating voices and experiences that could not be fully represented in the survey, this phase deepens understanding of how relational, cultural, and structural factors shape both caregiving dynamics and recovery outcomes.

This chapter is organised into four sections. The first outlines the socio-demographic characteristics of the interview participants (*see* Table 20). The second presents Figure 13, which displays the thematic framework derived from the qualitative data. The third provides a detailed thematic analysis, supported by participants' quotations and interpretive discussion. The final section offers a summary of the key findings, highlighting how these qualitative insights extend, clarify, and explain the statistical patterns identified in Chapter Seven.

In doing so, this chapter serves as the interpretive bridge between the quantitative patterns and the theoretical discussion that follows. The insights generated here prepare the ground for Chapter Nine, which synthesises findings across both phases to develop a deeper conceptual understanding of how family support functions as a resource for mental illness recovery in the Ghanaian context.

8.1. Participant's Sociodemographic (Interview Phases)

The section describes the sociodemographic characteristics of the selected MHSUs and their FCs that proved most helpful in deducing themes from the qualitative data. Out of the 140 sampled into quotas, only 12 participants were purposefully selected and consented to participate in the interview phases (*see* Table 5). The qualitative sub-sample is broadly similar to the profile of the survey sample (quantitative data) from which it was drawn. Quota and purposive sampling techniques were employed to select participants, ensuring representation of participants with varying levels of experience with family support and family involvement throughout the recovery journey (*see* Chapters Five and Six).

Of the six MHSUs interviewed, four were men, and two were women, with an average age of 40. The average age of MHSUs corroborates the results from the survey data, indicating that 90.00% of MHSUs fell within the age bracket of 26-65 years (*see* Chapter Seven). Similarly, the qualitative data revealed that most MHSUs were single, confirming the results obtained from the survey data (*see* Chapter Seven). Three of them were actively engaged in some form of gainful employment (working full or part-time) to meet their most essential needs. This included covering basic expenses like food, clothing, and medical care. All six participants reported residing with their FCs in different locations (alternating between rural and urban areas) in Ghana.

Furthermore, six FCs of MHSU were also interviewed: three male and three female close family members. The average age of FCs interviewed was 56 years. It is, therefore, realistic to assume that, at this age, family members in this sample will start providing care for adult relatives

experiencing mental health problems. Of the sampled FCs, four were married, one was single, and one was recently widowed. FCs reported actively providing care and support, suggesting a long-standing relationship and connection to the MHSUs. Nonetheless, close family members who served as caregivers reported receiving both regular and sporadic material support (such as money, housing, food, and clothing) and non-material support (such as encouragement and guidance) from extended family members living in diverse geographical contexts.

In summary, participants' sociodemographic factors, including *gender*, *occupation*, *age*, *marital status*, *place of residence* and *family structure*, may have more bearing on the recovery journey than any medical care advancements (*see* Chapter Seven).

Table 20: Sociodemographic Profile of Qualitative Participants

Participant(s) Socio-demographic characteristics	Mental Health Service User(s)					
Pseudonyms	**Wusu**	**Adwoa**	**Kwadwo**	**Afia**	**Kwabena**	**Sei**
Gender	Male	Female	Male	Female	Male	Male
Age (years)	30	52	46	26	37	50
Marital Status	Single	Married with 4 children	Single	Single	Single	Single
Employment	Primary School Teacher	Unemployed	Unemployed	Hairdresser apprentice	Errand runner for a welder	Unemployed
Participant(s) Socio-demogr	**Corresponding Family Caregiver(s)**					
Pseudonyms	**Akua**	**Akwasi**	**Ama**	**Kofi**	**Akosua**	**Kweku**
Gender	Female	Male	Female	Male	Female	Male
Age (years)	60	57	32	73	70	46

Occupation	Retired Teacher	Petty Trader	Dress Marker /Seamstress	Pensioner	Unemployed	Unemployed
Marital Status	Married	Married	Married	Widow	Married (not living with husband)	Single
Relationship to the mental health service user	Mother	Husband	Sister	Father	Mother	Brother
Residency	Urban Area	Urban Area	Urban Area	Rural Area	Rural Area	Rural Area

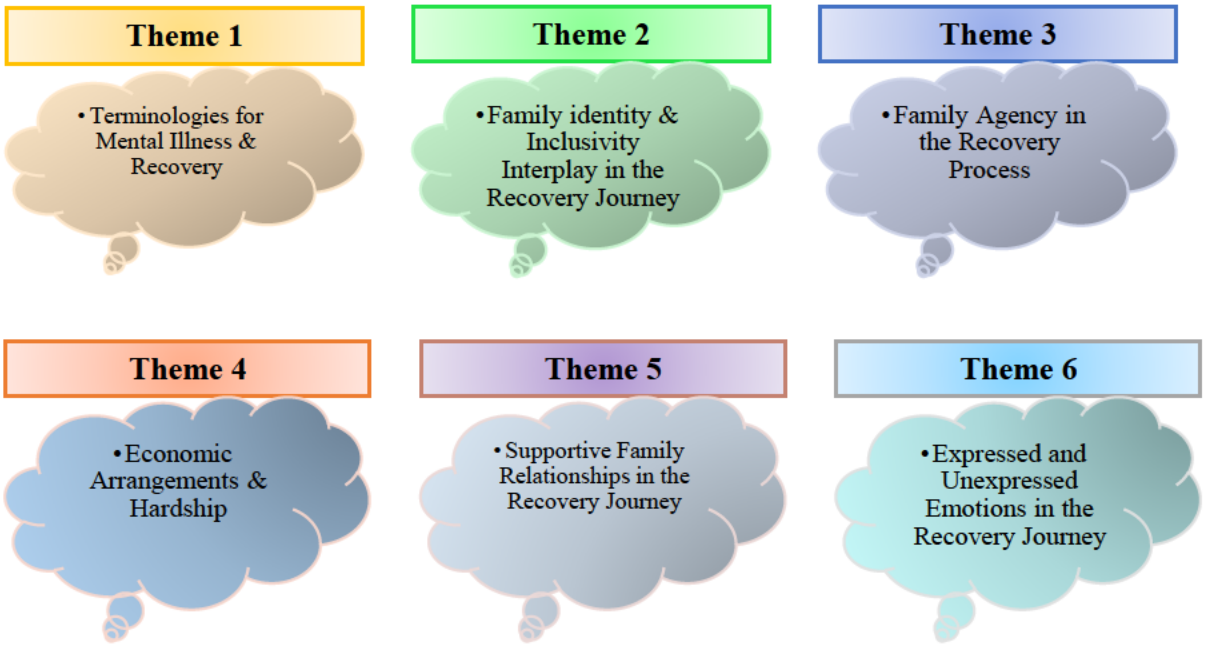
Source: Researcher's Construct (Fieldwork, September 2021- February 2022).

NB: All participants' names have been anonymised using pseudonyms for ethical reasons.

8.2. Qualitative Theme Development

The themes' development followed the abductive approach to theory development, as far as possible, within a pragmatic mixed-method research design (Braun and Clarke *et al.*, 2023). The study's abductive technique of theme development involves moving from data to theory and then back to data (Saunders, Lewis, and Thornhill, 2019). Thus, emergent themes were abductively identified after synthesising and triangulating the survey dataset and participants' verbal accounts to synchronise with the study's theoretical framework. The entire qualitative process followed Braun and Clarke's (2006) thematic analysis approach, and NVivo data management software was used to manage the data (*see* Chapter Five). Figure 12 (below) illustrates the themes that emerged from the thematic analysis, which was mirrored between MHSUs and their FCs, and mapped across the three distinct categories of levels of support.

Figure 12: Summary of Emergent Themes



Source: Thematic Analysis of Participants' Qualitative Data (Fieldwork, September 2021- February 2022).

8.3. Discussion of Themes

8.3.1. Theme 1: Terminologies for Mental Illness and Recovery

Expressing meaning/language on mental illness is probably a controversial issue in mental health social work, social care and diverse sociological contexts. In the Akan-speaking communities of Ghana, acceptable language for certain health terminologies is coined from the part of the body people experience illnesses. For example, '*3ti* yareɛ/yadeɛ' translates as illnesses affecting the head, including headaches/migraines, '*afu* yareɛ/yadeɛ*'* [stomach illness], 'akoma yareɛ/yadeɛ' [heart diseases] etc. People's emotionally challenging behaviour experienced through the brain or mind malfunctioning is said to be '*adwene* yareɛ/yadeɛ*'* [brain/mind diseases including mental illnesses]. '*dam /adammɔ'*, '*adwene muka*', '*adwene ay3 basa basa*', '*adwene no adi kyihyia'*, '*adwene nnyi fie', 'adwene ny3 papa', 'adwene ahoma atsew', 'ɔbɔdamfoɔ'* [madness, insanity, crazy, bonkers, distorted mind, the mind is not sound/distorted, mad persons/lunatics] are some of the terms used by participants in this study to express their mental health problems/condition or circumstances.

These terms, as used by MHSUs and their FCs, are adopted without undermining participants' identities or aspirations. This is a term with which many people who also use the mental facility feel comfortable and does not imply incapacity or inferiority:

> *…I will say that n'adwene ny3 papa [mind is not sound] because of how he behaves abnormally from my other children (Akosua, FC, low category).*

> *As for how I behave, you mean concerning* '*adwene* yareɛ*'? I was told that at the beginning, they suspected that na me tsir mu ahoma atsew [I had gone bonkers/crazy] because I was too compulsive, aggressive and obsessive. If I do not get what I demanded, all hell will break loose in the house [participant chuckles]. I can get so angry and violent that everyone close to me hides. My family keeps me away from others in my community. I remember being taken to a prayer camp where I was chained to a post in my room or sometimes to a tree on the compound for days because I became violent and defiant. I sometimes relapse, especially when I do not take my medication (Kwabena, MHSU, low category).*

… "For what reasons am I acting this way?", "Is it true that I am experiencing Hay Fever as a relative has told me or is that m' abɔdam [I am mad]?",…(Wusu, MHSU, high category).

From the data, participants' use of the term *adwene* [mind, thought, intentions] yareɛ/yadeɛ [ailment/illness] in describing mental health problems is an Akan idiomatic expression referring to mental illness and perceived deeds of the MHSUs indicating that the individual is not in a sound frame of mind or portraying an abnormal behaviour suggesting that attention should be paid to him/her. Participants' words, even if they are difficult to understand or translate, should not be dismissed as mere "symptoms" since they may represent their attempts to make sense of and find meaning in the experience of living with mental illness. In reality, it should be seen as their effort to convey the significance of mental illness in their lives and the difficulty of dealing with it.

8.3.1.1. Understanding Mental Illness and Recovery

MHSUs and their FCs from the three categories (*high, moderate* and *low*) expressed a variety of perspectives concerning the causes and their understanding of mental illnesses:

I was having a nap one afternoon as I had not rested for a while, just normal sleep, okay, and then I began hearing voices, inner voices, okay, it was not outside, it was inner… that was when everything started. I am doing well now by God's grace. Mmmm, it is a very confusing, frustrating and really really stressful situation^… I was really depressed because many things were going on in my mind yeah…It changed many of my perceptions about myself and the people around me. It is like… hmm, I thought I was an elder in my church, so this should not be happening to me. I saw it more as a spiritual attack, making me cower in fear. I tend to lose my confidence and faith in God (Wusu, MHSU, high category).

Some MHSUs presumed mental illness [*adammɔ*] resulted from disputes with some family members. For example, Kwadwo, a MHSU in the moderate category, said:

I suspect that the fight I had with my nephew over my washed jersey he took from the drying line without my permission. He walloped me in the head with a stone, causing an injury to my head that might have resulted in my mental 'disease'. I have been thinking about that incident since I

came to live at my mother's place. I seem not to understand the origin of this 'disease'… (Kwadwo, MHSU, moderate category).

Sei, MHSU from the low category also had this to say:

I quarrelled with my aunty over a plot of land which belonged to me, and she told me you wait, you will see what will happen to you! Three days later, I started nonsensical talks, I could see and hear things even when no one was around (Sei, MHSU, low category).

8.3.1.2. Identifying Mental Illness through Spiritual and Biomedical Definition

Akosua, a FC from the low category, shed more light on the spiritual attribution of mental illness, describing the 'disease' from witchcraft within the family:

...I know some of my family members envy my child, so they have used their witchcraft [bɛye] to ruin my child's bright future. My child was brilliant and hardworking and bought everything I needed. He was very generous and kind to everyone. My child started exhibiting abnormal behaviour when I announced to some members that our brother in the United States had decided to come for my child to live with them abroad. I took him to church, and my pastor told me about those individuals in my family who brought this misfortune to my child. I confronted them and said that if they destroyed their children's destiny, mine was beyond their reach in Jesus's name! As God sits high in the sky watching over us, they will not have the last say in my child's destiny. It saddens me to see my beloved child in this state. I have been praying and fasting so God can intervene (Akosua, FC, low category).

Kofi, a 73-year-old FC of Afia a MHSU, moderate category, had this to say:

Traditionally, when someone is ill, you go for abesa [a spiritual consultation], which I did, but to no avail…Mental health hospitals are not available here in the village, so we travel to the big city…Until she was admitted, I did not know dam yareɛ [mental illness] had variations and levels. The doctor told us that some are acute, severe or chronic. He said mood, anxiety, psychotic, eating, substance abuse, and post-traumatic stress disorders. She was diagnosed with acute psychosis. To this very day, I do not understand this disease and making sense of it is difficult. I am an old man with little education to understand some of her mental health issues discussed during reviews. As you can see, we are already at our wits' end. Managing her has really been difficult for us as a family (Kofi, FC, moderate category).

…From my own experience and what I have seen others go through and heard, I believe mental illness is a spiritual 'disease' because I cannot explain how I got it. When you get it, your life is ruined forever. You do not think humanly again. It is like your mind is off and on all the time…Yes, I go to the hospital for treatment because someone told my dad is now treated at hospital, but they [medical professionals] are not able to explain how and what is essentially the root cause of this 'disease'. It's like no one really knows and could provide an explanation, but when we

visit the traditional places, we get to know the reasons and the individuals involved if any (Afia, MHSU, moderate category).

Commenting on spiritual and biomedical perspectives of identifying and understanding mental illness, Adwoa and Akwasi participants from the high category said:

…Yes, I left the spiritual camp, and the family members took me to a [mental health facility in the central region] they kept me there for a while before they gave me a transfer to another facility in Ghana. That place was far from where I lived with my husband and children,…left with me alone, my bible doesn't teach me to be consulting, but they [family members] say we don't believe anything, and when we are sick, we should seek help [consultation] by going to the fetish priests and prayer camps and using our own traditional medicine but my bible does not teach me that, but for them they will go… (Adowa, MHSU, high category).

… we must assess ourselves when my husband or wife comes to this situation what will I do to help the situation? We have to accept the situation and seek medical help to stop spiritualising the issue and putting the blame on people; otherwise, in the end, we will leave the person and be roaming from one traditional healer to another, which usually worsens the symptoms and that alone will be a big disgrace on the family ...By God's grace, the medications the doctors are giving her are helping… (Akwasi, FC, high category).

The following event portrays a high-category MHSU who is a teacher living in an urban area with a good educational background, needing medical help in comprehending his diagnosis of mental illness, illustrating how the label, even though ominous, might be more reassuring than ambiguity.

After several months of formal medical treatment and counselling, I finally asked my doctor, "Doctor, can you at least give me the name of this disorder?",
"*I can't figure out what's wrong with me*"..., "*is there a cure for it*?"
My family feels mystified by how I communicate in codes. It seems strange to them but not to me. You see something, you watch TV, and you see something, you think something is talking to you, and you start writing codes you know. I wrote something on a sheet, and during one of my reviews with the doctor, I showed it to him to explain my condition to my parents. He told us to watch this movie: 'a Beautiful Mind' to help us understand what is happening to me…(Wusu, MHSU, high category).

...I used to think it was a spiritual attack...when the Doctor spoke with him during his review, I was also encouraged. Being at the [facility], I saw that he wasn't the only person; people from all walks of life and professions come there, with the 'disease'. Sometimes, I remember this and come to the realisation that he is not the only one with this problem (Akua, FC, high category).

The data suggest that participants' inclination towards spiritual understanding and informal care is not a recent development, nor is it solely linked to stigma and discrimination. As *Kofi*, a FC in the moderate category, alluded, historically, many Ghanaian families have sought such care for various reasons, including better availability in rural areas. Additionally, spiritual beliefs such as the perception that mental illness is caused by an enemy's jealousy or supernatural curses and the notion that religious or traditional healers offer more "naturalistic" cures further contribute to the preference for this form of care and understanding of mental illness. Biological understanding of mental illness and the need to seek hospital/formal care appeared to have gained prominence owing to the establishment of mental health facilities, education of mental health professionals and mental health awareness programmes, which are still inadequate both in quality and quantity in many rural areas in Ghana.

8.3.1.3. Blaming Others for Mental Illness

MHSUs reported attributing the cause of their mental health problems to others and described displaying aggression, both physical and verbal, towards members of their immediate and extended families. A smaller number also indicated that their aggression, suspicion, and blaming behaviours extended beyond the household to individuals in their communities, including friends, neighbours, church members, and partners, whom they perceived as contributing to their mental health difficulties:

> *… I started perceiving or suspecting some people in my family as being behind my condition. Hmm.. Like you erm you meet your relatives, and you think this lady is doing me…, this uncle is doing this and that aunty is doing this and a whole lot. I insulted them using very filthy words and also started threatening them. It has affected my relationship with my relatives (Kwadwo, MHSU, moderate category).*

> *Usually, when I relapse, I become verbally aggressive towards my family and feel it has somehow affected my interactions with them. I see a change in how they used to engage cordially with me. Some external relatives who are aware of my condition do not come closer like before when they visit (Kwabena, MHSU, low category).*

…hmm, at church, I was blaming others too, I was blaming and suspecting some people at church too… During a prayer session, I started manifesting and shouted: Oh yes!, you people are the ones, you are the sources of my problem…God's fire burn all of you, you all will die one by one, m'adammɔ [my specific mental health problem] should extend to all of you and your families… I will not sit nor come close to them. It was serious oh! (Wusu, MHSU, high category).

From the data, it could be deduced that participants' expressions of belief in religion, especially faith in God and spirituality, can play a vital role in the recovery journey, acting as a definitive explanation for the cause of mental illness and protective and coping factor to the welfare and wellbeing of MHSUs and FCs within the family space. However, there are also times when faith or belief systems can emotionally burden the interpersonal and caring relationship, especially when MHSUs presume and accuse family members of spirit possession and witchcraft as the imminent cause of mental health predicaments. MHSUs' unpredictable behaviour, religious beliefs and stigmatisation due to inadequate public information about mental health problems could also make it difficult to sustain relationships within and beyond their immediate (close) family.

8.3.1.4. Complexity of Understanding Mental Illness

A majority of the FCs interviewed expressed their continuous difficulty in understanding the mental health condition of their relative (MHSU), even though they claim they know the MHSU very well. MHSUs were characterised as mysterious and complicated individuals, a cause of concern and bewilderment for people with whom he/she interacts. To be more precise, the following situation highlights a FC's description of the inability to configure mental illness, defining it as indeterminate:

In the morning, Afia [MHSU] eats, takes her medication, looks fine, smiles with everyone and engages in banter conversations with her siblings…I am talking about the usual things. In a few hours, she gets angry, screech and scatter items within her reach, then heading back into her room and starting to write on the walls with charcoal, things we do not understand. Sometimes, she locks herself in the room and does not respond or engage with anybody. Other times, she would go out without informing anyone, roam in the community with no or dirty clothes on her,

and not get back home for, I don't know, two or more days. Because of our lack of knowledge about this illness, all of this has persisted for a long time (Kofi, FC, moderate category).

A common view amongst FCs was that MHSUs' behaviours were unpredictable and usually difficult to control:

…he would not experience any mental health symptoms for a while, as if the illness had vanished into thin air. Suddenly, out of nowhere, he begins to experience symptoms like mood swings, aggression, feeling sad and losing interest or pleasure in social activities. It takes a long time, sometimes several months, for him to recover from the sustained episode of the symptoms (Akua, FC, high category).

It is common for MHSUs and their FCs to experience a period of uncertainty and disorientation after receiving a diagnosis:

…The doctor mentioned a big name, which I cannot pronounce well. I am not well educated oh [laughs]… He said my brother has acute shi-co-frenia [Schizophrenia]. There is no Akan word for it. It is difficult to understand what it means; her explanation was in English and a bit of Twi. She was struggling to explain it in our local language. I am not able to know more about it and the symptoms he is experiencing in the local language (Kweku, FC, low category).

8.3.1.5. Pluristic Approaches to Mental Illness Recovery: Traditional and Medical Services

Commenting on the support, family relatives needed to understand mental illness [*dam yareɛ/yadeɛ*], two FCs recounted the various traditional and religious healing centres, including shrines, churches, and family members had taken them for healing to understand the mental illness and its origin better. It appears family members still believe mental illnesses are caused by evil spirits and the need to purify the family of any bad omen and remove curses, especially when they believe it is not a common 'disease' from their bloodline or lineage. Medical service becomes the last resort, usually when the mental illness symptoms become severe, more complicated to treat or life-threatening:

Some family relatives were initially divided on how to tackle my wife's condition. During discussions, both external families suggested traditional healing approaches, but my wife and I thought it wise to adopt the hospital approach. My Aunt revealed to me that they visited some

traditional healing camps in our village, and the attendant [priest] performed some spiritual rites to placate the spirits of our lineage with the items they were told to bring... She explained that they went there for answers so that the spirits would forgive the family for any wrongdoings and restore my wife's sanity and the whole family to its neutral state. She even brought some natural herbs for my wife to consume; she took them and had terrible bowel incontinence (Akwasi, FC, high category).

..I have roamed paa [a lot] across the country with him seeking healing. I have also been to ungodly places and performed different kinds of rituals. I wish I could tell you! I was prepared to get whatever it required to save him from this madness! As for things for his healing, I have bought several things. Some are expensive, but I got others for free from extended family members and friends. Aside from this hospital guidance, I believe fighting it requires a holistic approach. When doctors use their medical knowledge and medicines, we still tackle it spiritually and use traditional herbal medicines. It is for the family's good, and we have seen the improvement. He was not like this; initially, he was aggressive, but now he is a lot calmer and interacts with us better (Akosua, FC, low category).

Talking about this issue, Sei (MHSU, low category) and Kwadwo (MHSU, low category) said family members took him to the hospital first and later visited some religious healing centres for prayers and guidance:

I am whisked away to the mental health facility anytime I relapse. I am told that they invite our church pastor and elders to the facility or home to pray for me. I have also been to several prayer camps recommended by family members and friends for akwankyere [direction/ guidance] (Kwadwo, MHSU, low category).

...while medical treatment was ongoing, they prayed and informed our church leaders and some members to remember me and my family in their prayers. I believe God heals the sick so that I will be well (Sei, MHSU, low category).

8.3.1.6. Overarching Expectations of MHSUs and FCs

From participants' narratives, a complete remission of mental health problems (a total disappearance of the signs and symptoms of mental illness) towards self-dependence appears to be an overarching expectation for both MHSUs and their respective FCs. This was very evident in their

perspectives about/ understanding mental illness and recovery and the financial and emotional strains experienced in the performance and receiving of care.

Some FCs had this to say:

> *Wusu [MHSU, high category] being totally healed from abodam yare3 [mental illness] is important to us as a family, so he becomes efficient at his work to look after himself…(Akua, FC, high category).*

> *This is such a disgraceful 'disease' that can occur to any family…all we need is a cure so she [MHSU] becomes well. I cannot attend to my own needs or go anywhere because I fear she might harm herself or another person. It has affected my business and the income I could generate to support the household (Akwasi, FC, high category).*

Sei, MHSU, low category, expressed recovery as regaining lost independence, building coping strategies and capacities to care for self and others:

> *My girlfriend who I was planning to marry, left me when I had this condition. She said she did not want to be associated with someone like me and that she deserved better. I don't blame her, but I don't think she loved me enough to stay by me through thick and thin. I want to have my own family someday, kids strolling around the house, calling me Daddy!, Daddy! [smiles]. It is a good feeling you know! This condition has changed my life. For me, recovering means being at a level of functioning that allows me to keep a decent job, where I can maintain a marital relationship and provide for my spouse and our children in all the ways they need and want. I do not think it is terrible to desire these things (Sei, MHSU, low category).*

Perceptions regarding mental illness are crucial in shaping our understanding of the "disease" and its recovery. They may have far-reaching implications for stigmatisation, health-seeking behaviours, and the support offered to MHSUs. The interpretation, treatment, and perception of mental illnesses vary significantly depending on cultural contexts, family values, and personal beliefs. Participants' accounts demonstrate how different forms of assistance material and non-material alike, and knowledge of mental illness are intertwined. Based on their own personal experiences, participants revealed that the stigma

associated with mental illness is directly related to the level of understanding of the condition and the sort of help one receives.

It could be deduced from participants' narratives in relation to their socio-demographics constructs and lived experiences to suggest that participants with good educational backgrounds (high and moderate categories), particularly those in urban areas, associated mental illness with biological or psychological factors compared to their counterparts in the low category. The data suggest that those in urban areas have better access to medical facilities for seeking biomedical intervention compared to those in lower categories in rural areas. However, even with this access, some participants (in high and moderate categories) still relied on spiritual means to address the symptoms of mental illness and uncover its root causes.

8.3.2 Theme 2: Family Identity and Inclusivity Interplay in the Recovery Journey

Multiple pathways exist through which families may influence recovery through the formation of identity, interest and family activities. Identity formation influences include social control and monitoring levels, warmth and closeness, as well as responsibility and hierarchical family relations, all of which contribute to achieving the common goal of family wellbeing and social functioning.

8.3.2.1. Family Ties and Care Provision

MHSUs described diverse kinship networks reflecting the significance of their support in their mental health recovery journey. Four MHSUs from the moderate and low categories provided comprehensive descriptions of the family. They included members of their close/immediate family and wider/external family: children, parents, grandparents, siblings, parents-in-law, cousins, aunts and uncles, nephews, and nieces.

The other two MHSUs in the high category were more selective. Wusu focused only on his family of origin, including parents and siblings, and did not have contact with any wider family members owing to issues with disappointment in how they understood mental illness:

> *…it was between me, my brother, and my dad and mom, the nuclear family that understood what was happening to me, and we dealt with it extensively… Even my two half-sisters did not know (Wusu, MHSU, high category).*

In response to this, Akua, the FC of Wusu, said:

> *We do not seek support from external family members because we fear they might ridicule him [Wusu] again… (Akua, FC, high category).*

Adwoa described family solely in terms of her newly formed family or family of procreation and excluded family of origin (parents and siblings) or all members of their biological family due to challenges with their wider family members:

> *I don't accept their support because they are very rude to my family because of my condition… My husband and I severed connections with them long ago (Adwoa, MHSU, high category).*

Participants' discussions on family support aligned with the literature on caring and family inclusiveness in the recovery journey. In this study, participants generally agreed on what constitutes caregiving responsibilities and a family bond. Participants in this research described their families in terms of lineage and blood ties, values, and dynamics specific to each family, indicating that there is no universal definition of a family. Participants provided significance to this description, even if it might hamper future studies of family participation in the recovery process. Families are made up of anyone their members want to include based on shared beliefs and actions. It is unclear if the Ghanaian concept of a family is universally applicable. It does, however, emphasise the necessity of inquiring from MHSU who they regard as active family members in their recovery journey and to do so at various times, since this may change depending on the circumstances.

8.3.2.2. Place, Space and Support for Recovery within Family Relationships

Some MHSUs recounted their feelings of being rendered useless and stultified by other family members:

> *I attended a family gathering at [City]. I was invited by the abusuapyanim[head of the extended family] to be part of the discussion concerning… At the meeting, Naamera [aunty of MHSU]. "As for this person s3 w'abodam oo[this person is mentally ill], some people started giggling…when we are asking for ideas, what does she have to offer? She has no business being here in the first place! I felt despondent and angry. This was someone I cherished and helped when she was in need. What pained me the most was that nobody defended me (Adwoa, MHSU, high category).*

> *…S3 ab de3 nyansa biara nni ne tirimu [a person with mental problem lacks common sense, wisdom and competence], you don't include him during family events! We will be a laughing stock to our invited guests, I do not want this disgrace, I am telling you, oh!, this I overheard my elder brother telling my uncle over the phone. I felt sad that day, and I still do. I isolated myself from them [him and my other step-siblings] for days. Keeping to myself and not responding to their calls behind my door. It is sometimes disheartening how they think about me and describe me to others (Kwabena, MHSU, low category).*

> *I do not feel comfortable being amongst them [wider/extended family members]; there is no sign of respect or acceptance of my mental health problem. You know, you go out of the room and come back, and all of a sudden, everyone becomes quiet. I sensed they were gossiping about me. They can not say things to my face because they know I will react. Very shameful!, their attitudes and behaviour towards me (Adwoa, MHSU, high category).*

They were not allowed the opportunity to make their own changes and express their desires for privacy:

> *… they were behaving as if I was going mad or something; that's how they were behaving, so anytime I wanted to move out, they started suspecting that maybe something would happen like security was very tight! Anytime I decide to go out, they will call me several times. Say, for example, maybe I want to go and see a friend, but they will call that friend several times till I get home (Wusu, MHSU, high category).*

Contrary to this view, MHSUs in the moderate and low categories perceive family's control of their movement and activities means they care about their social wellbeing:

> *Mmmh, I am not allowed to go anywhere by myself. They are scared I might ruin somebody's property which would be costly for them to replace. I think they expressed much love by doing that; I think that is how they are showing concern for me and the wellbeing of others (Kwabena, MHSU, moderate category).*

Every morning when they bring my food, my sister reminds me hwe n'ako bebiara [make sure you do not leave your room/go anywhere]. I understood them when they insisted because it had never happened to my family. They have not seen anything like that before, so I think I understood them; it is their way of showing concern and protecting me from the community's ridicule (Kwadwo, MHSU, moderate category).

Some MHSUs presume that support from family is essential in their recovery journey. However, they argued that there was a need for their FCs to guide them in making their own decisions, performing their personal care and household chores alongside them:

I wish to clean and cook like I used to, but my husband and children will not hear of it. They do not allow me near the kitchen in my own home. I am idle all day, sometimes sleeping or watching TV, and not really involved in any household chores. The children do all the house chores, and my husband goes to work, the children go to school, leaving me all by myself at home. It can be boring at times when there is no one to talk to (Adwoa, MHSU, high category).

Most of the time, I do not wear my clothes appropriately or forget to do my personal care. Everyone is too busy to notice, let alone prompt me to do it well. Those who do, shout at me as if I am a small child and being too demanding. Being a bit unwell does not mean I can not be re-taught to do things. A little patience will help, you know! (Kwadwo, MHSU, moderate category). ...I know my brother is supporting me in any way he can, which I am grateful for. Nevertheless, I wish he would allow me to receive the remittances from other family members on my own phone. I can manage my finances, what and when I want to eat and the personal items I want to buy. When I have a bit of money, I feel good about myself (Sei, MHSU, low category).

I can perform some personal care tasks, such as selecting clothes to wear, brushing my teeth, and taking a full bath. However, my mother does not trust that I can do it well, so she takes charge and does everything for me. She will scrub every path of my body, cut my nails, comb my hair, does my laundry; I mean practically everything (Kwabena, MHSU, low category).

Contrary to the perspectives of MHSUs, FCs said:

I do not allow her near the kitchen to prevent accidents. The kitchen contains sharp objects which she might harm someone with it. It is better to prevent this than saying had I known? It might be too late to rectify the situation (Akwasi, FC, high category).

....she is still the one that does everything at home. She cooks, washes, and cleans. When she becomes poorly, I support her to get better, and we do not involve anyone from the external family (Kofi, FC, moderate category).

In the high and moderate cases, participants reported opportunities for space, a sense of understanding and belongingness as compared to the experiences of those in the low category. Within the family space, getting along with MHSUs is not always easy. They may be frightened, confused or distrustful and aspects of what they say or how they act may be hard to understand on the first encounter. Being guided by some cultural values and orientations, such as family image protection, social control of MHSUs' activities and taking on authoritative positions not to allow MHSUs to access the community and re-learn basic life skills may fundamentally disempower them and may stifle the recovery journey.

Constructing relationships on the basis of 'care' or treatment can be problematic as this can tend to imply a model of 'doing to' which presumes an ongoing polarity between a superior person, in this case, FCs, who possess competence and expertise and relatively passive MHSUs receiving the help that they are given. However beneficial the care or treatment may be in the recovery journey, it may carry a compelling message that takes away control and responsibility and encourages MHSUs to see themselves as worthless individuals waiting for others to sort out their mental health problems.

Therefore, it is essential to cultivate an accepting and enabling family setting in which individuals can recover and make the necessary adjustments to themselves in order to prepare for and participate in social re-engagement.

8.3.3. Theme 3: Family Agency in the Recovery Process

MHSUs often perceive family members as the most suitable source of support on their journey to recovery. This perception is frequently based on the belief that family members can provide access to financial assistance that can be used to pay for medical treatment, provide personal allowances, cater for nutritional and housing needs, and fund apprenticeship training. In response to questioning, FCs have

reported providing MHSUs with "material and instrumental help," including suggestions, solutions, and guidance.

8.3.3.1. Practical Sources of Support from Family

Family members provided support to their relatives receiving mental health care in a variety of ways. MHSUs reported that families were an important source of emotional fulfilment and encouragement, and when combined with their religious beliefs, this strengthened their capacity to cope. Many emphasised that a strong faith in God fuelled their resilience in the face of ongoing challenges:

> *…there is no telling whether I would still be here if not for my family, particularly my mum and Dad (Wusu, MHSU, high category)*.

> *…She [Mother] will tell me bible stories and quotations to build my faith and trust in God (Kwabena, MHSU, low category)*.

> *…whether it [family support provisions]is sufficient or not, God is looking after me (Kwadwo, MHSU, moderate category).*

Similarly, one's loved ones were essential to their sense of purpose and belonging:

> "*Without my family's love and encouragement, I would not have the strength to keep fighting this illness. I would rather not be here after being mistreated at work and by certain individuals I trusted. In the same way that my spouse and children mean a lot to me, I also mean a lot to them. Everything they do is geared at making me feel welcome and appreciated (Adwoa, MHSU, high category).*

Some MHSUs emphasised the importance of having a family member present to keep an eye on them, not only as a form of monitoring but also as a source of reliable alliance, reassurance, safety, and support in their daily lives:

> *My brother observes and reads me very well; as soon as he notices any changes, he will talk to me, asking if I am okay, most at times I say yes, however, knowing him so well, he will call the psychiatrist to discuss it, and then the next day I am taken in for a check-up. There are times I have been instructed to quit taking certain medications and had the dosage of others raised. He also spends his time buying and cooking my meals and encouraging me to eat and take my medication. You know, he invested two hours of his time and money to do this for me…I needed the food (Sei, MHSU, low category).*

...amongst my family members, I will say that my sister and her husband have been very supportive. They are my only hope; I have not felt forsaken in any way [me ne naa]. They keep my valuable possessions and manage my medication (Kwadwo, MHSU, moderate category).

Likewise, financial, transport and housing support were offered. MHSUs indicated that they receive material support essential for their recovery. In particular, MHSUs in the high and moderate categories relayed the practical support afforded by family members:

My dad and sister have paid for me to attend hair styling apprenticeship training, so I can also become a Madam, open my own shop, and employ other people [laughs]... (Afia, MHSU, moderate category).

...when I cannot join her to the hospital for her appointment, I give her lorry fare and money for medical expenses and sometimes walk with her to the junction to pick tro tro [mini bus] (Akwasi, MHSU, high category).

The capacity to experience positive emotions and engagement in relationships and activities results in a subjective sense that life has meaning or purpose. Compared with MHSUs in the high category, family members enabled empowerment, inclusion and citizenship:

...my sister comes over, and we play our local games like Ampe, Ludo or Oware. However, most of the time, we play with my doll, learning how to braid hair. She and my dad know I am very interested in becoming a hairstylist. We use her phone to learn new hairstyles on YouTube (Afia, MHSU, moderate category).

...sometimes, she cracks jokes and engages in riddles with me. She lightens the mood and makes sure everything is okay. When she is in good spirits, I really enjoy her company (Kofi, FC, moderate category).

I relied on the networks and connections in the teaching profession, from which I had just retired, to secure a slot for my son. He said it was his passion to be a trained teacher, and he needed a job to sustain himself. I have looked out for his interest and will always help him in any way I can (Akua, FC, high category).

...by working together, families create a nurturing environment that promotes healing and resilience in the recovery journey (Kwadwo, MHSU in the moderate category).

Having my family's support in my recovery journey is incredibly important to me. I have a strong desire to reach my full potential and become everything I am capable of being (Wusu, MHSU, high category).

While many recognised the value of practical support, several FCs also highlighted the demanding physical and emotional toll of providing care:

… no day is the same in the recovery journey. Some days, Adwoa was cooperative and complied with personal care; other days, she was combative and physically struggled with me (Akwasi, FC, high category).

This illness causes her [Afia] to act with incredible physical strength. When she becomes aggressive, she hits, scratches, and pushes me aside. Given my age, it is physically challenging for me to manage her, even when trying to get her into a taxi to the hospital (Kofi, FC, moderate category).

"I have been subjected to many insults from him [Kwabena]. It is distressing and at times deeply emotional, and I find myself questioning what I have done to deserve such treatment." (Akosua, FC, low category).

...When he [Kwadwo] becomes aggressive like that, my husband and I cannot sleep all night. We have to stay awake to prevent him from going to my shop to break the lock or scatter the items… it seriously disturbs our sleep (*Ama, FC, moderate category*).

...I look after him [Wusu] day and night, sometimes even forgetting to take my own medication or food. He is my child, and I will do everything I can to support him (*Akua, FC, high category*).

…being a caregiver requires a great deal of patience and a forgiving heart. I have been spat on, slapped, bruised, and kicked in many places. I have even sustained injuries while trying to restrain him to take him to the hospital, as he becomes extremely aggressive (Kweku, FC, low category).

The data indicate that FCs in the *high* and *moderate* support categories enabled MHSUs to participate as full and equal members of society in areas they valued. These caregivers created opportunities for MHSUs to reclaim control over their lives, direct their own support, and build confidence in exercising agency. Knowledge and information were actively shared, providing MHSUs with the tools to pursue recovery on their own terms. In these cases, the quality of the relationship—based on collaboration and genuine respect for the perspectives of service users—proved more influential than any particular caregiving techniques.

In contrast, MHSUs in the low support category had limited opportunities to rediscover themselves, rebuild skills, or regain competence within the family setting. A lack of consistent support constrained their ability to engage meaningfully with recovery, leaving them more vulnerable to stagnation and isolation. This highlights the unequal impact of family dynamics on recovery outcomes.

Reliance on families to sustain recovery underscores both the vital role of familial relationships and the vulnerability of caregivers, particularly older relatives who face physical strain and safeguarding risks when managing aggressive behaviours. Many accounts also reflected the self-sacrificing nature of caregiving, where devotion to supporting an MHSU sometimes led caregivers to neglect their own health, compounding their vulnerability. These findings emphasise the importance of equipping FCs with the skills and resources needed to provide sustainable support. Effective capacity-building should include financial and emotional assistance, practical guidance, and advocacy training. Structured programmes designed to enhance knowledge of available resources, improve caregiving skills, and encourage collaboration with health professionals are essential. Such initiatives would empower caregivers, reduce their burden, and contribute to more sustainable recovery outcomes for MHSUs.

8.3.4. Theme 4: Economic Arrangements and Hardship

Economic hardship was a pervasive burden that permeated the narratives of participants across all support level categories. However, the experience of this burden and the economic arrangements adopted differed for each category in the recovery journey. Kofi, a FC and Afia, a MHSU from the moderate category, described the agony that they experienced due to the unavoidable nature of the treatment plan and the cost involved:

> *…Then the clinical psychiatrist said to us, this sort of condition has no cure as you are expecting but can be handled throughout your lifetime with therapy and medicines…you need to attend all your review meetings and have enough money to support yourself*". *Her response remains with us forever. I am a pensioneer and I cannot work at my age. The little money I saved for my old age is what I am using to maintain her treatment plan* (*Kofi, FC, moderate category*).

In response, Afia indicates that she does not work and cannot afford the treatment cost:

> *I am currently a hair dressing apprentice and I do not make any money. I rely on my sister and father to meet my personal and health needs (Afia, MHSU, moderate category*).

Akwasi and Adwoa from the high category shared more light on this issue:

> *…all is money!… You can't see the doctor and go away free, sometimes when you go to the hospital you pay certain amounts that the money on you won't reach. And it's not a place of mercy, now it's compulsory for you to check your sugar level whether you have it or not you will pay GHC5.00 [£0.36]. I even feel pity for people, they don't have the money and at the end you see them fight with the nurses… they tell you to go pay for consultation at first it was GHC29.00[£2.09] but now it is GHC40.00[£2.88] so it a challenge. When it's time for you to go the hospital, you get frighten and anxious, doctors have also made us aware that when the time for taking the medication elapse it bring another problem difficult and costly to treat. So, when the time is getting closer then you get frightened, wherever you have to go get the money you have to. It's very difficult for the families (Akwasi, FC, high category).*

> *…as for the sickness it has made me not accomplish a lot… I had a lot of setbacks I thought I could finish learning the job and do something for myself, when it happened like that, I left the work and stayed home for long without doing anything and not making any money…at first, they don't take money for the consultation but now when you go, they tell you to pay the money at the bank before treatment. I don't make much from my polythene bags selling business. The medicine I buy cost me GHC1500.00[£107.91] for the period of three months… not all people will have the money to buy. If not for my husband, I will be doomed (Adowa, MHSU, high category).*

Ama, a FC in the moderate category, had this to say:

> *…now, everyone is tired of contributing towards his [MHSU] care… sika y3de t) n'duro n'asa [money to buy medication is finished]. My other siblings refuse to take my calls. We provided what we have so far, hoping he receives healing and works to fend for himself. With him frequently relapsing, it makes it difficult for us. We have tried! Hmmm, this economic hardship and I having my kids to look after. I cannot continue like this [participant appears poignant, tissue offered to wipe tears and some time to relax before interview continued per consent]. This disease is a curse! Fighting it is hard; it eats all your savings (Ama, FC, moderate category).*

For Sei, MHSU in the low category, reported that formal care requires money, which he does not have in abundance because he has no job and heavily relies on support from family members:

> *…after seeing the doctor and buying medications, our total cost summed up to GH₵1,000.00 [£71.94]. Kweku [FC] paid for it with money he receives from other family members abroad. Fighting this disease requires money, and the medications are costly. Even when you choose to go the traditional way of using herbal medicines, money is required… we tried that and nothing improved (Sei, MHSU, low category).*

> *…I did not get far in my education to get a better-paying job… So what the doctors recommend is what we try to do for him (Kweku, FC, low category).*

FCs in the moderate and low categories acknowledged that the recovery journey has been overwhelming and fraught with external economic challenges, including the high cost of living and the COVID-19 pandemic. This has somewhat limited the support (financial assistance) they receive from their external family members. Nevertheless, FCs indicated that they are able to manage it by adding their own resources:

> *…how are we to maintain his medical treatment? You cannot afford the treatment cost if you do not have the financial means, and rightly so! When it comes to financing his treatment, family members support us, and we add on, but during COVID, the money from them reduced drastically, and we cannot fault them; everyone is struggling presently (Akosua, FC, low category).*

> *Right now, money is hard to come by… and the COVID pandemic has made the situation worse. The price of goods and services keeps going up… not leaving out his medication cost. We buy*

what we can and hope that help will come from other family members abroad (Ama, FC, moderate category).

Although economic hardship was cited as a burden of caregiving by most MHSUs and their FCs, Akua, the FC of Wusu (MHSU), shared a different perspective:

...So we didn't really face any peculiar financial problems…His Dad was the one paying for everything. I think with my son's situation it is better... I met one of my students there [facility], and his situation was pitiful. I had to step in to pay for his bills. No family member was there to support him (Akua, FC, high category).

My dad and my mum were the one paying for everything, it is just recently I told them I want to help in paying the treatment because I work. So, he pays the consultation and I pay the medication. He is a pensioner, so I must take over buying it…it's obvious my dad was doing that a lot. He always says to me, "you are my responsibility, and I must support you get better" ... (Wusu, MHSU, high category).

The experience of economic burden during the recovery journey may not be the same for all participants, especially those from affluent and economically stable homes who can adequately finance the treatment costs of MHSUs, as reported by Akua. Nonetheless, other participants' experiences revealed that the direct costs associated with formal care, including expenses for transportation, feeding, clothing, shelter, and medication, can weigh heavily on families and MHSUs. Informal spiritual care also comes with significant expenses. While healers generally do not accept payments, MHSUs and their FCs are expected to cover the costs of herbal medicines and items required for sacrifice.

Indirect costs, such as loss of income during treatment, further exacerbate the financial burden. In addition, the onset of symptoms during the formative years of MHSUs precludes opportunities for education or vocational training, thereby limiting their future earning potential. This, in turn, creates a vicious cycle of unemployment and poverty that aggravates mental health problems, making the journey to recovery more challenging and costly for MHSUs and their families.

8.3.5. Theme 5: Supportive Family Relationships in the Recovery Journey

The data show that in times of crisis, including illnesses, the family often reacts together as a unit, responding as though a combat unit, to achieve positive outcomes such as subjective wellbeing. In discussing with FCs and MHSUs what supportive interpersonal relationships towards recovery meant to them, there was an acknowledgement that recovery from mental illness is a family affair:

> *…he [Kwabena, MHSU, low category] is part of our asefoɔ [lineage] and our dehyeɛ (kin), and we cannot overlook his condition. They are supporting in one way or another. Not every family member can be present, so I accepted to look after him here in the village while the others work in kuro kɛseɛ [City] to bring money home for his upkeep, aside what I provide (Akosua, FC, low category).*

> *We [close family members] are in no way rejecting our own blood because of her condition. Our faith in God tells us we are one, and that's the promise we made to each other when we got married; for better or worse (Akwasi, FC, high category).*

> *Because I receive support from Kwadwo's [MHSU, moderate category] siblings and our external family members [uncles and aunties], I can look after him to the best of my ability. Their financial support is insufficient, but I accept and manage it like that. Nowhere cool, oh! I tell you! Considering Ghana's higher cost of living presently, I will say they have done well. COVID-19 has spoilt everything for all of us…hmm! What can we do? (Ama, FC, moderate category).*

> *Without the help of abusuakuo [close and wider family members (family group)], I cannot recover. Treatment is costly. Through their financial support, I have gotten this far (Kwadwo, MHSU, moderate category).*

> *Nobody can look after you well like your own close family would. The love and care from family in comparison to friends is unmatched (Wusu, MHSU, high category).*

Adwoa, a MHSU in the high category, reported that having children might serve as a motivating factor to get better, boost confidence and resolve:

> *My husband and children support me; they have really been helpful. They do all the house chores and market errands. They in no way burden me. Their support has been helpful; I cannot manage myself without them (Adwoa, MHSU, high category).*

From the above excerpts, it can be inferred that FCs acknowledged their embedded traditional role (enmeshed in religious and cultural values of kinship, intimacy, solidarity, faith in God, empathy, and reciprocity) of providing care and support to relatives who are ill and in no position to look after themselves. Participants' narratives indicate that familial relationships characterised by intimacy, affection, and familial cohesion are crucial and reliable mechanisms in the recovery process. It would suggest that the recovery journey of MHSUs appears to be largely dependent on the support and care provided by their families.

For *Akwasi, FC, high category,* his belief in God and marital vows motivate him to support his spouse in every circumstance. He asserts that he is honouring his marital vows, which bound him in blood and flesh with his spouse, and he cannot desert her due to mental illness. When a family member falls ill, the roles within the family often shift dramatically. The caretaker becomes the one who needs care, and other family members must step up to fill the void. Family members and MHSUs may need to come to a new understanding of what is "normal." This can be a challenging and emotional process, as it requires adapting to new responsibilities and finding ways to support one another. For example, family members not present due to migration send remittances to the members who may or may not have accepted the role of a caregiver to support MHSUs' recovery needs.

Besides, family members providing care may or may not reside in the same household as MHSUs. It can also be deduced from participants' accounts that many families seldom anticipate who would take on the primary responsibility of caregiving (within close family) and how others (extended family members) will pitch in to help. Migrant family members (close) involved in caregiving may send financial incentives to attract more distant relatives (extended family members) to assist, as in the cases of *Kwadwo, MHSU, moderate category, and Kwabena, MHSU, low category.*

Wusu, a MHSU in the high category, conveyed that his family's involvement and support in his recovery journey have been focused on acceptance, empowerment, and a lifelong commitment to a journey that is not without its challenges:

> *...dam /adammɔ* yareɛsa tesɛ *akwantuo [recovering from mental illness is a process] not always straightforward like other diseases. The beginning was difficult, especially when there was little knowledge about it. While resolving the areas of concerns and reaching a point, you relapse when financial support diminishes and when you later get some too you need to start the whole treatment process again. It is never-ending and stressful for me and my immediate family members (Wusu, MHSU, high category).*

Ama, a FC in the moderate category, expressed a perspective that differs from that of Wusu, a MHSU, in the high category. While Wusu's experience emphasised the positive role of family support in his recovery journey, Ama's perspective highlights the challenges and difficulties that can also arise in the context of family caregiving:

> *As a family, we have acknowledged our failures with him. We used not to support him so much because he did not contribute to anyone's wellbeing when he had the means to. His appearance and condition made us look bad, and community members complained a lot about the distraction of their properties. Now, we go above and beyond to support his treatment and caring needs. Not all family members agree to support or provide some form of help; I do what I can. Sometimes, my husband and I borrow from neighbours and receive food items from friends (Ama, FC, moderate category).*

Participants' narratives above underscore the presence of supportive familial relationships marked by a sense of affection and collective solidarity. Nonetheless, these same accounts also draw attention to the precarious nature of family life and the challenges and uncertainties that it can entail. Traditional views of family and home can significantly impact the dynamics of trust, reciprocity, and affection, potentially influencing the quality of support provided to MHSUs in their journey towards recovery. Based on the participants' experiences, it can be inferred that family relationships that aid MHSUs' recovery are driven more by feelings of personal and kinship obligations than by monetary

compensation. Nevertheless, MHSUs who do not invest in the welfare of others may be abandoned or left with little to no family support, potentially leading to feelings of stigmatisation, as accounted by *Ama (FC, moderate category)*.

8.3.6. Theme 6: Expressed And Unexpressed Emotions in the Recovery Journey

The data highlight the active involvement of family members in MHSUs' recovery journey. However, some MHSUs mentioned that their privacy was not respected and their revered position within the family was devalued. These experiences highlight the importance of striking a balance between familial support and individual autonomy.

In making a case for this view, *Afia* (*MHSU, moderate category*) stated that although her family was supportive, she often felt like she was not in control of her own life:

> *…no matter how clearly the limits were stated, they were never respected. For example, I once told one of my elder sisters, you don't need to check up on me every day, and I'm alright. It's not like I have to deal with the effects of my sickness every day, so just leave me alone! She acts as if she doesn't believe that and keeps coming over and calling my dad to check on me; I find the constant monitoring intrusive, but my dad insists that she's just being compassionate* (*Afia, MHSU, moderate category*).

Talking about this issue, Adwoa (MHSU, high category) said:

> *…I joined the ladies at the market to purchase the foodstuff for making the funeral refreshments. Upon inspecting the items, my akumaa [sister-in-law] retorted in front of everyone: "It is only a mad person who will purchase spoilt cassava."; they laughed at me, calling me names…"if you need someone to run the errands, why her?"... Whenever I freely opt to assist them, and whatever I do, I am seen in relation to my mental illness. I feel hurt hearing them disregard me in this manner. I did not choose mental illness for myself; anyone could get it. I always cry in my sleep and leave everything to God* (*Adwoa, MHSU, high category*).

The data revealed many unresolved or ongoing issues between participants and other family members, often drawn into each other's problems. It appears such issues were covered beneath an appearance of harmony, which could only be maintained by 'skewed' family dynamics, such as one or

two close family members becoming over-involved to protect the harmony, recognition, and social standing accorded to them in the family and society. For instance, in Adwoa's case (*MHSU, high category*), it appears *that Akumaa projected her unacceptable feelings onto Adwoa, possibly influencing other members present to laugh and ridicule her,* and perhaps encouraging her to play the victim. It seems Adwoa had lost the will to defend herself by clearly speaking up and articulating what her upset is about and to whom those feelings are directed, but instead turned everything over to God.

Similarly, Afia's (*MHSU, moderate category*) experience illustrates how her sister may be trying to compensate (emotionally dominating and demanding particular responses) by intruding and overprotecting her as a means of avoiding her own pain. Regardless of the specific interpersonal defence mechanisms employed towards particular patterns of emotional tension within the family, the ultimate consequence will likely be a shift from a functional and supportive family group to one that may be struggling badly and exhibiting various difficulties.

The experiences mentioned in the data highlight a crucial point about the need to balance familial support with individual autonomy. While family members play an active role in the MHSUs' recovery journey, it is equally essential to respect their privacy and maintain their position of reverence within the family. This balance between support and autonomy can go a long way in ensuring that MHSUs receive the care and attention they need while also maintaining their dignity and independence.

8.3.6.1. Stigmatisation and Shame within Family Relationships

Participants' interactions with others show how they perform a range of social identities that reflect their positioning within the family and in socio-cultural discourses. In this way, participants become influenced by their cultural and communal contexts, including family values and their own ways

of 'storying' their self-identity and self-efficacy (self-esteem) in response to their mental health problems and social experiences.

Nonetheless, membership in a family may not always be such a positive experience. Along with families providing care and support, they may also become avenues for legitimising explicit and implicit actions of bullying and abuse and serve to silence the voices of those victimised. Issues of stigmatisation and shame within the family were an experience that MHSUs were reluctant and not confident to share. In the high and moderate categories, it seems MHSUs did not want to sound ungrateful for the support they have received so far from family members:

> *I appreciate what they do for me. I cannot fend for myself, so I do not complain about the support I receive from my family… (Kwadwo, MHSU, moderate category).*

> *…a small help is better than nothing, so no complaining (Wusu, MHSU, high category).*

> *I don't want to be looked at as someone who is choosy and overbearing. As for a sick person without support from the government, why should I moan about the support I am receiving? Some do not even have a quarter of what I get. Their situation is more pitiful than mine. So I am thankful for having a family [close] providing their widow's mite to support my recovery. I cannot behave like a beggar with a choice to dictate what should or should not be done for me (Adwoa, MHSU, high category).*

The narratives of *Kwadwo*, *Wusu* and *Adwoa* reveal undertones of shame in their experiences with their FCs and relationships with other family members. Nonetheless, they argue that the stigma they encounter within their families does not affect them. They appeared indifferent and resigned to it, possibly due to the cultural norm in Ghana that discourages MHSUs from appearing ungrateful and fastidious, particularly to FCs or individuals who support them.

Consequently, these MHSUs hesitated to articulate their needs and requirements, fearing that it might impose a burden on their families or subject them to criticism. For instance, assertive

communication and expressive behaviours may become labelled deviant, giving people identities seen as "difficult" and "unappreciative" in some way. Despite the complexity and potential conflict in identifying one's voice, place and space in the family and society, these MHSUs indicated that they derived their self-esteem and self-efficacy from their belief in God, which helped them through challenging situations and provided them with something to organise their resilience and recovery.

Contrary to the views shared by MHSUs in the high and moderate categories, participants in the low category mentioned instances in which they felt victimised and devalued within their family relationships:

> *…how they talk to me is not good. It feels like they are shouting at me… This affects me because I sometimes feel embarrassed to beg for money to buy food. I often do not engage them; I roam the streets and beg others. When I am lucky, I get enough for the next day (Sei, MHSU, low category).*

> *When I hear family members [extended] talking ill about Kwabena's [MHSU, low category] condition, I ignore them and get on with my life because that is their opinion about mental illness. I become helpless in explaining to them when they have already formed an idea of me and my child (Akosua, FC, low category).*

Sei's (MHSU, low category) narrative reveals his struggle to act assertively within his family space. Such orientations often strained his self-esteem and led to alternative forms of adaptation, including begging and learned helplessness in his recovery journey. Similarly, *Akosua's* (FC, low category) account demonstrates how easily family members can form judgements about MHSUs without sufficient understanding, empathy, or adequate knowledge of the MHSU's comorbidities, that is, the presence of more than one co-occurring mental health condition or an overlap of mental and physical health problems.

Within the family space, it is uncommon for people to openly express their stressful emotions or feelings towards family support, which may undermine their personal agency and ability to form and maintain healthy interpersonal relationships with family members. Consequently, perceived behavioural and temperamental differences often escalate into inter-relational conflicts, making it difficult for MHSUs to form the resilience to renegotiate their place and space (identity). This, in turn, could make them more susceptible to stigmatisation, develop a fragile sense of self and make their recovery more difficult.

8.3.6.2. Secondary Stigmatisation

Wusu (MHSU, high category) and *Afia* (MHSU, moderate category) reported that their social relationships were negatively affected because they were unable to move and interact freely with other people in their neighbourhood due to fear of being stigmatised. This connotes secondary stigmatisation against MHSUs and their family members:

> *My mental condition usually becomes a discussion topic when meeting friends. Instead of discussing business, they tend to dwell on matters happening at my home. I am sometimes ridiculed, and when I talk about how their behaviour towards me affects me, they tend to downplay my feelings. They presume the 'disease' is coming oh, we better go away! … show up for the subsequent meet-ups (Wusu, MHSU, high category).*

> *…I heard from someone that their parents have warned them not to be friends with me because they will also get mental illness. Maintaining the relationship becomes problematic since you cannot go near them (Afia, MHSU, moderate category).*

In discussing the issue of secondary stigmatisation, *Ama* (FC, moderate category) and *Sei* (MHSU, low category*)* remarked:

> *It is an uncomfortable situation that I feel ashamed and embarrassed. Kwadwo [MHSU, moderate category] has no job, so he often helps me at my sewing shop. I have made a small stand in front of my shop where he helps me sell the items…when customers hear that he has* '*adwene* yareɛ*'[mental illness], they do not return. Some customers return their purchases with*

the excuse that something is wrong with them. Some immediately change their minds after informing them that the sewing items wanted are in stock. "You, I will be back", they never turn up! You will see them coming from the other shop with the same items they had inquired about from me. It is a problem for my small sewing business. Sometimes, I have to drive my brother away to make intentional good clothing sales… (Ama, FC, moderate category).

…let's be honest with ourselves; I am incapacitated because of my illness. Who in Ghana here is ready to employ me to run at a loss? Have you seen any job advertisements for such individuals? Nobody can employ me except myself, and … I will not get customers... Our society is not too friendly towards mad people, and my investment and that of my family in any business venture will go to waste. "Of what value am I to my family?" (Sei, MHSU, low category).

The excerpts above describe the difficulties that FCs and MHSUs experience due to secondary stigmatisation. For *Ama* (FC, moderate category), it appears that working with her brother, *Kwadwo* (MHSU, moderate category), in her shop to help him resume appropriate interpersonal activities and behaviours has negatively impacted her business. *Sei* (MHSU, low category) contends that the Ghanaian community rarely create employment avenues for MHSUs to resocialise and, generally, to participate in community life through more vocational and adaptive skills. Lack of employment opportunities and loss of work productivity among MHSUs and their FCs have implications for growth and development. There appears to be little to no collective effort from the government to improve access to work; thus, the risk of providing suitable jobs for MHSUs is reduced to arguments for a "return on investment", as echoed by *Sei* (MHSU, low category). For participants to do meaningful work and provide for themselves and their families is inherent to a sense of wellbeing and identity. For many families, working and contributing to household income and the broader community is a significant milestone in achieving social status and respect.

Secondary stigmatisation experienced by MHSUs and their FCs revealed profound loneliness and isolation. Despite being close to their neighbours, they expressed dissatisfaction because their neighbours believe that Adwoa's (a MHSU, high category) condition is transmissible, which leads to isolation:

> *"When people hear she has psychosis, they will simply not come close" (Akwasi, FC, high category)*.

FCs perceive socially stigmatising behaviours as a significant threat to their family's daily life. This perception motivates them to isolate MHSUs from neighbours, confine them in their rooms, and conceal them from the public to maintain a constant state of vigilance. This is due to the shame and sadness that the family associates with MHSUs, contributing to the stigma they carry as a whole.

Kweku (FC, low category) relayed his regrets about involving himself in *Sei's* (MHSU, low category) recovery journey. This has to do with the increased burden, stigma and discrimination in society, the many difficulties FCs face in providing support, and their struggles with mental health delivery services in Ghana:

> *I try to explain to close relatives abroad who get to know about his condition that it resulted from a stressful experience… I thought that they, being abroad, may have adequate knowledge about it. However, they spiritualise it, sending me on errands to different traditional healing places… The hospital is choked, and you spend your whole day there. I lost my job, and my relationship with my then-girlfriend was impacted. With all these challenges, I sometimes ask myself why I got involved (Kweku, FC, low category).*

The data suggests that family members who have assumed the responsibility of caring for MHSUs may experience secondary stigmatisation, which may have an impact on their personal lives. This, in turn, may lead to feelings of resentment and regret, as observed in the case of *Kweku*, FC, in the low category. Despite the advancements in biomedical interventions, the data suggests that family members continue to spiritualise mental illnesses, which influences their health-seeking behaviours, interpersonal

relationships with MHSUs, and the community at large. Generally, illness has been regarded as a private and confidential matter, discussed discreetly behind closed doors. However, the data suggest that the Ghanaian community's propensity for gossip exacerbates stigmatisation, as privacy concerns are often overlooked, and information is disseminated and exaggerated rapidly, affecting the social and economic lifestyle of MHSUs and their families.

8.4. Summary

The developed themes are presented to reflect participants' cultural understanding of mental illness, despite some issues being related to Western medically defined conditions. The study's findings revealed that all FCs shared similar feelings of bewilderment, anxiety, uncertainty, confusion, worry, ambivalence, and meanings of processes in MHSUs' recovery journey.

Many MHSUs interviewed reported receiving some level and type of care and support from their families to aid in their recovery. They considered the assistance they got the "sole reason for their healing," and they were thus very reliant on their families to maintain their health, social wellbeing, and functioning (ability to interact with others). It was also observed that MHSUs belonged to small families (often consisting of one or two individuals from their immediate families), lived in shared accommodations with their families in both urban and rural areas, had a relatively low educational level, and frequently held low-paying jobs. Because of this, FCs are commonly compelled to centre their daily lives almost entirely on providing care support for MHSU (dependent).

FCs frequently described feeling responsible for their dependent who has a 'disease' that is hard to grasp and is consequently seen as stressful and harmful. Because of its incomprehensible ("nobody knows what is going on in her mind," "he is tough to grasp") and, in most instances, irreversible character ("she will never be healed"), mental illnesses are regarded as an exceedingly worrying 'disease', ''dirt

on the image of the family'' in addition to being prohibitively expensive to MHSUs and their families to manage. The cultural portrayal of mental illness in socially deprived contexts was found to amplify stigma and emotional distress, deepening the caregivers' feelings of helplessness and isolation.

For MHSUs, daily living activities, including personal care, mobility, and household responsibilities, were frequently assumed by FCs. Although a positive gesture for FCs to be involved in MHSUs' daily lives, this could make it difficult for MHSUs to negotiate their space and place in the family, thereby maintaining some level of autonomy, voice, and independence. Decisions/choices concerning their general wellbeing are often made without their full consent/participation, reinforcing a dynamic of dependence that complicated their sense of self, dignity, and recovery within the family setting.

Overall, these findings reveal the interdependence and tension between care, control, and autonomy within Ghanaian family systems and the enduring influence of stigma on recovery processes. Chapter Eight thus provided rich, contextualised insights into how MHSUs and FCs experience, interpret, and negotiate family support in everyday life. Chapter Nine builds directly on these insights by synthesising the qualitative and quantitative findings to provide an integrated discussion of the study's overall results. It situates these findings within the broader theoretical and empirical literature to explore how cultural meanings, stigma, and caregiving practices shape the forms and functions of family support in the recovery process.

CHAPTER NINE

DISCUSSION OF FINDINGS AND IMPLICATIONS

9.0. Introduction

This chapter discusses the study's overall findings. Given the explanatory sequential mixed-methods design adopted in this research, which incorporates both quantitative and qualitative phases, the results presented in Chapters Seven and Eight are not intended to imply causal relationships but rather to illustrate correlational patterns and provide contextual explanations. In line with the principles of the Explanatory Sequential Mixed-Methods Design outlined in Chapter Five, this discussion integrates and triangulates both datasets, with a critical emphasis on the qualitative evidence, to interpret and explain the varying levels of family support experienced by MHSUs. The discussion examines the interconnections and situational influences shaping FCs' involvement and the diverse forms of support MHSUs receive throughout their recovery journeys. The complex interplay of perspectives from both MHSUs and FCs highlights the importance of a nuanced, interpretive analysis that acknowledges the social, cultural, and relational contexts within which caregiving and recovery occur.

The subsequent sections are organised around key sub-themes that emerged through the synthesis of findings within the study's theoretical framework (*see* Chapter Four). These sub-themes include *family support and inclusivity*; *lay versus Westernised conceptualisations of mental illness*; *health-seeking behaviours*; *complexity of relationships*; stigmatisation; and *family caregiver burdens*. Together, these themes reflect the complex and multi-layered nature of family caregiving and mental illness recovery in the Ghanaian context.

The chapter progresses as follows. It begins by discussing the findings in relation to the Family Support Scale (modified SPS-10, quantitative data) and then integrates these with the qualitative insights

to provide a deeper, contextually grounded understanding. The discussion situates these integrated findings within relevant theoretical and empirical literature to address the study's four research questions. In synthesising the findings across both quantitative and qualitative phases, this chapter moves beyond description to develop a deeper theoretical understanding of how family support functions within the recovery process. The integrative discussion that follows lays the foundation for Chapter Ten, which consolidates the key conclusions of the study and presents the broader implications for policy, practice, and future research on family caregiving and mental illness recovery.

9.1. Family Support and Inclusivity

It was evident from participants' narratives that the recovery journey from mental illness is a family affair, and the family's role in supporting MHSUs cannot be underestimated. Participants' experiences may help us to understand the nature of family caregiving in mental healthcare in Ghana (*see* Chapter Eight). These experiences are testaments to Ghanaians' consideration of kinship solidarity, intimacy, and devotion as the ideal virtues of family care. A comparison of participants' experiences with those of other studies (*e.g.*, Quinn, 2007; Van der Geest, 2016; Read and Van der Geest, 2019; Van der Geest, Dapaah, and Kwansa, 2019; Saunders, 2003) echoes these views. Hence, it could conceivably be hypothesised that the family's inability to care for MHSUs and allowing them to roam on the streets and unsanitary places with no supervision, usually unkempt (as typically observed), may be regarded as a moral failing of the family. This study, therefore, raises intriguing questions regarding the role of family support in recovery.

MHSUs' narratives underscore how social support provisions from close and wider family members serve as a protective factor in their recovery journey and from many socioeconomic issues. The experiences of MHSUs showed that their family's involvement and support in the recovery journey has

a structural component referring to (a) the size and nature of their family and the willingness of members to take up caregiving responsibilities, (b) a functional aspect, referring to overt behavioural transactions (support provisions) between MHSUs and their FCs.

In terms of family size and nature, all MHSUs described their family from a nuclear perspective (with or without children). Nevertheless, support in the recovery journey also came from their extended family members. These external family members were reported to be absent in MHSUs' daily lives and not actively involved in providing physical or personal care. Participants mentioned that external family members provided financial support or remittance, which family members (actively involved in caregiving) used to provide the basic needs of MHSUs. It seems possible that participants' accounts attest to the changing family structures, a shift from extended family systems to nuclear families, reducing the number of family members available to provide care. This implies that the support network of MHSUs is small and typically made up of close family relations who may be relied on to provide practical help and compassionate care while they get back on their feet.

These FCs (interviewed in this study) were also found to be deeply committed to the people they were helping (MHSUs), which led them to view themselves not as "carers" but rather as an expression of their love and support. They perceived their actions and involvement in MHSUs' recovery journey as a natural part of who they are. This supports Read and Nyame's (2019) findings that initiating caregiving may begin with little assistance from a close family member or the assumption that the MHSU's closest relative with financial means would take care of any emotional or physical care requirements.

Another finding that stands out from FCs' narratives is that men and women were involved in the caregiving of MHSUs. This finding is contrary to previous studies, which have suggested that female family members (nuclear or extended) have been expected to take on responsibilities for children, the

elderly, and medical care (Sackey, 2009; Manful and Cudjoe, 2018; Nukuyan, 2016; Abekah-Carter *et al*., 2024; Quinn, 2007; Spillman and Pezzin, 2000). Traditionally, women have been the primary caregivers, undertaking time-consuming and demanding tasks such as bathing, feeding, laundry, dressing, and medication support—roles often linked to socially constructed gender expectations and norms of nurturing. However, this study indicates a shift in these traditional roles, contributing to evidence that men are increasingly engaged in complex aspects of care, including managing finances, coordinating services, and providing direct assistance with personal care. A possible explanation for this gender implication is that women are increasingly entering the workforce, creating a "care deficit" in many families. Ghana's struggling economy has heightened the need for dual-income households, resulting in less time for family caregiving. Consequently, many families face difficult choices between work and caregiving responsibilities. These findings corroborate Read and Van der Geest's (2019) contribution to the complexities of caregiving within Ghanaian families in the 21st Century.

Several factors can be deduced from the study to explain the complexities of family caregiving for MHSUs in Ghana. Firstly, economic pressures and migration have reshaped family structures. Increased global mobility has led to relatives relocating for work or education, making direct caregiving more challenging. This has led to the growth of long-distance caregiving, often through remittances from family members abroad, while the day-to-day responsibility increasingly falls on those who remain at home (Aboderin, 2004; Apt, 2002; Mazzucato, 2008). Secondly, globalisation has exposed families to new ideas and lifestyles that challenge traditional expectations of filial piety and kinship obligations (Oppong, 2006; Aboderin and Beard, 2015). These shifting values may reduce extended family members' willingness to provide care, thereby intensifying the burden on immediate caregivers of MHSUs (Kpessa-Whyte, 2018). Taken together, these changes demonstrate the need for mental health

policies and community-based support systems in Ghana that acknowledge the dual pressures of globalisation and migration while strengthening families' capacity to support recovery (Ae-Ngibise *et al.*, 2015; WHO, 2021a; UN Department of Economic and Social Affairs (UN DESA), 2019).

Regarding the functional aspects, MHSUs described several types of supportive behaviours of FCs, and this can be grouped into six broad categories that characterise Wesis's (1974) social provisions theory (*see* Chapter Four). The narratives of MHSUs provide further support for the findings of the social provisions scale used in the quantitative phase of the study (*see* Chapter Seven). In the qualitative phase, the main issue discussed with MHSUs regarding social provisions is what functions of a family's supportive behaviour are responsible for the support provisions to be perceived as helpful in the recovery journey. Some participants in the *low category* indicated that certain types of support received from family are inherently supportive, especially the emotional component. For example, family members encourage MHSUs to pray, have faith and hope in God, and establish intimacy through empathetic communication and interactions (*see* Chapter Eight). That is when family interactions with MHSUs are seen as emotionally supportive. Other participants in the *moderate* and *high categories* assert that the match between the type of social support provisions and the characteristics of the presenting situation is crucial, with implications for relational interactions and levels of support received throughout the recovery journey. In corroborating this argument, the quantitative data shows that MHSUs in *these categories* had higher scores on the modified SPS-10, indicating their families' agency in their recovery journey compared to their counterparts in the *low categories*. These findings are consistent with Tew's (2013) postulation of recovery capitals as a framework for understanding social approaches to recovery.

It is encouraging to compare these results with those found by Cutrona and Russell (1990), who discovered that high scores on the SPS may stem from the fact that caregivers providing social support

to recipients often have a good understanding of what constitutes supportive behaviour. Therefore, they provide support in appropriate ways. This assertion is evident in MHSUs' experiences in the *high* and *moderate* categories. Based on Wesis's (1974) postulations of social provisions, MHSUs indicated that their FCs provided non-assistance-related social provisions when needed and offered *assistance-related* social provisions when those were required during their recovery journey. This explanation is empirically plausible, as there appear to be differences in the family's ability to recognise situation-specific needs, especially for FCs in the *low category* of this study.

There are similarities between the supportive attitudes expressed by FCs in this study and those theorised by Cutrona and Suhr (1994) concerning "action-facilitating" versus "nurturant support", which is reminiscent of Bourdieu's (1990) "practical kinship" concept seen in services users' account of their experiences in the recovery journey. This implies that the functional aspects of the family's social support provisions towards recovery should exude the feeling that MHSUs are worthy, capable and valued group members of their families. It is interesting to note that MHSUs perceive the family as supportive in their recovery journey when support provisions were most predictive of their continuous physical health, satisfy a need to belong, and be accepted and cared for.

The critical question about family social support provision towards recovery is not only what type of support should be given and when, but also whether FCs do what can legitimately be expected from them and whether they do this in a way that communicates caring and understanding of MHSUs' unpredictable mental health behaviours and builds MHSUs' self-esteem and resilience in the recovery journey. MHSUs perceive that their family's comprehensive mental health care practices and helpful support in their recovery journey are likely to have these characteristics. This is an important issue for future research to confirm and validate these findings.

9.1.1. Symbolic and Emotional Meaning of Family Support

MHSUs' perspective showed that they do not really distinguish social support provisions received from family members in their recovery journey. Rather, they reframe the question in terms of FCs being "helpful" or "supportive" in general. In their everyday life, interpersonal transactions often involve the exchange of more than one type of social support and may have symbolic meaning. MHSUs describe many family-supportive behaviours and actions as helpful due to their emotional quality, as they communicate caring, empathy, respect, and acceptance. The description of family support provisions and helping behaviours, as reported by MHSUs, was considered essential to their recovery journey (*see* Chapters Seven & Eight). Nevertheless, from participants' narratives, it could be argued that the emotional constituent is decisive and not tied to only one type of supportive family actions. Instead, ostensibly, the family's transactional actions may well carry emotional and moral judgement, and these connotations significantly matter to MHSUs. This explanation is strongly supported by Adjieteh, Amponsah, and Amoanoo's (2017) study. In responding to a social support standardised vignette, participants indicated that family support was perceived as emotionally characterised. The emotional character of each assistance-related support type was rated even higher than its more overt instrumental character.

The study's findings broadly support Abraham Maslow's motivational theorisation of human needs (McLeod, 2018). From the study, it could be deduced that FCs' supportive behaviours are intended to meet MHSUs' physiological, safety, love and belongingness, esteem, and self-actualisation needs (*see* Chapters Seven & Eight). It is therefore likely that such connections exist between MHSUs' deficiency needs and growth needs in the recovery journey. This study supports evidence from other studies in this area, which links family contributions to recovery (*e.g.*, Waller *et al*., 2018). MHSUs' quantitative results

show that FCs pay attention to their emotions (expressing genuine concern, closure and empathy) and help more tangibly (helping solve housing and employment problems, providing food and clothing and paying medical bills). Therefore, it is plausible that MHSUs in the higher category of levels of support will have a higher percentage (55%) of supportive family interactions towards their recovery compared to MHSUs in the *moderate* (35%) and *low* (10%) categories (*see* Chapter Seven). It is difficult to explain this lower result, as this study did not seek to identify and control for causative factors; however, it is unlikely to imply that all results pointing to specific effects of social support provisions received from family members are basically random. Nonetheless, it could be argued that FCs in the *high-moderate category* matched the necessary family's supportive actions to tackle the symptoms of the presenting mental health problems of MHSUs.

An alternative explanation for these results might be triangulated from participants' narratives (*see* Chapter Eight). It appears that assistance-related social support provisions were especially appropriate in controllable situations, while non-assistance-related social support provisions, such as emotionally comforting behaviours, seem more appropriate when nothing can be done about the problem. From MHSUs' account, it is conceivable that each type of family social support provision may carry multiple meanings. Thus, FCs assisting MHSUs with their daily living activities, including personal care, directly demonstrate a *reliable alliance*. Still, it can also convey something about the interpersonal relationship between the MHSU and the family member, namely that the family member cares about the MHSU (*see* Chapters Seven & Eight).

MHSUs' accounts align with the assertion that the emotional aspect is the essential feature of the family in providing social support during the recovery journey. In an even broader sense, they correspond to the belief that the beneficial impact of a family's supporting actions typically arises from fulfilling the

fundamental human need for inclusion, acceptance, and nurturing. More specifically, the emotional meaning could signal MHSUs' trust and standing in their connection and interpersonal relationship with family (Tew, 2013; Van Corven *et al*., 2022; Cohen and Wills, 1985; Semmer *et al*., 2008). Therefore, the study suggests that MHSUs' satisfaction with their interpersonal relationships and support from family members, at least in part, is determined by the emotional meaning of the support given, which is crucial in the recovery journey. Further studies, which take these variables into account, will need to be undertaken.

9.2. Lay vs Westernised Language

Another finding that stands out from the qualitative data reported earlier is how participants use language to conceptualise (perceive and define) mental illness. Many participants interviewed had limited English language capacity to communicate their experiences in the recovery journey. Most felt comfortable expressing these in the lay language, predominantly the Twi dialect (one of the Akan languages of Ghana). It was observed that the choice of language in expressing mental illnesses is often at variance with Western medical terminologies. Participants shared personal experiences of their recovery journey, transcending daily life's ordinary challenges and setbacks, which proved difficult to express in the Western tongue. These experiences included a wide range of emotions, behaviours, and thoughts that are unique to participants requiring specialised attention and care, as well as a unique communication approach that goes beyond conventional language and methods.

Participants' accounts of their experiences show the way mental illness is described, the terms used (*see* Chapter Eight), and the way it is shown might differ across different ethnic groups in Ghana. These differences can provide a cultural framework for understanding and describing mental illnesses. Consequently, this impacts perspectives on family caregiving, support, and traditional and Westernised

interventions for recovery. This finding supports evidence from previous observations (*e.g.*, Appiah *et al*., 2020a; Opare-Henaku and Utsey, 2017; Quinn, 2007; Ae-Ngibise *et al*., 2015; Kleinman, 1980; Helman, 2007; Ansah and Klugah, 2020) that the shared understanding of mental illness may partly explain why FCs continue to source treatment from traditional and faith healers in MHSUs' recovery journey. It is important, therefore, to understand how culture, especially language, influences the meaning of and response to mental illness.

Further analysis of the data revealed that participants' experiences in the recovery journey cohered to a social construction of mental illness through the use of local/lay languages such as '*adwene* yareɛ/yadeɛ*'* '*dam/'ɔbɔdamfoɔ',* in the Twi dialect, which translates as, brain/mind diseases including mental illnesses, madness/insanity, mad persons/lunatics (*see* Chapter 8.4.1). These traditional colloquial expressions offer an explanatory framework for addressing and communicating mental illness issues and are not intended to do harm to participants' identity or classify them as inferior. Although it may, in part, be lexically translated as demeaning in some Western languages. Participants equated mental illness to pathologies of the brain, cultural beliefs and the extent to which the illness interfered with social functioning and everyday life. Participants' tendencies to describe mental illness as somatic illnesses reflect how they actually experience and conceptualise the mental illness recovery journey, which may likely not fit with the lexical meanings in English, leading to a lack of understanding of mainstream cultural norms and expectations. This further contributes to the difficulties they experience when communicating with mental health professionals. The lay language appears to be the medium through which MHSUs and FCs fully grasp what is happening in their physical and social environment.

The current study shows that the wide range of symptomologies that highlight deficits in brain and social functioning thought as cardinal features of Western categorisation of mental disorders listed

in the DSM-IV-TR; APA, 2000 and the 10th revision of the International Statistical Classification of Diseases presents a communication barrier to MHSUs, FCs and mental health practitioners resulting in orientation deficits into the nature of their caregiving roles. It was also discovered that psychiatric care services were geared towards the mainstream English-speaking population and, therefore, inaccessible. It was, therefore, unsurprising that participants with good educational backgrounds in the *high* to *moderate* categories, especially in urban areas, tend to associate mental illness with biological/psychological attributions and often seek medical services compared to those in the *low categories*. These findings broadly support the work of other studies that problematise the use of Western recovery models and language in African contexts (*e.g.*, Mamah *et al.*, 2013; Kleinman, Eisenberg, and Good, 1978; Appiah *et al.*, 2022; Kwame, 2016; Nkosi, 2012; Ansah and Orfson-Offei, 2022). An understanding of language in the social construction of mental illness is critical in mental health delivery in many African contexts because it provides insight into how people perceive and define being mentally ill and how they choose to address their mental health needs.

9.2.1. Mental Illness Constructs

The data reveal that participants comprehend mental illness through symptomatology and categorisation explanatory models. Symptomatology centres on altered behaviour, nonsensical speech, and hallucinations/loss of awareness, while the categorisation of mental illness focuses on its origin, severity, and temporality. Spirituality-related issues were particularly prominent in the interview data (*see* Chapter Eight). Participants' narratives showed that spiritual causes and morality shaped responses to care, needs and support towards mental illness recovery at both the individual, family and community levels.

Across all cases, it is evident that mental illness is often compared to the religious concept of demonology and spiritual possession, and these ideas persistently play a role in participants' explanations of mental illness. Thus, demons or spiritual possessions are frequently introduced in situations without discernible social or physical origin. These ideas further facilitate participants' categorisation models: mental illness resulting from family tensions, curses and genetics. It's worth mentioning that participants' attribution of mental illness to curses, which are also believed to be potential generational causes of mental illness, is conceptually akin to the medical model's use of family history in diagnosis and therapeutic interventions (Asafo, 2021; Osei, Asare and Roberts, 2021a; Salifu *et al*., 2018). Both the spiritual and medical models recognise that certain characteristics of mental illness tend to be inherited within families.

Participants' categorisation models and language helped them understand and communicate complicated occurrences by breaking them down into manageable units, especially when they lacked advanced expertise in this field. Understanding how people perceive mental health problems is crucial, as it has been shown that categorisation plays a significant role in lay knowledge of this subject (Furnham and Hamid, 2014; Yendork, Kpobi and Sarfo, 2016; Ofori-Atta and Linden, 1995). This is particularly true within contexts similar to Ghana (*e.g.*, Togo, Nigeria, and some Asian countries). Previous research suggests that public perceptions of various disorders, including mental illness, can be influenced by different forms of categorisation (Rogers and Pilgrim, 2014; Fleku, 2020).

This study shows that most participants had a basic understanding of mental health issues based on their social construction of mental illness. Thus, within the context of biomedical care, the social construction of mental illness was clearly communicated by some of the participants interviewed. For instance, participants with some level of literacy skills indicated access to mental health facilities to seek

biomedical intervention, yet still resorted to spiritual means of resolving the symptoms and behaviours associated with mental illness and finding the root causes of it (*see* Chapter Eight). These findings are similar to studies conducted in South Africa (Motlana *et al*., 2004; Smolak *et al*., 2013; Tuliao, 2014), which found that spiritual beliefs were even common among FCs and MHSUs who are educated and from urban cities.

Regarding symptomology, participants relied on traits and observed qualities that deviated from their typical self and society's standards or expectations for normal human behaviours and acceptable actions. This implies that the participants rely on the observable behaviours or external signs of mentally unwell individuals to comprehend their current state, demonstrating a restricted understanding of disorders that are undoubtedly among the most intricate health issues (Kendler and Aggen, 2017).

Several symptoms reported by participants aligned with clinically and empirically validated signs of mental disorders. FCs (across all groups) reported changes in MHSUs' conduct and speech, as well as fluctuations in dispositional factors such as emotions, temperament, beliefs, and attitudes. Some MHSUs described mental illness based on their aggressive behaviours and disrespectful actions, which were a departure from their typical demeanour. These symptoms may align with the cognitive, emotional, and behavioural disturbances (such as delusions and hallucinations) that are characteristic of mental health disorders, including schizophrenia and psychosis. Consequently, FCs without specialised training may not understand the internal cognitive processes that produce these observable behaviours. In this context, MHSUs are more likely to perceive their families' attempts to exert influence or control as a source of frustration and a threat to their recovery. Likewise, FCs may feel stressed and redundant in their caregiving roles. It would be beneficial for future research to explore these issues via the use of particular mental health illnesses as case studies. For example, future studies may prioritise investigating mental

health diseases, including schizophrenia, depression, and drug misuse, among others. This would provide the chance to explore further the social constructs of these 'diseases' and the behaviours of families in exercising their capacity for action and influence in the recovery journey.

9.2.2. Recovery Constructs

From participants' narratives, recovery meant *ayaresa,* translated as *being relieved of ailment/sickness*. Participants' social construct for recovery is synonymous with healing. A recurrent theme in the interviews was a sense amongst FCs that mental illness is a very complex long-term disorder, unlike other illnesses, with little chance of complete recovery for MHSUs. A rhetorical question often asked was how MHSUs can be deemed recovered with symptom manifestation, including but not limited to confusion in terms of thinking, feeling, and behaving, which is marked by inappropriate actions and emotions, detachment from reality, personal and social connections, distorted perceptions and a sense of mental disintegration (*see* Chapter Eight).

It appears participants equate recovery to the biomedical remission of symptoms and not necessarily the living of meaningful lives despite the ongoing constraints imposed by mental health issues, as some researchers would suggest (*e.g.*, Duff, 2015; Onken *et al*., 2007; Tew, 2013). Within this study, some FCs framed mental illness as a condition that constrained opportunities for social and economic productivity. From this perspective, the recovery journey was sometimes understood less as a pathway to renewed contribution and more as an ongoing challenge, since MHSUs were seen as offering limited tangible support to the family's continuity and wellbeing. They take more from the family's resources than they bring to it. This implies that the definition of recovery can vary among individuals depending on the context. Therefore, it is crucial for researchers to ask participants about their personal

interpretations to develop accurate analytical approaches and to gain a comprehensive understanding when developing social recovery interventions.

Some FCs' perspectives emphasise the social construction of recovery from mental 'disease' occurrence as discussed by critics of psychiatry and labelling theorists (*e.g.*, Read *et al*., 2006; Szasz, 2006; Carr and McNulty, 2016; Choudhury and Slaby, 2016). It was observed that the description of the manifestation of MHSUs' symptoms was deeply intertwined with power, which Roberts (2005) regards as knowledge held as leverage in the formation of mental illness in others. Most people in privileged social situations do not give much thought to the fact that their reality-based assumptions lead them to attribute abnormal behaviour to others. This was shown throughout the fieldwork by the fact that certain FCs had little understanding of how their social construction of recovery from mental illness could contribute to stigmatisation and how their caregiving role and support provisions might stifle MHSUs' recovery journey. Such perceptions are consistent with broader research (*e.g.*, Corrigan and Miller, 2004; Ae-Ngibise *et al*., 2015; Addo *et al*., 2018), highlighting how stigma, cultural expectations of productivity, and the economic strain of caregiving often shape family attitudes toward mental illness.

9.3. Health-Seeking Behaviours

The current study highlights how FCs take a pluralistic approach to caregiving by involving the services of faith-based healers (cultural/spiritual) and biomedical care (psychiatric care). This was observed to be the treatment strategy of all FCs in this study; hence, there is no joined-up approach to how recovery may be supported (*see* Chapter Eight). An existing body of literature (*e.g.*, Agyapong *et al*., 2015b; Ae-Ngibise *et al*., 2010; Read, 2011; Musyimi *et al*., 2016; 2017; 2018) supports the finding that FCs' views on recovery and their health-seeking behaviours are often centred on searching for a cure by all means and every means necessary.

Critical among the issues identified as influencing FCs' treatment choices on behalf of MHSUs were their understanding of mental illness and recovery (*see* Sections 9.2.1 & 9.2.2), the processes and practices involved in treatment, perceived efficacy, cost, and the hope for recovery (*see* Chapters Four & Eight). Given that participants were recruited through biomedical health centres, it is unsurprising that FCs predominantly reported biomedical approaches. This should be understood as a methodological artefact of the recruitment strategy rather than a stand-alone finding. Nonetheless, many FCs also described exploring traditional medicine and faith-based healing as complementary strategies for managing MHSUs' symptoms. Some FCs frequently attributed successes in the recovery journey to their belief in God and the use of traditional medicine and relied on religious faith to cope with the negative emotions associated with caregiving responsibilities. In some accounts, medical help was reported as a last resort, especially when MHSUs' conditions deteriorated. These patterns are consistent with the family caregiving beliefs and health-seeking behaviours identified by Bähetibeb, Wondimagegn and Law (2024) and those described by Soori, Regmi and Pappas (2024) in other jurisdictions.

While FCs may explore pluralistic approaches to caregiving, the combination of psychiatry care (biomedical care) and traditional/religious practices in Ghana has historically been marked by tension concerning different ideologies concerning health and illness, resulting in friction between them (Burns and Tomita, 2015; Abekah-Carter *et al*., 2024; Mensah, 2021; Ayeh *et al*., 2025; Brace, 2021). The decisions concerning healing and treatment processes and practices were observed to be shaped mainly by FCs' cultural and religious/spiritual conceptions of mental illness. Under the present findings, previous studies have demonstrated the challenge of discouraging most citizens from accessing faith healing centres for mental healthcare purposes due to the detriments it has on MHSUs' recovery (*e.g.*, Kpobi and Swartz, 2018c, 2019b; Ae-Ngibise *et al.*, 2015). A possible explanation for people's

preferences for faith-based healing in addition to psychiatric care might be individual preferences, values and beliefs, secondary stigma influenced by socio-cultural belief systems underpinning mental illness and inadequate government funding towards professional mental healthcare services and delivery in Ghana (*see* Chapter Four).

As mentioned in the literature review, the movement towards collaborative care between faith-based and Western mental health practices (biomedical care) has several opportunities (Ae-Ngibise *et al*., 2010; Agyeman *et al*., 2019; Arias *et al*., 2016; Kpobi and Swartz 2019b; Ofori-Atta and Ohene, 2014; Opare-Henaku and Utsey 2017; Read, 2019; Read and Nyame, 2019; Campbell and Burgess, 2012; Mathias *et al*., 2024; Tabi, Powell and Hodnicki, 2006; Akpalu *et al*., 2010; Mirzoev *et al*., 2012; Nyame *et al*., 2021). There is, therefore, the need to form a collaborative model between the operators of the faith healing centres and orthodox biomedical practitioners, involving psychiatrists, psychiatric nurses and psychologists to ensure that diagnostic activities and practices are safe for MHSUs and that their rights are protected throughout recovery. Collaboration, as argued by FCs in the *high* and *moderate categories* and corroborated by the findings of Badu, Mitchell and O'Brien (2019), shows the opportunities to provide biomedical mental health knowledge to faith-based practitioners and access to the practice space of faith healing centres, and streamline activities of faith-based practitioners in mental health spaces in Ghana within a framework of a national policy and regulations on facilitating collaboration between the biomedical, traditional and faith healing service providers.

Future research should investigate how pluralistic health-seeking behaviours among families can be better understood and managed within Ghana's mental health system. In particular, studies could explore models of collaboration between biomedical practitioners and faith-based/traditional healers, examining both opportunities and challenges in ensuring safe, rights-based care for MHSUs.

Longitudinal and comparative research across regions would be valuable to capture how family decisions are shaped by cultural beliefs, stigma, perceived efficacy, and economic factors. Further studies might also examine existing integrative practices in Ghanaian healthcare, such as herbal medicine units in some hospitals, to assess whether and how similar approaches could be applied to mental health services. Such research could inform the development of a culturally grounded collaborative care framework that respects families' pluralistic practices while safeguarding the wellbeing and rights of MHSUs.

9.4. Complexity of Family Relationships

The family, a social environment, fosters therapeutic experiences that are more positive and may, over time, be reflected in a gradual process of psychosocial readaptation. The study shows that family relationships underpinned by reciprocity, consistency and protection may start to stimulate pathways into re-socialisation activities for MHSUs and practising new ways of experiencing self and interactions with others within the family space. This may trigger processes of emotional and physiological changes in establishing trust for the care and support received from the family. Consequently, this study validates the significance of establishing a meaningful engagement between MHSUs and their FCs, since MHSUs indicated reciprocal advantages for both parties. The current investigation found that some MHSUs and their FCs experienced difficulties in making meaningful connections, while others succeeded in constructing togetherness despite socio-economic challenges in their recovery journey, for example, verbal interactions or undertaking activities together. This resulted in enjoyment and improved mood for MHSUs, and for FCs, it brought about feelings of satisfaction and fulfilment of their natural roles.

Nevertheless, the study found great diversity in the day-to-day interactions between MHSUs and their FCs. For some FCs (*in the high-low categories*), keeping a meaningful connection with the MHSUs came easily, but for others, it was hard, like when the relationship stopped being mutually beneficial,

especially when MHSUs experience distressing episodes, making them appear aggressive and abusive towards FCs. A previous study investigating relational capital for social recovery emphasises that FCs should focus more on recognising modest positive responses from MHSUs to establish a sense of mutual support (Tew *et al.*, 2012). FCs may also benefit from viewing these responses as manifestations of affection or gratitude. It appears valuable for future research to investigate methods of assisting FCs in recognising and experiencing mutual and reciprocal relationships.

Furthermore, it was found that FCs employed a variety of tactics, including physical contacts and contextual approaches, to establish meaningful interactions with MHSUs. Prior studies have shown similar outcomes. For instance, one study indicated that walking hand-in-hand and maintaining a joyful atmosphere helped FCs and MHSUs to maintain an emotional connection (Read, 2013; Roe and Aspinall, 2011). In all cases, FCs tend to employ similar tactics for building togetherness with MHSUs. For instance, FCs may find that inviting MHSUs to join them at work, playing in door games or going for a stroll helps them connect with MHSUs, while others may find that it helps them avoid other social engagements. Consequently, while the applied approach cannot guarantee a meaningful connection, it may provide a solid foundation for assisting FCs in developing such a connection, thereby encouraging pleasant experiences (Bemme *et al*., 2024; Read *et al*., 2023; Kuipers, Bebbington and Garety, 1992). It is therefore imperative that MHSUs, FCs, and their unique situations be taken into consideration when developing psychosocial education and strategies.

Given that meaningful engagement may be empowering, it is expected that offering support for meaningful connections could be valuable for both FCs and MHSUs. Having meaningful interactions can have a profoundly positive impact on one's sense of identity, self-worth, perceived usefulness, and sense of control (Read, 2012a). These factors are essential for feeling empowered. FCs must understand

their role and adopt the appropriate attitude in the process of empowering MHSUs. A supportive approach fosters the recognition of the person's unique talents and abilities, which can lead to more balanced and reciprocal relationships (Tew *et al*., 2012). The study's findings shed light on the challenges that FCs encounter and the strategies they employ to foster meaningful engagement. It provides a basis for supporting FCs to promote empowerment among MHSUs in the recovery journey. Future ethnographic studies on the current topic are therefore recommended.

9.4.1. Family Dynamics

The role of family members (as caregivers) involves much more personal contact, and it is plausible that interactions are coded as support, which is instrumental in both describing the family's supportive behaviours/actions and attributing meanings (*see* Chapter Eight). This reasoning can be extended to Bowen's (1976) Family Systems Theory and Bronfenbrenner's Ecological Theory (1979), which describes the family as a microsystem within other systems (*see* Chapter Four). Participants' experiences show that families react as nested dolls to resolve problems and maintain functionality. Other external system failings may directly or indirectly affect the functionality of families and their abilities to support the welfare of their members. According to the study's qualitative data, it could be inferred that life experiences, including bullying, stigmatisation, death, divorce, breakdown of external family system, loss of job, poor healthcare systems, economic hardships, may cause MHSUs to fluctuate between their levels of support from family. Comparison of the findings with those of other studies (*e.g.*, Mfoafo-M'Carthy and Grischow, 2021; Manderson and Block, 2016; Goldapple *et al*., 2004; Reupert *et al*., 2021; Read and Nyame, 2019; Gerhardt, 2019) indicate that vulnerable members, especially those with chronic and mental health problems, may be most affected should families experience these social dysfunctions.

Participants' experiences align with recent studies exploring social change and its impact on Ghana's kinship culture and family care (*e.g.*, Read and Nyame, 2019; Darko, 2020; Read, Sakyi and Abbey, 2020). The current study's context revealed that most FCs operate in an economically challenging environment, characterised by poor healthcare systems and a lack of extended family support or state welfare provisions. Quality healthcare in Ghana appears to be a prerogative of affluent families and those who can afford it (Read, 2014; Read and Doku, 2012; Bonsu and Yendork, 2019; Anokye, 2018; Nartey *et al*., 2019). MHSUs described their families as having close relations with impoverished living conditions and struggling to look after themselves (*see* Chapter Eight). This is the typical configuration of MHSUs' support network, made up of small, isolated units of immediate relatives providing care and economic support with little to no support from extended family members and the government. Despite these challenges, family members' provision of practical support (*see* Chapter Eight) may be overtly instrumental in the recovery journey, but it might also convey social disorganisation under the right circumstances. The communal nature of families may lead them to be quite willing to go beyond individual obligations or performances for the collective good of the family, as exemplified in the lived experiences of participants in this study. The interactions could be interpreted as members caring about each other's social welfare and wellbeing.

Although African families are generally known for their caring disposition, this is not the case. Some MHSUs contend that a family's supportive actions may be carried out with the aim of saving face in public to conceal shame and the fear of prejudice, and it is a topic in need of further research. Some participants in the *low category* shared these sentiments. This observation may corroborate the findings of the quantitative data that within MHSUs' family interactions, there is a likelihood for them to experience stigmatisation. It was also observed that most participants refrained from talking about their

family in an undignified manner as tradition demands that "one must not wash their dirty linen in public". This may imply that there is more to MHSUs' experiences within their families than what is seen or discussed, and it could be that most are not able to negotiate what helps or hinders their recovery journey.

MHSUs may feel it is a disservice to them if they refuse the material support provided by families, even when such support is limited and arguably all that families can afford during the recovery journey. This creates a dilemma for both MHSUs and their relatives, who must navigate care provision and receipt amid scarce household resources, external economic pressures, and stigmatisation (*see* Chapter Eight). In high-income countries such as the UK, USA, and Canada, social and mental health care is more frequently organised through multiagency systems, which can provide broader access to services and formal protections of rights. However, these systems also face challenges, including funding constraints, service gaps, and inequalities in access (Thornicroft, 2006; Livingston *et al.*, 2014). In many low- and middle-income countries, by contrast, such coordinated approaches remain limited due to resource shortages, governmental priorities, and cultural expectations of family responsibility (Van der Geest, 2002). Consequently, families often remain the primary providers of support for MHSUs.

The study also found that the care of MHSUs, including their housing arrangements, may undergo several changes of hands within the family to share caregiving responsibilities and burdens. MHSUs indicated that having a family home or dwelling space (such as a house or shelter) served as a base from which to move in and out, providing continuity in a fragmented life situation. Having a home means having a way to bring control into MHSUs' lives, being strongly connected to others, patterning daily living activities, and developing coping strategies to deal with the trivialities of everyday life. Consequently, MHSUs may become familiar with and attach themselves to members who provide constant support throughout their recovery journey. This study supports the findings of Hanlon *et al*.

(2025), showing that the home (whether permanent or temporary) may be the only place where MHSUs can express themselves, have fun, enjoy hobbies, and develop self-confidence, faith, and the energy to keep going.

Consistent with the literature, the symbolic meaning of the family's support and involvement in the MHSUs' recovery journey carries a moral and cultural value judgement (Van der Geest, 2016). Family caregiving is an expression of intimacy and solidarity; however, for some participants, the family support received may fail to convey care or understanding, or it may even be perceived as offensive. One prominent result from the analysis of qualitative data, which illustrates this point, is the case of *Adwoa, MHSU in the high category* (*see* Chapter Eight). Arguably, not all close or extended family members can consistently provide financial support to MHSUs throughout the recovery journey, as they have their own personal responsibilities. In such circumstances, they will communicate the emotional aspect of support through words of affirmation, hope and belief in God and might thus be appreciated and regarded as appropriate. Family support should be provided in a manner that conveys empathy. MHSUs could also consider what can be legitimately expected from close or extended family members involved in their care.

9.4.2. Family Tensions

From the study, it is observed that interpersonal relationships within families, which Carsten (2000) defines as relatedness (a constant process of getting attached to individuals), are just as susceptible to detachment and disjuncture. To some FCs in this study, providing care is not necessarily a natural expression of family life, but rather an enacted achievement of affinity, rapport, and compassion for the elderly, even among those from the wider family network. This finding exemplifies Tew's (2013) analysis of this issue. While members of the family (both immediate and extended) may be held

accountable for the care of a loved one with mental illness, such obligations and the burden of caregiving might make some people apathetic and ambivalent. Consequently, people invest in "a maintenance work of family interpersonal relationship to ensure a safety net of support in times of incapacity" (MacGregor, 2018, pp. 2).

In this manner, moral and value judgements become implicit in the caregiving process, determining factors such as who is worthy of care, who should provide it, and what is at stake. Therefore, it is understandable that MHSUs' care needs might cause friction and disagreement among family members (Sackey, 2009; Tawiah, Adongo and Aikins, 2015; Maahs, 2015). When someone in the family is dealing with a mental health issue or another form of long-term disability, it can put a strain on family life, redefining interpersonal relationships by upending long-held notions of who should be responsible for what (across gender lines and throughout the generations) and how people should behave ethically in social situations (Reupert and Maybery, 2016; Cohen *et al*., 2012; Livingston, 2005; Rapp and Ginsburg, 2011; Das and Addlakha, 2001; Levine *et al.*, 2015; Mattingly, Gron, and Meinert, 2011). Although life pressures may inspire creativity and innovation in caregiving, they also necessitate a re-evaluation of the role of families in providing care to one another and maintaining social connections.

The findings of this study show that MHSUs and family members do not experience recovery in isolation. A comparison of the findings with those of other studies confirms that MHSUs develop their personality adaptations and coping strategies within the context of their particular family and social relationships (Tew, 2013; Read, 2017; De-Graft Aikins, 2005). Recovering from mental illness is, therefore, a mutually influential process for MHSUs and their FCs. MHSUs' adaptations and orientations, as well as the family's involvement, may have an impact on constructive social intra- and interpersonal relationships within the external social system of which they are a part. It may also become

a vicious circle in response to negative experiences within the family and the external system. Individuals may perhaps react by becoming withdrawn, aggressive or losing their self-esteem, and this may then lock into wider relationship dynamics dominated by guilt, blame or recrimination, resulting in increasing alienation, loss of support and stigmatisation.

This study suggests that MHSUs' and FCs' modes of social participation all evolve in parallel with one another through processes of mutual interaction, influenced to some extent by genetic predispositions and brain physiology and, more importantly, by how responses to particular constructive or damaging social experiences may become internalised as part of the ways of dealing with the social world, resulting in either vulnerability or resilience. MHSUs experiencing relapses in their recovery journey do not just happen (although it may seem that way at that time). Still, they may reflect particular vulnerabilities which may adversely affect their ability to deal with certain forms of stress or problems. Vulnerability is context-specific; most people have areas of strength and resilience in addition to particular sensitivities or trigger points. While there may be a significant genetic component to this, much of MHSUs' vulnerability can stem from adverse social experiences (Moses, 2010a, 2010b; Lin and Okyere, 2020). For instance, in Ghana, poor health care systems, social inequalities, illiteracy, poverty and economic hardships compounded by high levels of unemployment are some of the factors accounting for the stresses people face in their daily lives. In addition, MHSUs' relationship difficulties within the family, especially from childhood, and external social systems, including oppression, loss and failed struggle, may be internalised and reproduced through a range of cognitive, emotional and behavioural adaptations that may subsequently make them vulnerable to mental illnesses such as depression and psychosis.

Consistent with the literature (*e.g.*, Boyd *et al.*, 2014; Tew, 2013), this study found that MHSUs who reported *low levels of family support* often described experiencing abusive treatment and chaotic interactions with family members linked to their mental health diagnosis. These experiences appeared to undermine opportunities to develop trust, empathy, and reciprocity in relationships. As a result, some participants seemed to struggle with engaging constructively with others, and their strategies for coping with painful or conflictual situations sometimes came at the expense of progress in their recovery. In some instances, this led MHSUs to passively accept stigmatising or inhumane treatments, motivated by a wish to avoid bringing further embarrassment or shame to their families, reflecting the decisive role of face-saving in their relational worlds. This dynamic reflects broader Ghanaian cultural values around family honour and reputation, where maintaining dignity and avoiding shame can take precedence over addressing individual suffering (Ofori-Atta, Read and Lund, 2010; Ae-Ngibise *et al*., 2015; Read, 2012).

In the Ghanaian family context (both close and wider), a person's standing in society is important (Read and Doku, 2012). People may interact unseemly with people with mental illness or tacitly make rules about how families should accommodate MHSUs (Adu-Gyamfi, 2017; Bonsu and Yendork, 2019). Due to these perceptions and treatments, MHSUs face challenges in voicing their concerns about the conditions of service and other welfare issues. MHSUs have been given an identity that limits how, when, and where they can speak. They have been given codified rules of speaking, which require them to listen and obey, and are therefore discouraged from using language to persuade or protest. Their voices are limited, which affects their place within the family.

The findings are consistent with other research that has found that othering creates boundaries that forge and stratify identities within the family, assigning identity role-playing to such identities created (*e.g.*, Weis, 1996; Collins *et al.*, 2006; Hooks *et al.*, 2013). Thus, interpersonal relations and

identity role-playing are enacted to maintain power and hierarchies (Wasson, 2004; Tew, 2011; 2013). Discussions with MHSUs (*see* Chapter Eight) demonstrate how language is used in identity creation, which empowers authorised speakers to impose specific ways of speaking on minority members (those classified as inferior, such as Gyimifuo [Idiot/Fool/Stupid]), particularly during family interactions. Passing "demeaning comments" towards them creates a kind of identity for them. Other members being "cool with all these things" gives other members the authority to refer to MHSUs as "useless beings" whose opinions do not matter. This assigned identity creates ways of speaking and hearing amongst family members, which ensures identity role-playing, resulting in MHSUs accepting an identity label that is "demeaning". It may be the case, therefore, that by continually creating and stratifying the identities of MHSUs, their actors create the powers and authority that devalue the once-held position or place of MHSUs within the family and society.

Given these interpersonal interactions and situations, it may be understandable that MHSUs exhibit unusual behaviours as coping mechanisms for underlying hostilities that they cannot manage, such as balancing competing family expectations and unreasonable demands. Such underlying hostilities described by MHSUs may become the legacy of family conflict, trauma and abuse that can affect not one individual but their relationships with those around them. As stated by Kuipers *et al*. (1992), MHSUs' exposure to emotional dynamics and difficulties within the family may affect their propensity for relapse and, indirectly, the possibility that their family support will initially break down. While sometimes, in the aftermath of relapse, family members may change their behaviours so that they become closer to MHSUs and support each other, often people will not know how to cope with their own pain and each other's pain, and defence mechanisms such as denial or blaming may become embedded within family relationships.

9.5. Stigmatisation

This study underscores the role of family and community members in perpetuating stigmatising behaviours associated with mental illness. Participants' narratives adduced that individual identities and self-representation reflect connections and relationships with others in any ecosystem. This implies that individual identities are not solely determined by personal characteristics but by their external interactions. This assertion highlights the importance of examining social contexts when attempting to understand how MHSUs and FCs perceive themselves and others in the recovery journey. MHSUs' narratives also show how the negative attitudes of others become internalised as acceptable beliefs and self-stigma. An existing body of literature (*e.g.*, Werner *et al*., 2012; Dadson, Annor and Yendork, 2018; Tawiah, Adongo and Aikins, 2015; Corrigan, Watson and Miller, 2006) supports the finding that FCs' and MHSUs' views on stigma were connected with an increased internal and external social burden, including shame and social exclusion. It is, thus, not surprising that the quantitative data found an association (*see* Chapter Seven) between MHSUs' experience of stigmatisation within their family and family involvement in their recovery journey.

Secondary stigma experienced by MHSUs and their FCs revealed profound loneliness and isolation. Despite being close to their neighbours, they expressed dissatisfaction because community members believed that a MHSU's condition was infectious (*see* Chapter Eight). FCs view these socially stigmatising behaviours as a severe threat to their family's everyday life, which motivates the decision to keep MHSUs confined in their rooms to maintain a constant state of alertness. This is because the family may feel ashamed and sad as the whole family carries the stigma associated with MHSUs. This finding reflects the phenomenon of courtesy stigma, conceptualised initially by Goffman (1968) and further explored in later research as secondary or affiliate stigma (Halter, 2008; Mak and Cheung, 2008;

Singh, Mattoo and Grover, 2016; Neupane *et al*., 2016; Vayshenker, Yanos and Roe, 2018; Poon, Joubert and Harvey, 2018; Kaggwa *et al.*, 2023; EghbalManesh, 2023; Carrillo, 2024; Favina *et al.*, 2025; Handebo *et al.*, 2025). This form of stigma arises from the close association between FCs and MHSUs, whereby FCs are perceived as part of a stigmatised group, reflecting a spoiled collective identity.

In Ghanaian households, family members experiencing chronic diseases, including HIV/AIDS, mental illnesses and COVID-19, are usually concealed from members of the public because the family may feel ashamed as the whole family carries the stigma associated with the illness (Gyamfi *et al.*, 2025; Van der Geest, Dapaah, and Kwansa, 2019; Asare, 2020). Traditionally, illness is generally believed to be a very personal and private matter, discussed secretly in hushed tones behind closed doors (Adhvaryu, Fenske, and Nyhadham, 2019; Barke, Nyarko, and Klecha, 2011; Bonsu and Yendork, 2019). Nonetheless, the Ghanaian community's propensity to be somewhat "gossipy"—for lack of a better term—also contributes to stigmatisation. Following the "small town model", there is little concern for other people's privacy, and information dissemination and exaggeration happen quickly (Opare-Henaku, 2013; Rowe, 2012; Van der Sanden *et al*., 2013; Tawiah, Adongo and Aikins, 2015). It can be inferred from the data that family members who have accepted the responsibility of caring for MHSUs have experienced secondary stigmatisation, which has impacted their personal lives, potentially leading to resentment and regret (*see* Chapter Eight).

Nevertheless, discussions with MHSUs in the *high* and *moderate levels of family support* revealed that they do not appear to be affected by the *secondary stigma* that they encounter through their families. These individuals displayed a sense of indifference and passivity towards the stigma, which can be attributed to Ghana's deeply ingrained cultural practice that discourages individuals from appearing ungrateful or demanding towards FCs. This finding suggests that MHSUs are concerned about how their

mental illness affects their families and seek to avoid overburdening them with their needs or fearing their judgement. Consequently, MHSUs are hesitant to articulate their needs, fearing that it might impose a burden on their families or subject them to criticism. The cultural norm in Ghana, where people are nurtured not to "bite the hands that feed them," is an essential consideration when designing mental health interventions. This kind of disposition, as Reupert *et al*. (2015) assert, does not enable MHSUs to actively engage in their treatment plans or advocate for improvements in the quality of support they receive from family and mental health services. This study, thus, extends the scant research on stigma associated with mental illness in Ghana that focused mainly on MHSUs' experiences to include external social contexts influencing stigmatisation practices and their impact on caregiving and recovery.

MHSUs' interactions with others reveal how they assume a range of social identities, reflecting their positioning within the family and in socio-cultural discourses. In this way, participants become influenced by their cultural and communal contexts, including family values and their own ways of 'storying' their self-identity and self-efficacy (self-esteem) in response to their mental health problems and social experiences. It was revealed that MHSUs often struggled to act assertively within their family space. Such orientations frequently strained their self-esteem and led to alternative forms of adaptation, including passivity and learned helplessness in their recovery journey. In the Ghanaian context, it is uncommon for people to openly express their stressful emotions or feelings towards negative behaviours towards family members, which may undermine their personal agency and ability to form and maintain healthy interpersonal relationships (Gyamfi, Hegadoren, Park, 2018; Mfoafo-M'Carthy and Grischow, 2022b). Consequently, perceived negative behavioural and temperamental differences often escalate into inter-relational conflicts. For instance, assertive communication and expressive behaviours may become labelled as deviant, giving people identities seen as "difficult" and "unappreciative" in some way, which

is internalised by MHSUs, leading them to believe they are not worthy of the support received from their family (*see* Chapter Eight).

Despite the complexity and potential conflict in identifying one's place and space in the family and society, some MHSUs indicated that they derived their self-esteem from their belief in God, which helped them through challenging situations and provided them with something to organise their resilience and recovery. However, participants in the *low category* could not develop resilience to renegotiate their place and space (identity), which, according to Price-Robertson, Obradovic, and Morgan (2016), could make them more vulnerable to stigmatisation, develop a fragile sense of self, and their recovery more difficult. From the study, it is observed that participants' experiences, such as boredom and frustration, as well as conflict and loss, which are unpleasant, are accepted aspects of their family relationships and part of ordinary human living, crucial to their wellbeing.

Families' experiences of upset and discontent and the emotions of anger, sadness or fear that may accompany them are nevertheless seen as part of a mentally healthy life. Nonetheless, Schön, Denhov and Topor (2009) posit that it is by working through these emotions that we grow, move on and empower MHSUs through their recovery journey. Rather than not involving family at all, participants described the importance of setting boundaries whereby they decided which family members they wanted to involve and how (*see* Chapter Eight). This corroborates the ideas of Waller *et al.* (2018), who suggested that MHSUs need help in negotiating clear boundaries and adjusting these when required. This implies that MHSUs may take responsibility for their own self-care and for how others treat them, a stance that strongly resonates with the principles of social recovery. Therefore, there is a need to develop interpersonal relationships that are formative and supportive, characterised by a partnership.

9.6. Family Caregivers' Burdens

One of the objectives of this study was to explore the experiences of FCs with MHSUs during the recovery journey. FCs described providing care for MHSUs as physically, emotionally and economically challenging. From participants' narratives, it can be deduced that mental health delivery and the role of FCs are significantly lacking in the quality of care and safety. Ghanaian society depends on FCs to continue providing care for MHSUs, but does little to teach them how to do it and support them in this stressful work (Ae-Ngibise *et al*., 2015; Nyarko, 2022b). At the minimum, family members could recognise and respect their efforts, assess their needs and provide concrete instructions on the specific care they are giving to MHSUs (such as medication administration, preparing meals, housing support, physical hygiene and personal care) and taking MHSUs to potential sources of treatment such as biomedical and faith-based healing centres. These efforts have made MHSUs highly dependent on FCs for all their support needs. This finding supports Anokye's (2018) assertion that, in the context of family care in Ghana, giving and receiving care assistance often strips away MHSUs' personal agency and autonomy. Society and FCs frequently view MHSUs as incapable of performing activities independently and, therefore, believe they cannot make substantial contributions to the country's economic growth (Mensah, 2021; Sackey, 2024). Consequently, MHSUs' personal and social inadequacies strain FCs' agency and family resources in the recovery journey.

Research documents that FCs' failure to involve MHSUs in all points of their 'disease' trajectory was connected with an increased burden of caregiving and underdeveloped competencies and skills of MHSUs for independent living (Werner *et al*., 2012; Tew, 2019; Deborah *et al*., 2020). While it is a positive gesture for families to take control of MHSUs' daily living activities, it is also crucial for them to create opportunities for MHSUs to be part of the decision-making process regarding their needs. FCs

must actively collaborate with MHSUs to transition from an ideology of 'doing for' to 'doing with,' fostering a more mutualised relationship that helps bolster their self-esteem and independence throughout the recovery journey. To accomplish this, FCs must actively listen to MHSUs, be patient with them, and be more empathetic when re-teaching life skills. Tew (2013) indicates that these dispositional factors are essential competencies in all encounters with MHSUs.

9.6.1. Economic Hardships

FCs reported the negative economic impact of caregiving in the recovery journey of MHSUs. This perspective resonates more with FCs in the *moderate* and *low categories* (*see* Chapter Eight). Among these participants, experiences of financial burden were attributed to the expression of sympathy for the socio-economic disadvantages faced and empathy towards their MHSUs' perceived workplace psychosocial risk (such as disruptive behaviours causing financial loss and damages to property) and the fear of being fined for damages to other people's properties and business ventures.

In Ghana, mental health problems often impose extreme financial hardship, leading to wider socio-economic exclusion. This aligns with the notion of catastrophic health expenditure, where the cost of care exceeds a household's ability to pay (Xu *et al*., 2003; Saksena, Xu and Elovainio, 2010; Opoku-Boateng *et al*., 2017; Daliri *et al*., 2024; Mfoafo-M'Carthy and Grischow, 2022a; Greif and Dodoo, 2015) and reflects broader patterns of economic marginalisation documented in studies of mental health and poverty (*e.g.*, Lund *et al*., 2011; Patel *et al*., 2018). This study revealed that MHSUs are highly disadvantaged in engaging in any economic activity, even when they are deemed to be in a state of continuous recovery. FCs noted that the recovery of MHSUs is not absolute, as there is a fine line between normalcy and abnormality. MHSUs can be easily triggered when stressed and are more likely to cause harm to others and properties. Most FCs believed that MHSUs lacked the right frame of mind

to cope with the stresses of economic activities. They feared that this might cause frequent relapses and, in the long run, increase MHSUs' healthcare expenses. These findings are consistent with the Ghanaian literature (*e.g.*, Akazili *et al.*, 2017; Harden, Gyimah and Osei, 2023; Read, 2017; Darko-Gyeke and Asumang, 2013; Read, Sakyi and Abbey, 2020; Antonio, Kwakye and Essel, 2023) and other countries (*e.g.*, Phanthunane *et al*., 2012; Jiang *et al*., 2018; Laidi *et al*, 2023; Abdulmalik *et al*., 2019; Addo *et al*., 2018; Ebrahim *et al*., 2020), which found that most FCs experience a significant economic burden in their caregiving responsibilities. As Ae-Ngibise *et al*. (2015, pp.2) remarked, despite Ghanaians' communal and solidarity dispositions, 'there is a lack of economic assistance for conditions like mental health, which are highly stigmatised'.

Within low socio-economic status households, there is a clear negative correlation between employment (income inequalities) and the overall mental wellbeing of MHSUs (*see* Chapter Seven). Communities characterised by inequality, status competition and relative deprivation are deleterious to mental illness recovery, not only of those families with MHSUs but also of those who are apparently recovering as a result of social relations and biomedical interventions. From the study, even though FCs and MHSUs faced financial constraints, the sources of burden were similar for all groups. The financial burden emanated from FCs' inability to engage in income-generating activities due to their caregiving commitments and the conflicting financial needs of other relatives. This could suggest a potential lack of concrete assistance from different relatives and community resources. Ankrah (2023) reports that the Ghanaian government's endeavour to incorporate mental health treatment into the National Health Insurance Scheme (NHIS) since its declaration in 2023 has not materialised. Furthermore, it was apparent that there is a significant knowledge gap in understanding medical and life insurance schemes as a life cushion for families during financial difficulties. In light of global economic challenges due to pandemics

such as COVID-19 and wars, it is becoming increasingly important for families and governments to develop a sustainable approach to support mental healthcare in Ghana (Magna and Yemoh, 2018).

The insufficient financial resources and support implied that some FCs could not cover the costs of medication, transportation, feeding, therapy, or rehabilitation. As a result, they often had to postpone MHSUs' medical reviews, reschedule treatment appointments, or seek more affordable care options, such as faith-based services. This finding corroborates the research conducted by Addo, Nonvignon, and Aikins (2013) in their randomised controlled trial on the household monetary expenses of mental health care in Ghana reporting that around 64% of individuals utilising mental health services (biomedical and traditional) and 72% of their households faced emotional distress because of the financial burden associated with mental illness. The average monthly family spending on mental healthcare amounts to $60.24, while the average reported monthly household income was $184.48. The projected growth rate for this statistic is 10% per annum, assuming family income remains unchanged. It is, therefore, unsurprising that FCs and MHSUs may be part of the 712 million individuals living below the poverty line of $2.15 per day (World Bank, 2023), in addition to their staggering healthcare and maintenance costs. This circumstance exacerbated the emotional suffering of FCs since they may be anxious about their capacity to cover the costs of caring for MHSUs while also taking care of other family dependents.

9.6.2 Risks, Burdens, and Resilience

The study reveals that FCs face significant physical risks in their caregiving role, which are heightened by age, limited skills, and the prolonged intensity of care. Some elderly FCs, in particular, reported strain when escorting MHSUs to hospitals or prayer camps, leaving them vulnerable to injury and aggravation of chronic conditions such as hypertension. Some sustained direct physical injuries, including bruises and cuts, when managing aggressive behaviours. These findings align with Ghanaian

and wider African evidence showing that caregiving for people with severe mental illness often results in physical strain (Ae-Ngibise *et al.*, 2015; Makanjuola *et al.*, 2016; Addo, Agyapong and Asante, 2018) and are echoed globally in studies on ageing caregivers' vulnerability (Schulz and Eden, 2016; Greenwood *et al.*, 2019).

Alongside physical demands, FCs reported a heavy emotional burden. Strained family relationships and verbal aggression from MHSUs undermined their wellbeing and sense of self-worth. Constant vigilance, such as staying awake through the night to monitor aggressive behaviour, led to severe sleep deprivation and stress. These experiences mirror wider evidence that blame, mistrust, and stigma can escalate conflict in mental illness (Bebbington and Kuipers, 2011; Magliano *et al.*, 2000) and resonate with Ghanaian findings on the psychological strain borne by caregivers (Ae-Ngibise *et al.*, 2015). International research similarly links verbal hostility and family conflict to caregiver exhaustion, psychological distress, and reduced resilience (Magliano *et al.*, 2005; Steele, Maruyama and Galynker, 2010).

Supervising MHSUs, observing early signs of relapse, and recognising side effects of medication were described as major responsibilities. Nevertheless, FCs with low levels of education felt ill-prepared to provide adequate care, often uncertain about the urgency of clinical symptoms. This finding supports Anokye's (2018) observation that family caregivers in Ghana frequently lack adequate knowledge and training and receive little guidance from formal health providers. Limited preparedness may compromise the quality of care while increasing stress for both FCs and MHSUs.

Despite these burdens, the accounts also demonstrate resilience. Caregivers described drawing on perseverance, familial obligation, and coping strategies developed over time. Many highlighted the role of faith, cultural duty, and community resources in sustaining their caregiving. These findings are

consistent with research emphasising the dual reality of caregiving: marked by vulnerability, yet underpinned by resilience (Chang and Horrocks, 2006; Ae-Ngibise *et al.*, 2015). Similar patterns across sub-Saharan Africa show that integrated support services can strengthen resilience and wellbeing among caregivers (Hanlon *et al.*, 2010; Nyaaba *et al.*, 2019).

Overall, the findings highlight the vital role FCs play in supporting recovery, while also exposing the significant toll caregiving takes on their health and wellbeing. To address these challenges, interventions are needed that reduce caregiver burden, provide training and practical support, and recognise FCs as integral partners in mental health care. Such measures are consistent with recommendations in the literature that emphasise the value of training caregivers in de-escalation, safe restraint, and crisis management strategies to minimise harm and improve outcomes (Stewart *et al.*, 2009). Strengthening support for caregivers not only protects their wellbeing but also enhances recovery outcomes for MHSUs (Schulz and Eden, 2016; Greenwood *et al.*, 2019). Within the Ghanaian context, targeted interventions for family caregivers are therefore essential to sustaining both family resilience and the recovery journeys of service users.

Future research should examine more closely the role of social support networks and community resources in shaping the caregiving experience. While some supports may alleviate caregiver strain, others may inadvertently intensify it, depending on factors such as accessibility, quality, and cultural expectations. Comparative studies between communities with stronger versus weaker support systems would provide valuable insights into how these structures influence caregiver resilience and the recovery outcomes of MHSUs. Methodologically, such work could benefit from longitudinal designs to capture changes over time, cross-cultural studies to highlight contextual differences, and participatory approaches that foreground the voices of caregivers and service users in shaping interventions.

9.7. Summary

This chapter has discussed the study's findings and implications by synthesising the results from the quantitative and qualitative datasets with the extant literature and theoretical perspectives. The findings hold significant implications for understanding mental health outcomes for MHSUs and for advancing knowledge of familial and social care approaches within the Ghanaian context. The analysis has shed light on the complexities of family caregiving and highlighted how interpersonal relationships within families influence the recovery process. It has also examined variations in levels of family support unique to the circumstances of MHSUs in this study, while drawing attention to the physical, emotional, and socioeconomic challenges faced by both MHSUs and their FCs. Finally, the chapter has outlined suggestions for future research, paving the way for the concluding reflections presented in Chapter Ten.

CHAPTER TEN

RECOMMENDATIONS, LIMITATIONS AND CONCLUSION

10.0. Introduction

Chapter Ten summarises the study's implications and suggests recommendations for family caregiving, mental health policy reforms and professional practices. This is followed by a discussion of the study's limitations and conclusions.

10.1. Summary of Study's Implications

The study's findings contribute to the ongoing discussion about the importance of collaborative multi-agency mental health care in Ghana, specifically concerning the roles, support and involvement of MHSUs' families. This is particularly important considering that in Ghana, the family home serves as the hub for outpatient recovery processes. Therefore, to strengthen family-centred recovery practices in Ghana, there is a definite need to adopt a multifaceted practical approach that unifies the imported Western biomedical system with traditional systems concerning mental healthcare delivery. Along with MHSU's own needs, the multifaceted recovery plan should also consider the needs of other family members and the needs of the family as a whole, and mitigate social, cultural, and economic challenges in the recovery process. Personal and social aspects of recovery should be integral to policy and professional practice. Theoretically, the findings broaden knowledge of social approaches to recovery, the social construction of mental illness and recovery, and provide a critical examination of family systems and interrelation dynamics, including family relationships, the family's social support provisions, health-seeking behaviours, and their impact on the recovery journey.

10.2. Recommendations

The recommendations in Table 21 below are based on the study's findings, theoretical and conceptual framework, outlining the necessary steps to improve family caregiving and mental healthcare in Ghana.

Table 21: Summary of the Study's Recommendations

Area	Recommendation(s)
Bidirectional Nature of the Caregiving Relationship	Recovery is not a one-sided process; it involves ongoing interaction between MHSUs and their FCs. Emotional exchanges, communication patterns, and shared decision-making are critical components. Health services should provide structured opportunities for service users and caregivers to jointly participate in care planning, therapy sessions, and discharge preparation. This collaborative engagement enhances trust, promotes mutual respect, and reduces power imbalances that may arise during recovery.
Relational Psychoeducation for Both MHSUs and FCs	Most mental health interventions target either MHSUs or their FCs in isolation. Psychoeducation programs should instead be designed to address both parties together. This includes education on illness management, communication skills, problem-solving, and conflict resolution. When MHSUs and their FCs understand each other's perspectives—such as MHSUs' struggle for autonomy or their FC's concern for safety—it helps reduce misunderstandings, guilt, and resentment.
	Given that various family members may assume different responsibilities at different points in time—during periods of good health and relapses, for example, or at various stages in MHSUs' development—it is essential that these discussions continue over time. This helps safeguard MHSUs' rights concerning care and the families' health-seeking options. It is necessary to have a conversation about privacy and confidentiality regarding the disclosure of MHSUs' information, the recipients of that information, and the timing of such disclosures. Talks should also emphasise how family members can assist MHSUs in achieving specific recovery goals. This implies that, in addition to offering fundamental psychoeducation and therapies, mental health professionals should also speak about how MHSUs could communicate with their families about their aspirations and experience of the 'disease'. This diminishes the likelihood of MHSUs encountering familial stigmatisation.

Stigma and Misattribution Within the Family System	Cultural beliefs in Ghana often lead to spiritual or moral attributions of mental illness, which can create tensions in the caregiving relationship. Some FCs may blame MHSUs or believe that the illness is a punishment. Conversely, service users may feel shame or mistrust due to perceived judgement. Targeted interventions should challenge harmful beliefs and promote empathy through storytelling, role-plays, and facilitated dialogue between MHSUs and FCs.
Support Structures for Caregiver-Service User Relationship	Family-based interventions, such as joint support groups or family therapy, can foster healthier relationships. These spaces allow families to share experiences, celebrate progress, and navigate setbacks together. Community mental health workers can facilitate family meetings where roles are clarified, expectations are managed, and emotional dynamics are addressed in a safe and structured way. These workers can assist family members in working together to share caregiving responsibilities. Rotating duties and scheduling regular breaks can prevent burnout and reduce the physical toll on any one individual. Open communication within the family about the challenges and needs of the caregivers can foster a more supportive environment. Ultimately, a well-supported FC is better able to provide the necessary care and support for MHSUs, promoting a healthier and more sustainable caregiving environment.
	One of the most effective ways to reduce the physical burden of caregiving is through proper education and training. Targeted interventions should equip FCs with knowledge about the specific mental illness they are dealing with, including its symptoms, treatment options, and progression. Understanding these aspects can help FCs anticipate challenges and respond more effectively. Moreover, practical training in safe care and physical support techniques is essential. FCs should learn appropriate methods for assisting MHSUs during episodes of aggression, safely accompanying them to hospitals or prayer camps, administering medications, supporting with daily hygiene-related tasks such as bathing and responding to emergencies (*e.g.*, First Aid). By developing these skills, FCs can minimise risks of injury to themselves and to MHSUs, while reducing reliance on coercive practices.
Economic and Social Resources for Stabilising Family Environment	Economic strain often shapes the emotional health of the FC-MHSU relationship. Overcrowded living conditions, unemployment, or financial dependency can exacerbate stress and lead to conflict. Therefore, mental health recovery programs must be linked to broader social protection initiatives such as income support, job training, or housing assistance for families affected by mental illness. These resources create an environment where relationships can flourish rather than fracture.

MHSUs' Empowerment Programs in the Family Context	Family caregiving should not unintentionally disempower MHSUs. Programs should support the autonomy of MHSUs by encouraging shared decision-making and supporting their goals for education, employment, or social participation. Recovery is most successful when FCs shift from a protective role to a collaborative one that enables independence, resilience, and hope.
Mental Health Policy Reforms and Strengthening Family Social Work Practices.	Family as a social care system in Ghana operates within the contexts of other social systems (such as economic, social, and health), shaping how MHSUs and FCs navigate the recovery journey. It is therefore essential to view the family not merely as an isolated unit within a social context, but to identify the external social factors that influence the nature of family relationships and the support provided during the recovery journey. One way to ensure that external social factors do not negatively affect the recovery journey is through deliberation on mental health policy. This is necessary to ensure that the various elements of supportive family relationships and the socio-economic challenges faced by FCs and MHSUs are acknowledged and addressed. The study's findings also highlight the need for policy to prioritise both personal and familial aspects of recovery. This means that Ghana needs to take several crucial policy steps to strengthen family-focused recovery approaches. A key policy priority should, therefore, be to plan for the long-term care of service users by addressing issues related to family welfare and mental healthcare policy, infrastructure, logistics, legal protections, and both non-professional and professional service delivery.
	1. The Government of Ghana can explore various strategies to enhance legal safeguards. The Government should fully implement and enforce the 2012 Mental Health Act, which bans inhumane caregiving practices in families, traditional/faith-based healing centres and biomedical facilities where abuses often occur. These strategies should include adequately resourcing visiting committees to monitor caregiving facilities and home care for service users. This committee helps carry out oversight activities to ensure accountability. The visiting committees should be granted independent status to operate like other human rights institutions. This would allow them to conduct unannounced inspections of all homes and mental health facilities, interview MHSUs and their FCs, as well as medical and non-medical mental health staff, without interference, and issue binding recommendations to address rights violations.
	2. There is a need to establish a Mental Health Tribunal to investigate complaints and implement a mental health levy to fund services nationwide. Key areas include support for housing and independent living, job training programs for service users, regular public

	education to combat stigma, and proper training for mental health professionals and family caregivers on mental health legislation and human rights standards. This will enhance knowledge of proper procedures, such as the Certificate of Urgency for involuntary treatment.
Respite Social Care Services	Creating frameworks for social care and assistance to alleviate the responsibilities faced by FCs. The Government of Ghana's mental healthcare intervention should consider funding community social care groups, such as self-help groups and respite care services. These support groups (*e.g.*, Edwenase Rehabilitation Centre) are known to provide valuable skills to service users and family caregivers, helping them learn proper techniques and self-care strategies. Support groups offer a platform for caregivers to share their experiences, receive emotional support, and learn from others who face similar challenges. Respite care services offer temporary relief by providing professional care for service users, allowing FCs to rest and recharge. These non-financial forms of support are crucial for families to provide continuous care and can help compensate for other areas where resources may be lacking.
Traditional and Biomedical Collaboration	In Ghana, mental distress is commonly understood through both biomedical and traditional frameworks. To provide holistic support for MHSUs and their FCs, it is essential to integrate these perspectives within mental health services. One practical strategy is to develop integrated care frameworks that foster collaboration between medical professionals and traditional or faith-based healers through mutual referral systems and coordinated care plans that reflect the diverse treatment pathways families may pursue. Future research should prioritise the evaluation of such integrative support models to assess whether both MHSUs and FCs derive sustained benefits. Particular attention should be given to involving families in service design and evaluation, ensuring that cultural, relational, and emotional needs are addressed. Existing examples of integration in Ghana's health sector, such as the Kumasi South Hospital (Ashanti Regional Hospital)**,** the Centre for Scientific Research into Plant Medicine in Akuapem Mampong, and the Eastern Regional Hospital in Koforidua**,** which has maintained a dedicated herbal unit since 2012, offer valuable models for further investigation. Examining these institutional experiences could yield insights into the operational, ethical, and cultural challenges of integration, as well as the factors enabling effective collaboration between biomedical and traditional systems. Findings from such research could inform national policy, particularly the Mental Health Policy 2019–2030 (Ministry of Health, Ghana, 2019) and the Mental Health Act, 2012 (Act 846) (Government of Ghana, 2012), thereby supporting the

	development of culturally responsive and sustainable mental healthcare that recognises both biomedical and indigenous systems.

Source: *Researcher's Construct.*

10.3. Limitations of the study

The study's mixed methods data collection approach had some limitations, but it should act as a guide to the interpretation and application of findings:

- This study is small-scale mixed methods research with a limitation on the extent to which findings can be generalised to other mental health contexts. With adequate research logistics, future researchers could consider employing ethnography and longitudinal, large-scale, country-level methodologies to explore the potential of family and professional collaborative mental health care for recovery. This could help bridge the gap between small-scale studies and validate the generalisability of this study's findings and warranted conclusions. It is crucial that the question of relational support and social recovery outcomes be considered.

- The findings from the quantitative data focused on MHSUs. Therefore, responses from FCs were not captured in this phase of the study, and neither were the perceptions of mental health practitioners, including social workers and faith-based or traditional healers. Caution must be exercised when applying these findings to other social care systems. Although participants in this study did not explicitly mention mental health social workers, their potential role in strengthening Ghana's mental health system remains an important area for future exploration, particularly given evidence of their contribution to recovery-oriented care and system development in low- and middle-income countries.

- MHSUs and their FCs (participants) were recruited from one (1) mental health facility, which may not provide a sufficient basis for the representation of the population. Nevertheless,

participants were recruited from one of Ghana's largest hospitals, indicating that MHSUs and their FCs were more likely to come from the nearest urban and rural communities to the facility or other parts of Ghana, which alleviated concerns about representation issues.

- The responses from MHSUs could be doubted for fear that their mental health condition could compromise their ability to respond effectively to the questions. The researcher recruited persons with mental illness who were outpatients and had been on biomedical treatment for more than six months. These individuals had experienced mental illnesses for many years, were not in a relapse episode at the time the study was conducted, lived in their communities with their family members and could respond effectively to the questions. Mental health professionals at the facility screened them to ascertain their capacity to participate in the study. Therefore, the quantitative data collection phase did not focus on any particular mental illness but on MHSUs' ability to complete the items on the survey due to fundamental differences in and manifestations of different mental illnesses. Considerably more work will be needed to explore the complexity of family support and social recovery processes uncovered in this study, as well as how they differ among those in the early stages of their illness.

- Although probability sampling techniques (simple random) were initially employed in the quantitative phase to enhance representativeness, this approach could not be sustained throughout recruitment due to contextual and logistical constraints common in community and mental health research. Limited sampling frames, uneven participant accessibility, and resource constraints restricted the consistent application of random selection. Consequently, the qualitative phase relied on non-probability methods, specifically a combination of quota and purposive approaches, to ensure analytic representation and depth of insight across subgroups. While this strategy aligns

with the logic of an explanatory sequential mixed-methods design, where the qualitative phase follows up and expands upon quantitative patterns (Creswell and Plano Clark, 2018; Teddlie and Yu, 2007), it also introduces potential selection bias and limits the extent to which findings can be generalised. The reliance on cut-off scores to categorise participants may also have oversimplified the complexity of family support experiences, potentially masking nuances that fell between the defined categories. These methodological constraints should be considered when interpreting the findings and evaluating their transferability. Nonetheless, non-proportional quota sampling was the most pragmatic and contextually appropriate strategy within the Ghanaian setting, where comprehensive sampling frames were unavailable. Its use ensured that the voices of low-support families, who represented a small proportion of the survey sample, were not lost in the qualitative phase and that integration of quantitative and qualitative data remained coherent and robust.

- The study's *participant selection model*, employed in the qualitative phase, produced a degree of cultural homogeneity both within family units (between MHSUs and their FCs) and across the sample as a whole, which limits the transferability of the findings. Participants broadly shared similar ethnic, linguistic, and socio-cultural backgrounds, reflecting common norms and values within the study setting. This shared cultural context, while enabling rich, in-depth insights into the dynamics of family caregiving and recovery, also constrains the range of perspectives and experiences captured. As a result, the findings are contextually specific, representing the social realities, kinship expectations, and caregiving practices embedded within a single cultural milieu. Such cultural homogeneity may have reinforced shared understandings of family obligation, stigma, and recovery, limiting the opportunity to explore how these concepts might differ in more

heterogeneous or cross-cultural environments. Consequently, while the study provides a nuanced portrayal of family support and recovery within the Ghanaian context, its conclusions should be interpreted as situated and context-dependent rather than universally generalisable. Future comparative and cross-national research would therefore be valuable in testing the applicability and effectiveness of developing culturally sensitive and family-focused recovery services across diverse socio-cultural settings.

- In the qualitative phase, access barriers posed further challenges. Many participants, particularly MHSUs without personal mobile phones, were difficult to reach. To address this, family caregivers' telephone numbers were used as points of contact, enabling the inclusion of MHSUs who might otherwise have been excluded. While this improved participation, it may also have influenced recruitment dynamics, thus representing a contextual limitation. Nevertheless, the study's validity was strengthened through methodological triangulation, transparent documentation of recruitment procedures, and explicit acknowledgement of sampling limitations, ensuring the findings remain credible and contextually grounded.

- While ethical safeguards were applied in line with international standards (NCPHSBBR, 1979; WMA, 2013), the reliance on gatekeepers during recruitment and data collection, although culturally appropriate and effective while necessary for access and trust-building, may have shaped the participant pool and limited the inclusion of perspectives from those less inclined to engage, and this is acknowledged as a methodological limitation (*see* Chapters Five and Six). Nevertheless, the absence of decliners does not undermine the validity of the findings, as all participants were reminded of their rights, provided informed consent, engaged, and provided contextually rich accounts that align with the study's aims and ethical standards.

10.4. Conclusion

This study set out to explore the role of family caregiving and support in the recovery journeys of Ghanaian MHSUs, focusing on the interactions, experiences, and relational dynamics between MHSUs and their FCs. The integration of the quantitative and qualitative phases, supported by a quota sampling strategy, enhanced the rigour of the study by ensuring that the qualitative findings were both representative and contextually grounded in Ghana's caregiving realities. This sequential design strengthened the credibility of the findings by capturing diverse experiences across levels of family support. Together, these features demonstrate how the mixed-methods approach provided a more comprehensive understanding of family caregiving and recovery from mental illness. In doing so, it has illuminated the deeply embedded role of the family in shaping recovery outcomes, especially in a context where formal mental health systems remain underdeveloped and culturally contested.

This study makes several significant contributions to understanding mental health recovery in Ghana, particularly by foregrounding the relational dynamics between MHSUs and their FCs. While mental health discourse in Ghana has increasingly acknowledged the importance of family and community-based care, there remains a lack of empirical insight into how caregiving relationships and support actually function in the everyday lives of people with mental illness and their families. This study shows that generally, the Ghanaian home plays a central and multifaceted role in the recovery journey of MHSUs. The Ghanaian home is rooted in strong kinship networks, collective responsibility, and cultural values that emphasise interdependence. The home serves not only as a physical shelter but also as a site of emotional support, care, and social reintegration. Despite challenges such as stigma, limited mental health literacy, and economic constraints, families often become the primary caregivers, offering a sense of belonging and continuity that formal mental health services may lack. The current data highlight the

importance of recognising and strengthening the supportive functions of the Ghanaian home through culturally sensitive interventions, caregiver empowerment, and integration with community-based mental health services, which can significantly enhance recovery outcomes. Ultimately, the Ghanaian home remains a vital, if sometimes underacknowledged, space where healing, resilience, and hope can be nurtured.

The study contributes methodologically by adopting a mixed-methods explanatory sequential participant selection approach, utilising the modified Social Provisions Scale and semi-structured interviews that privilege the voices of those often excluded from mental health planning—MHSUs and FCs. Through this pragmatic grounded lens, the research aligns with decolonial approaches to knowledge production and highlights the importance of culturally situated mental health research in Africa. This research is not meant to be exhaustive but rather to provoke reflection among African-based mental health researchers and practitioners about the limitations of current models and priorities.

MHSUs reported higher statistical scores for support provisions experienced within the family. These scores suggest that MHSUs, despite their ongoing distress, can lead meaningful lives within their families and fulfil social roles. However, support received from family can be *low*, *moderate* or *higher*, offering a nuanced statistical analysis of the quality of supportive relationships in MHSUs' recovery journey. The qualitative explanation contributes to knowledge by providing a subtle and contextualised understanding of how these supportive family relationships (*high*, *moderate* or *low*) influence the recovery process. It moves beyond binary interpretations of caregiving as either supportive or burdensome, highlighting the complex, dynamic, and sometimes contradictory nature of these relationships. By doing so, it expands existing theories of recovery to incorporate relational and cultural dimensions that are particularly salient in the Ghanaian context. The findings of this study provide a

foundation for future research in sub-Saharan Africa, where similar structural, cultural, and familial dynamics shape mental health experiences. As such, the study offers transferable insights that may inform regional efforts to strengthen informal care networks and build more inclusive mental health systems.

One of the more prominent findings emerging from this study is the uniqueness of the recovery trajectories and experiences reported by FCs and MHSUs. Across the dataset, it was observed that family members have significantly more personal contact and opportunities to provide comprehensive support to MHSUs, thereby sustaining their recovery journey. Overall, MHSUs viewed the family's continued presence as a sign of hope for the future that is not shaped solely by their mental illness. Some MHSUs maintained that they were overwhelmed by the optimistic plans of FCs for their future. There was a sense of hopelessness among some FCs, which emanated from their lack of understanding of the nature of mental illness and their perceived inability to intervene in the MHSUs' mental health state. While FCs in the *moderate* and *low categories* perceived caring for MHSUs as a lifetime process with associated loss of resources and human capital, they often internalise blame for their relative's condition, leading to secrecy or withdrawal of support, those in the *high category* viewed caregiving as a potential avenue for reciprocal care during old age and often adopted a compassionate and informed caregiving roles which was transformative in MHSU's recovery, enhancing self-esteem, promoting reintegration, and fostering hope. Nevertheless, all FCs described their caregiving role as a sense of solidarity, attributing to the improvement observed in MHSUs' living conditions, providing them with a sense of accomplishment for contributing positively to transforming the lives of MHSUs despite the socio-economic odds, which can sometimes lead to strained relationships, conflict, or unintentional reinforcement of stigma, thereby impeding the recovery process for MHSUs.

The above methodological approach showed considerable certainty in MHSUs' perception of their family's support provisions in their recovery journey. The qualitative follow-up interviews provided an in-depth understanding of how the family's support provisions and interactions enhanced their coping, confidence and competence in the recovery journey. FCs also highlighted the importance of their interactions with MHSUs and their impact on their recovery journey. Thus, the qualitative interviews explained the nuances and complexities of caregiving towards recovery that would not have been gained if only statistical results were considered. The findings confirmed that FCs play a critical, complex role in recovery. Supportive family relationships were shown to enhance significantly *social integration*, *attachment (emotional support), reassurance of worth, reliable alliance (material support), guidance* and *opportunity for nurturance,* which resulted in treatment adherence, provided emotional reassurance, reduced isolation, and fostered a sense of belonging and identity for MHSUs.

On the other hand, these same relationships sometimes acted as barriers to recovery, particularly when shaped by stigma, miscommunication, excessive control, socio-economic hardships and caregiver physical burdens. FCs' experiences revealed their emotional, economic, and social burdens—often in silence and without adequate institutional support. It was also revealed that gender made no significant difference to the recovery journey. Thus, the support MHSUs receive from their family is not determined by gender, but rather by the quality of interaction that informs the social support provisions received during their recovery journey. The findings further highlighted the crucial role FCs play in recovery, while also revealing the significant strain caregiving places on their health and wellbeing. Interventions that reduce burden, provide training in de-escalation and crisis management, and recognise FCs as partners in care are essential, both to safeguard caregivers and to improve recovery outcomes for MHSUs.

In Ghana, targeted support for family caregivers is particularly vital to strengthening resilience and sustaining recovery pathways.

Notwithstanding the relatively limited sample, this study offers valuable insights into how MHSUs' family structures (close/wider) offered a basic form of protection when government and society fail to sustain MHSUs' recovery journeys. Family members seem to play a vital role in the general care and support provision, often the only significant intervention team for many MHSUs in African societies, including Ghana. Following the conceptual framework of the study, there is a need for an interdisciplinary strategy to effectively promote recovery that prioritises the wellbeing of the family unit. To effectively assist the recovery process, families must be resourced to champion the rights and demand better economic opportunities for their loved ones. Services should focus on enhancing professional abilities that facilitate the involvement of MHSUs' families within a social recovery framework befitting the Ghanaian context. Mental health professionals must participate in a collaborative decision-making process with FCs and MHSUs to determine the scope of their involvement, including the individuals in their families and the timing and manner of their participation and support. Based on the consistency of evidence from the literature and the study's findings, adopting more extensive models or approaches, beyond the traditional foci of understanding and treating mental illness, is required to advance mental health and its associated positive impacts at the individual and societal levels.

The present study is one of the first attempts to comprehensively examine the social approaches to recovery through the lived experiences of Ghanaian MHSUs and FCs. By centring their voices, the study contributes to a more relational and culturally grounded understanding of recovery—one that moves beyond biomedical narratives to include the everyday realities of living with and caring for mental illness in Ghana. The study also exposes significant gaps in policy and practice, particularly the absence

of formal recognition and support for FCs within the national mental health system. Consequently, strengthening the caregiving environment through inclusion, education, and systemic support is essential for improving the wellbeing of MHSUs and fostering resilience and sustainability within families. The study is the first of its kind and invites further research into culturally adapted family-centred mental health strategies that reflect the lived realities of those most intimately involved in the recovery process. The study concludes that recovery from mental illness in Ghana is not solely an individual journey, but a shared, relational process embedded in the family and shaped by broader cultural and systemic forces. To promote sustainable recovery, future mental health policies and interventions must prioritise family engagement, invest in caregiver education and support, and bridge the gap between biomedical, traditional, and community-based models of care.

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LIST OF APPENDICES

Appendices A

College of Social Sciences

School of Social Policy

Department of Social Work and Social Care

Date:……..

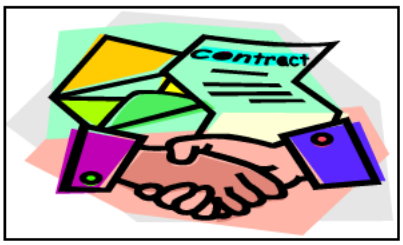
PARTICIPANT INFORMATION SHEET

This is an invitation to participate in my research project to fulfil a Doctorate Research Degree from the Department of Social Work and Social Care, University of Birmingham, UK. This research is being conducted by Miss Mary Ayim, a postgraduate researcher at the University of Birmingham, UK. This research is about **Family-Systems and Support for Recovery: Experiences of Mental Health Service User(s) and their Family Caregiver(s) in Ghana**.



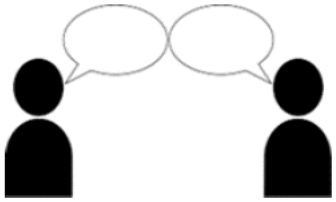
Mary Ayim

Why am I doing this research



Before you decide whether or not to take part, it is essential that you understand why the research is being done and what it will involve. Please take time to read the following information carefully. If there is anything you do not understand, please feel free to ask me.

Purpose of the research



This research aims to understand your close and wider family caregiver relationships, their 'support' and the extent to which family caregivers are involved in recovery from mental health problems. Within this, I would like you to consider your thoughts about your family's help-giving concerning mental illness recovery. Specifically, I would like you to consider your thoughts about the relationship between you and your family, the roles your family plays in your recovery journey, and the necessary support you receive from them. Similarly, I will like your family caregiver(s) to share their own experiences supporting and helping you throughout your recovery journey.

Who has ethically assessed this study?



Many people have checked it, namely, the [redacted] and the University of Birmingham Research Ethics Committee. They have given their approval and said, that it is ok to conduct this study**.**

Your involvement in the research



Participation in this study is in **two (2) stages**.

In **stage one**, medical staff at the [redacted] and I will announce and introduce the study to you at your waiting places/reception. Following your expression of interest and voluntary desire to participate, a mental health professional (nurse/doctor) will assess/check if you are fit to engage in this study. You will then be given a consent form and questionnaire to self-complete. However, if you cannot read or write, I /mental health professional will assist you throughout the process. Therefore, all questions will be read and explained to you, and your responses will be ticked on the questionnaire per your consent. All this should not take very long to do – around **20-30 minutes**.

The questionnaire will be given to you to complete at the [redacted] conference room. Alternatively, some of the questionnaires will be given to mental health professionals to be administered to you as part of their consultation. After completing the questionnaire, you will be asked whether or not if it is ok for the researcher to interview your family caregiver(s), and this consent will be recorded.

Within a month, your responses will be processed to select some mental health service users and their family caregiver(s) to participate in **stage two (2)** of this research. In addition, your names and telephone number(s) will be requested to arrange a suitable date for the subsequent interviews at the [redacted] conference room**,** [redacted] The time for the interview will be negotiated during the telephone call.

In **stage two**, Separate interviews with you and your family caregiver(s), if selected, will follow. Telephone calls will be made to all selected participants to invite and determine your availability and negotiate the interviews' date and time. A subsequent phone call will be made, text message or WhatsApp message will be sent to each selected participants a day before the scheduled interviews.

This is to remind participants about the scheduled interview arrangements (interviews may be organised before or after your clinical appointments). All interviews will be held at the conference room of the [redacted]. The interviews will take place when mental health professionals (Doctor or Nurse) are on duty at the clinic. They will check your wellness to engage in the interview and may be asked to join the session if needed. Their involvement will be subject to your approval. During the interview, your responses will be audio-recorded not to miss anything that you have said. The concurrent interviews will each last around **40-60 minutes**, and we can take breaks if you would like to. Anything you say or write can be taken back within five (5) weeks from the date this interview is conducted.

Similarly, I will turn whatever you say into a readable document (manuscript). If interested, I will send a copy of this document for you to cross-check. A follow-up phone call (within two (2) weeks) will ask whether you feel that the document resonates with your experiences and if you wish to make any changes. This is expected to take around 10-15 minutes.

Expenses



I will provide you and your family caregiver(s) with food, non-alcoholic/soft drinks, water, hand sanitisers, facemask. Also, your transportation will be provided at the end of the interviews. This form of compensation may be estimated at **GH₵ 75/£ 10.00**. It will only be given to participants involved in stage/phase 2 of the project (interviews).

Do I have to take part?



Your involvement in the research is *entirely voluntary*. It is up to you to decide whether or not you wish to take part. If you do decide to take part, you will be given this information sheet to keep and

be asked to sign a consent form. You can sign by audio recording, signature and thumbprinting. Please, read and understand the consent form fully before signing. If you choose to take part, you are still free to withdraw at any time without giving a reason. If you choose to do so, you may also remove any data you have supplied which has not been processed or analysed within five (5) weeks.

Disadvantages and benefits of taking part



There are no apparent health dangers in taking part. During the meeting, I will ensure that we observe all Covid-19 protocols and the Unit's policies and procedures to keep you and me safe. However, the questions I will ask you are simple but might get you upset or emotional if you talk about a challenging time/experience in your life. Anytime you feel this way, the process will be halted entirely and only carry on if you want to. Also, if you become unwell, I will not bother you with any more questions. If you wish, I will get rid of anything that you have already said to me. Also, I will check in procedure the following day(s) and contact the [redacted], to assist you if needed.



By taking part, you will benefit from actively reflecting on your aspirations for improvement in treatment and recovery through family-focused interventions for people diagnosed with mental health problems. It will also serve as a reference for the government of Ghana to review and reform its Mental Health Act to meet better the needs of people with mental health problems and their families.

Confidentiality of what you tell me



As a researcher, I will ensure that no one can identify you after your information has been collected and replaced with a code. Thus, any information that is obtained in connection with this research and can be identified with you will remain confidential and will be disclosed only with your permission. If at any time you say anything that you do not wish me to include in the research, please notify me, and I will respect these requests fully. I will not pass anything on to anyone who gives you help.
Subsequently, I will ensure that the data collected from you is stored securely at the University of Birmingham. It will be kept for a minimum period of ten (10) years. This approach will help preserve anonymity and maintain privacy. Confidentiality will only be broken if some information is shared that suggests you or someone else is at risk or possible criminal offences come to light.

Findings of the research



I will turn what I have discussed with you into a report, and If you like, I will keep a hard copy of this report at [redacted] or send you a soft copy on Whatsapp and email.
Similarly, information obtained from you will be used for academic research purposes, including conference and seminar presentations, research magazines/papers and journal articles. Again, these may include some of what you have said but not anything personal about you.

Fair processing statement



This information is being collected as part of a research project. Any information which you supply and that which may be collected as part of the research project will be entered into a filing system or

database. Also, it will only be accessed by authorised supervisors involved in the project. The University of Birmingham will retain your information. It will only be used for research and statistical and audit purposes. By supplying this information, you consent to the University storing your information for the purposes stated above. The University of Birmingham will process the information per the provisions of the Data Protection Act, 1998. No identifiable personal data will be published**.**

Any concerns



If you have any concerns about this research, please feel free to contact the [redacted] and the researcher, Miss Mary Ayim, using one or more of the means below:

[redacted]

Email: [redacted]

Telephone: [redacted]

Miss Mary Ayim, PhD, University of Birmingham, UK

Email: [redacted]

Telephone: [redacted]

If you still have more concerns, you can contact the researcher's supervisors:



Professor Jerry Tew
Professor of Mental Health and Social Work
Email: [redacted]
Telephone: [redacted]

Professor Jon Glasby
Professor of Health and Social Care
Email: [redacted]
Telephone: [redacted]

Address
Department of Social Work and Social Care
Muirhead Tower
University of Birmingham
Edgbaston, Birmingham
B15 2TT, United Kingdom

My supervisors will do their best to sort it out for you.

Alternatively, if you have any concerns about the conduct of this research, please feel free to contact the University of Birmingham Ethics Committee and [redacted] by the following email: ethics@birmingham.ac.uk. **or** [redacted]

Thank you for taking the time to read this information sheet and your interest in this research.

Appendices B



UNIVERSITY OF BIRMINGHAM

College of Social Sciences

School of Social Policy

Department of Social Work and Social Care

SURVEY CONSENT FORM (MENTAL HEALTH SERVICE USER(S)).

INTRODUCTION

I am Miss Mary Ayim, a postgraduate research student at the Department of Social Work and Social Care, University of Birmingham, UK. This questionnaire is designed to obtain your responses on how your family interpersonal relationships and 'support' contribute to your recovery. The information you provide is for academic purposes only and will be treated with the strictest confidentiality. Thus, any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission. Your name will not be linked to any written or verbal report of this research project. If you volunteer to be part of this study, you can choose to withdraw at any moment without consequences. You can also refuse to answer some questions and still remain in the study. If you require any clarification of the survey questions, please do not hesitate to ask me. The survey will take approximately 20-30 minutes to complete.

The survey consent form should be completed by the mental health service user(s) and their family caregiver(s). The questionnaire should **only** be completed by Mental Health Service User(s). You are deciding to participate in this study. Your signature below indicates that you have read the information sheet and decided to participate in the study.

A copy of the signed and dated consent form and the participant information sheet will be given to you and retained by the researcher to be kept securely on file.

Please read this form carefully and tick the boxes if you agree.



Participant, please tick this box

1.	I have had a chance to read the participant information leaflet for this study and to ask questions about what you might want me to do.	
2.	I understand that my participation is voluntary, and I know that I do not have to take part.	
3.	I know I can stop at any time without saying why. If I withdraw, my data will be removed from the study and will be destroyed completely.	
4.	I understand that my personal data will be processed for the purposes detailed in the participant information sheet under the Data Protection Act, 1998.	
5.		
6.	I know that whatever I write or say, I can ask to take it back within five (5) weeks.	
7.	It is ok for a mental health professional (Doctor or Nurse) to help me complete the questionnaire.	
8.	I would be happy to provide you with my name and telephone number(s) and to talk to you about my experiences in a follow-up interview.	
9.	I know that you will not share anything I write with anyone in power unless I tell you someone is breaking the law, doing wrong to me, or anyone else is in danger.	
10.	I know that I can speak to mental health professionals at the [redacted] and the researcher's supervisors if I have concerns about how the researcher is conducting the research.	
11.	Based on the above, I agree to take part in this study.	
12.	**YOUR FAMILY CAREGIVER(S) ONLY** I would be happy to provide you with my name and telephone number(s) and to talk to you about my experiences in an interview.	

Name ……. and

Telephone number(s) of the mental health service user:……

Name(s)……. and

Telephone number(s) of family caregiver (s):…….

Participant's Signature: _____ Date: _____

Mental Health Professional's (Doctor/Nurse) Signature: _____ Date: _____

Researcher's Signature: _____Date: _____

Participant Identification Number: ……..……..

If you have any concerns about the conduct of this study, please do not hesitate to contact.

Researcher: Miss Mary Ayim; [redacted]

Research Supervisors: Professor Jerry Tew,[redacted]
Professor Jon Glasby,[redacted]

[redacted]

University of Birmingham Ethics Committee: ethics@birmingham.ac.uk.

Appendices C



UNIVERSITY OF BIRMINGHAM

College of Social Sciences

School of Social Policy

Department of Social Work and Social Care

QUESTIONNAIRE (MENTAL HEALTH SERVICE USER(S)).

SECTION A: SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENT(S).

INSTRUCTION: Please, answer the following questions by ticking (√) in the appropriate option(s) and write the appropriate responses where necessary.

1. Sex/Gender of the respondent.

A. Male ( ) B. Female ( )

2. Age of respondents

A.18-25 ( ) B.26-35 ( ) C.36-45 ( ) D. 46 and Above ( )

3. Highest level of education attained.

A. Primary ( ) B. Junior High School ( ) C. Senior High School ( ) D. Tertiary ( )

4. Religious background of the respondent.

a. Christian ( ) b. Muslim ( ) c. Traditionalist d. Others ( )

(Please specify) …….

5. What is your current marital status?

A. Married ( ) B. Divorced ( ) C. Single ( ) D. Separated ( )

E. Widowed ( )

6. What is your current employment status?

A. Employed ( ) B. Self Employed ( ) C. Unemployed ( )

7. Where do you live?

A. Kumasi City ( ) B. Towns surrounding Kumasi ( ) C. Other parts of Ghana ( )

D. Other ( ) (Please specify) …….

SECTION B: FAMILY CAREGIVERS SUPPORTIVE RELATIONSHIP AND INCLUSIVENESS IN MENTAL HEALTH SERVICE USERS' RECOVERY.

INSTRUCTION: The table below explores the supportive relationship of family caregivers (external and nuclear family relatives) and their involvement in your recovery journey.

Kindly tick (√) to the appropriate option(s) provided the extent to which you agree that each statement describes your feelings about the questionnaire survey.

Use the following scale to indicate your opinion.

SD= Strongly Agree, D= Disagree, A= Agree, SA= Strongly Agree

So, for example, if you feel a statement is very true of how you felt while answering the questions, you would tell me/tick "strongly agree". If you feel a statement clearly does not describe your relationship(s), you would respond/tick "strongly disagree".

	STATEMENTS	**Strongly Disagree (SD)**	**Disagree (D)**	**Agree (A)**	**Strongly Agree (SA)**
1	Within my family, I feel part of a group of people who share my attitudes and beliefs.				
2	Within my family, there are people who enjoy the same social activities I do.				
3	Within my family, I feel a strong emotional bond with at least one other person.				
4	Within my family, I can depend on people to help me if I really need it.				

5	Within my family, there is someone I could talk to about important decisions in my life.				
6	Within my family, there are people I can count on in an emergency.				
7	Within my family, I have close relationships that provide me with a sense of emotional security and wellbeing.				
8	Within my family, I have relationships where my competence and skills are recognised.				
9	Within my family, there are people who admire my talents and abilities.				
10	Within my family, there is a trustworthy person I could turn to for advice if I were having problems.				
11	I feel that members of my family (close or wider) are ashamed of me because of my mental illness.				
12	Wider/extended family members (such as grandparents, aunts, uncles, cousins or grandparents) are really important in my day-to-day life.				

Appendices D

UNIVERSITY OF BIRMINGHAM

College of Social Sciences

School of Social Policy

Department of Social Work and Social Care

INTERVIEW CONSENT FORM (MENTAL HEALTH SERVICE USER(S)).

I want to request your permission to participate in my research study**.**

Please read this form carefully and tick the boxes if you agree.



Participant, please tick this box

1.	I have had a chance to read the participant information leaflet for this study and to ask questions about what you might want me to do.	
2.	I would be happy to talk to you about my experiences in an interview.	
3.	I understand that my participation is voluntary, and I know that I do not have to take part.	
4.	I know I can stop the interview at any time without saying why. If I withdraw, my data will be removed from the study and will be destroyed completely.	
5.	I understand that my personal data will be processed for the purposes detailed in the participant information sheet under the Data Protection Act, 1998.	
6.	I know that whatever I write or say, I can ask to withdraw from the study within five (5) weeks.	
7.	I agree that you can record anything I say through an audio recorder.	
8.	I agree with the use of anonymised quotes in publications.	
9.	I know that you will not share anything I say with anyone else.	
10.	It is ok for a mental health professional to be part of our meeting in case their support is needed.	
11.	I would be happy to provide you with my name and telephone number(s)	

12.	I know that you will not share anything I say with anyone in power unless I tell you someone is breaking the law, doing wrong to me, or anyone else is in danger.	
13.	I know that I can speak to mental health professionals at [redacted] and the researcher's supervisors if I have concerns about how the researcher is conducting the research.	
14.	Based on the above, I agree to take part in this study.	

Participant's Signature: _____ Date: _____

Mental Health Professional's (Doctor/Nurse) Signature: _____ Date: _____

Researcher's Signature: _____Date: _____

Participant Identification Number: ……..……..

If you have any concerns about the conduct of this study, please do not hesitate to contact.

Researcher: Miss Mary Ayim; [redacted]

Research Supervisors: Professor Jerry Tew, [redacted]
Professor Jon [redacted]

[redacted]
University of Birmingham Ethics Committee: ethics@birmingham.ac.uk.

A copy of the signed and dated consent form and the participant information sheet will be given to the participant and retained by the researcher to be kept securely on file.

Appendices E



UNIVERSITY OF BIRMINGHAM

College of Social Sciences

School of Social Policy

Department of Social Work and Social Care

SET A

FACE-TO-FACE SEMI-STRUCTURED INTERVIEW SCHEDULE WITH MENTAL HEALTH SERVICE USER(S).

Prelims:

- **Greetings and Pleasantries (ask participants about their day and issues concerning the COVID-19 pandemic in Ghana).**
- **Permission to Audio Record**
- **Presentation of Information Sheet**
- **The signing of Participant Consent Form**

Main Questions

1. Can you please tell me something about yourself and your mental health problem?

2. Tell me about your family and who you are closer to?
   Follow-up: Does having a recent experience of mental illness affect your place within your family?

3. In what ways do your relationships with your family provide support to you in your mental health recovery process?
   Prompt: material support (financial (payment of medical bills, transportation), housing, clothing, food)
   Prompt: acceptance and emotional support

4. What opportunities exist within your family for engaging in activities/roles that are valuable to you and them?

5. How have your family relationships helped you to regain control over decision making concerning your wellbeing (if at all)?

6. In what ways are your family helping you reconnect with the broader community and re-establish personal relationships (if at all)?

7. What are your family's expectations of you?
   Follow up: How do you think this affects your recovery?

8. In what ways (if any) may family relationships be stressful for you or make it harder for you to recover?

9. In what ways have you felt powerless within your family relationships?

10. How can the psychiatric service better enable family support to facilitate your recovery?

11. What further comments/remarks do you have concerning this dialogue/ topic under discussions?

Appendices F



College of Social Sciences

School of Social Policy

Department of Social Work and Social Care

SET B

FACE-TO-FACE SEMI-STRUCTURED INTERVIEW SCHEDULE WITH FAMILY CAREGIVER / FAMILY MEMBER(S) OF MENTAL HEALTH SERVICE USER(S).

Prelims:

- **Greetings and Pleasantries (ask participants about their day and issues concerning the COVID-19 pandemic in Ghana)**
- **Permission to Audio Record**
- **Presentation of Information Sheet**
- **The signing of Participant Consent Form**

Demographics:

A. Sex/Gender of the participant.
B. Age of participant.
C. Highest level of education attained.
D. Religious background of the participant.
E. Current marital status of the participant.
F. What is your relationship to the mental health service user/patient?
G. How long have you been involved in your relative's recovery process?

Main Questions

1. Can you please tell me about yourself and how you got involved in caregiving and mental health services?
2. What does your relative's mental health situation mean to you?
3. What are your beliefs about the causes of your relative's mental illness?

Family caregivers' experiences with relatives diagnosed with mental illness

4. What are some of your experiences in caring for relatives with mental health problems in terms of;
    a. their relationship and interactions with you and other members of the family
    b. acceptance and emotional support
    c. providing material support (financial, housing, food)
    d. maintaining their personal care and daily living activities such as oral care, physical cleanliness, nutrition and excretions, etc.

Follow-up questions: What does providing material support mean to you?

5. What opportunities exist within the family to enhance communication, engagement and activities with relatives with mental health problems and other family members?
6. How have you helped your relative(s) with mental health problems regain control over decision making concerning their wellbeing?
7. What opportunities exist within the family to help them reconnect with the broader community and re-establish personal relationships?
8. What are your expectations of your relative(s) diagnosed with mental illness?

Follow-up questions: How do you think this affects their recovery?

Caregiver(s) needs and barriers to providing care.

9. What are some of your needs as a caregiver(s) to support relative(s) with mental health problems?
10. What are some of the difficulties you face while in the course of providing care and afterwards?
11. What strategies do you employ to cope with the stress/burden of caring for relative(s) with mental health problems?
12. What support is available within your community to assist you in providing care to relative(s) with mental health problems?
13. How can the psychiatric service better enable family support to facilitate your relative's recovery?
14. What further comments/remarks do you have concerning this dialogue/ topic under discussion?

Appendices G

GUIDELINES FOR REGISTERING AND OBTAINING ETHICAL CLEARANCE FOR RESEARCH AT [redacted]

Obtaining ethical clearance for your research at [redacted] through a **2-step process**. Part 1 is the registration. This **first part** involves [redacted] **Review and presenting the proposed research to the** [redacted] where the research is intended to be conducted for the research to be certified as being **feasible for its conduct (Scientific and Technical Review)** in the respective [redacted]. **The second part involves the ethical evaluation** of the proposed research by **the** [redacted]

The processes involved have been outlined below as a guide to applicants. Please do not hesitate to contact the [redacted] for any clarification on any aspects of the guidelines.

PART1: Research Registration Guidelines

1. Complete [redacted] egistration application online at [redacted]
2. Print out confirmatory submission email.
3. Upload the electronic copy of the protocol/proposal at [redacted]
4. Send your confirmatory submission email print-out to the [redacted] main [redacted]
5. Pay the non-refundable [redacted] for the funding category at any of the [redacted] at the hospital.
6. Submit one bound signed printed/hardcopy of the proposal, print-out of the confirmatory email and the official receipt of [redacted] for processing. Proposal/Protocol (***sample format on page 3 as a guide only***), should have been signed and dated by the [redacted]
7. [redacted] reviews the protocol/proposal and sends a copy of it to the [redacted] for comments/approval *(Applicants should no longer contact [redacted] directly for their departmental approval).*
8. Based on comments from [redacted] internal review, we will notify you by email to proceed to [redacted]
9. This email does not constitute site approval or ethical clearance for the conduct of the study.

NOTE:

- ***Note that all sponsored research studies to be conducted [redacted] must budget*** [redacted] ***their budget.*** [redacted] ***if you need further clarification(s).***
- ***All research studies to be conducted at [redacted] must have a collaborator (preferably a senior*** [redacted] ***in the respective*** [redacted] ***where the study is to be conducted.***
- ***Ethical clearance from the*** [redacted] ***(see Part 2-next page) is required and mandatory for every research to be conducted at*** [redacted] ***even if the work has been approved by other*** [redacted]

[redacted]

PART 2: [redacted] Application Submission Guidelines

1. Complete [redacted] Application form and send it with all the required documents to the [redacted] *(The latest version of the [redacted] Application form and other accompanying forms will be sent to applicants via email after the initial registration process is completed as described in Part 1 above).*
2. Submit all the required set of documents (see checklist of attachments on the [redacted] Application) in soft and hard copy to the [redacted] located at the [redacted]
   All soft copies should be:
   - exactly the same in content and arrangement order as the signed printed bound hardcopies (see arrangement order below).
   - merged into one file with filename format as "PI's Name plus the study title". e.g. [redacted]
   - submitted via email to [redacted]
   - put either a pen drive or CD to be collected at the [redacted]

   The required number of signed printed hard copies should be:
   - bound in one document
   - submitted with soft copies on a pen drive or CD.
   - submitted to the [redacted]
3. The arrangement **order** of both the soft (merged into one file) and all required hard printed copies (bound in one document) should be as detailed on [redacted] application form.
4. Please note that all documents in submission to the [redacted] should be *versioned* and *dated*.
5. Once [redacted] approval is granted, applicants are notified by either a phone call, email or text message to pick up their approved letters from the [redacted]
6. Next, the principal investigator notifies [redacted] the official start date of the study; and when the study closes.

NOTE:

- ***The principal investigators of all approved research projects are required to submit quarterly report to th[redacted]***
- ***All protocol amendment(s) for approved research studies conducted at the hospital should receive [redacted] approval prior to implementation.***

Administrative Approval

This kind of approval will be given to students up to undergraduate degree level OR studies undertaken by [redacted] hat do not require a [redacted] for the purposes of undertaking operational research. **However, if the results are to be published in a scientific journal [redacted] proval would be required.** Such applications **will go through Part 1 as indicated above** after whi[redacted] ll issue an administrative approval. Th[redacted] may require such studies to [redacted] f there are appreciable risks involved.

[redacted]

PROPOSAL FORMAT GUIDELINE

The Protocol/proposal should at least contain the following details:

Title page

- *(This page should have the title of the Protocol and the names, addresses, e-mail, departments and affiliations of Investigators).*

Structured abstract (Maximum of 300)

- *Background*
- *General Aim*
- *Methodology*
- *Expected Outcome*

Background

- *Problem Statement*
- *Hypothesis (if applicable)*
- *Aim(s)*
- *Specific objectives*
- *Literature review*

Methodology

- *Study design*
- *Study sites (Please indicate if it's a multicentre study and indicate the other centres)*
- *Subjects/study population*
- *Inclusion/exclusion criteria*
- *Sample size determination*
- *Procedures to be used*
- *Data collection methods and instruments*
- *Data handling*
- *Data security and confidentiality*
- *Statistical analysis*
- *Descriptive statistics (frequency, central tendencies, associations)*
- *Inferential statistics (test of means, correlation coefficient, etc.)*

Dissemination of results

- *To Project sponsors, policymakers and study participants (where applicable)*
- *At workshops, seminars and conferences*
- *In different types of publications*

Ethical issues

- *Recruitment and sampling procedures, Potential risks and benefits,*
- *Confidentiality*
- *For vulnerable subjects (children, pregnant women, institutionalized subjects), state how subjects' protection will be ensured.*

[redacted]

- *Consent Form with simple and clear language.*

Timelines/work schedule

- *This may be in the form of a Gantt chart.*

Personnel of the study team

- *Please state all personnel involved in your study including the role of each member of the team*

Budget & logistics

- *To be detailed even if there is no external funding*
- *This should include funding agency, total funds available to the project and the institution administering funds.*
- *If it's a multicentre study, please give details of the site-specific budget with reference to* [redacted]

References

Appendix

- Copy(ies) of all regulatory approvals already acquired (e.g., [redacted])
- Questionnaire (if any)
- CV for the PI (maximum 2 pages)
- Any other attachments

[redacted]

Appendices H

[redacted]

CERTIFICATE OF REGISTRATION

REG. NO: .....

This is to certify that

Prof/Dr/Mrs/Mr/Ms. Mary Ayim .....

has registered his/her proposed study titled Family Systems and Support for Recovery: Experiences of Mental Health Service Users and their Family Caregivers in Ghana.

.....

.....

Date of issue: 06-July-2021..... Date of expiry: 05-June-2022.....

Signature

Dr Kwadwo.....

*Receipt number

Note

This certificate does not constitute ethical clearance for the conduct of the study but proof of registration of stud is required to conduct the study at

Appendices I

UNIVERSITY OF BIRMINGHAM

School of Social Policy
Muirhead Tower
University of Birmingham
Edgbaston
Birmingham B15 2TT

4th May 2021

To whom it may concern,

As Head of School for Social Policy I can confirm that Ms Mary Ayim, is a fully registered PhD student at the University of Birmingham.

I also confirm that her proposed research fieldwork has been approved and risk assessed by the School and by the College of Social Sciences.

Yours sincerely,

Prof Anthea Hucklesby
Head of School for Social Policy
School of Social Policy
University of Birmingham

University of Birmingham Muirhead Tower Edgbaston Birmingham B15 2TT United Kingdom
T: +44 (0) 121 414 5030 W: www.socsci.bham.ac.uk

Appendices J



University of Birmingham

School of Social Policy

To whom it may concern,

As lead supervisor for Ms Mary Ayim, I can confirm that she is a fully registered PhD student at the University of Birmingham and that the conduct of her research is bound by relevant University regulations. I can therefore provide the assurance that she has been provided with appropriate research training and that her research will be governed by the highest standards of ethical practice and data management.

Yours sincerely,



Prof Jerry Tew

Professor of Mental Health and Social Work

School of Social Policy

University of Birmingham