A COMPARATIVE STUDY OF ATTITUDES
TOWARD MENTAL ILLNESS

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TABLE OF CONTENTS

ACKNOWLEDGMENTS ........................................ ii
LIST OF TABLES ........................................ v
ABSTRACT ................................................ vi

Chapter

1. INTRODUCTION AND PURPOSE OF THE STUDY .......... 1
   INTRODUCTION ........................................ 1

ERRATA

3. Page 57, insert the following after line 23:
   JAHODA, G. Traditional healers and other institutions concerned with
   mental illness in Ghana. International Journal of Social
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<table>
<thead>
<tr>
<th>Chapter</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. STATISTICAL TREATMENT OF DATA</td>
<td>37</td>
</tr>
<tr>
<td>CHI-SQUARE STATISTICS</td>
<td>37</td>
</tr>
<tr>
<td>5. DISCUSSION AND CONCLUSIONS</td>
<td>47</td>
</tr>
<tr>
<td>DISCUSSION</td>
<td>47</td>
</tr>
<tr>
<td>CONCLUSIONS</td>
<td>53</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>55</td>
</tr>
<tr>
<td>APPENDIX</td>
<td></td>
</tr>
<tr>
<td>A. INSTRUCTIONS AND QUESTIONNAIRE ITEMS</td>
<td>62</td>
</tr>
<tr>
<td>AS ADMINISTERED</td>
<td></td>
</tr>
</tbody>
</table>
# LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Breakdown of Subjects by Nationality, Education, Sex and Race—Americans</td>
<td>32</td>
</tr>
<tr>
<td>2.</td>
<td>Breakdown of Subjects by Nationality, Education, Sex and Race—Ghanaians</td>
<td>33</td>
</tr>
<tr>
<td>3.</td>
<td>Attitudes and Opinions About Care of the Mentally Ill</td>
<td>38</td>
</tr>
<tr>
<td>4.</td>
<td>Family Influence on Attitudes and Opinions About Mental Illness</td>
<td>39</td>
</tr>
<tr>
<td>5.</td>
<td>News Media as a Source of Information on Mental Illness</td>
<td>39</td>
</tr>
<tr>
<td>6.</td>
<td>Demonic Forces as Causative Agents of Mental Illness</td>
<td>40</td>
</tr>
<tr>
<td>7.</td>
<td>Knowledge of What Behavior Constitutes a Mental Illness—Psychoneuroses</td>
<td>40</td>
</tr>
<tr>
<td>8.</td>
<td>Knowledge of What Behavior Constitutes a Mental Illness—Psychoses</td>
<td>41</td>
</tr>
<tr>
<td>9.</td>
<td>Attitudes and Opinions About Mental Illness for the Three Populations</td>
<td>41</td>
</tr>
<tr>
<td>10.</td>
<td>Attitudes and Opinions About the Mentally Ill and the Ex-mental Patient for the Three Populations</td>
<td>42</td>
</tr>
<tr>
<td>11.</td>
<td>Percentage Responding Yes to Items on Attitudes and Opinions About Mental Illness for the Three Populations</td>
<td>45</td>
</tr>
<tr>
<td>12.</td>
<td>Percentage Responding Yes to Items on Attitudes and Opinions About the Mentally Ill and the Ex-mental Patient for the Three Populations</td>
<td>46</td>
</tr>
</tbody>
</table>
ABSTRACT

A study of attitudes toward mental illness and the mentally ill compared 280 Ghanaian and 564 California high school and undergraduate college students. The Ghanaians were found: a. to be more rejecting of the mentally ill and the ex-mental patient; b. to have more beliefs in demonic forces as causative agents of mental illness; c. to have less enlightened and favorable attitudes and opinions about the care of the mentally ill; d. to be more likely to recognize psychotic symptomatologies as constituting mental illness; e. to be significantly influenced by their family system in their attitudes and opinions about mental illness and the mentally ill; and f. to be significantly more "external" in their personality structure than their American counterparts.
Chapter I

INTRODUCTION AND PURPOSE OF THE STUDY

Introduction

Within the last three decades there has been a tremendous increase in the number of studies dealing with social attitudes toward one of the oldest, most difficult and most controversial ailments ever to affect people—mental illness and toward the mentally ill. The increase in the number of studies is especially great in this country. The results of these studies, while being far from conclusive in many areas, seem to indicate an overwhelming agreement among the researchers that the public in this country is better informed about mental illness than it was three decades ago. Such a consensus is probably related to the fact that mental illness is now discussed more openly in this country—and is therefore less of a stigma—than in the recent past.

However, while studies on public attitudes toward mental illness are being conducted in this country and a few other nations such as Britain, Canada, and Mexico, there has been an almost total absence of such studies in Africa. The few studies that have been conducted in some sub-Saharan African states such as Ghana, Nigeria and Kenya, present social attitudes toward mental illness in these countries as resembling those of the late nineteenth century in Europe—fear, rejection,
superstitiousness and ignorance. The researchers involved—all Western Europeans—are very well-known and capable in their respective disciplines, but their works did not specifically contrast Western European with African attitudes toward mental illness and the mentally ill. The literature from sub-Saharan Africa is replete with excuses that owing to the diversified nature of the cultural makeup of the African, there could not be any meaningful comparison made between the Africans and Europeans on this subject.

On the contrary, this writer believes that a systematic delineation of the cultural differences between the African and the Western European would immensely help to discover some possible common factors that influences peoples' attitudes toward the mentally ill and the ex-mental patient. In this regard, African researchers could play a very important role in helping to establish some of these differences. There are now many research-oriented African graduate students in the field of mental health. Consequently, it is now possible accurately to determine current social attitudes toward mental illness and to develop programs aimed at helping those afflicted. Certainly the need for such programs seems pressing when one views the rapid cultural and industrial changes—a factor which Leighton has noted as resulting in "an increase of mental illness"—now taking place in many African states.

One of these states is Ghana, a former British Colony in West Africa. The influence of Western culture in this country is over one hundred and fifty years old. Yet one of the most enduring and important differences between Ghana and the United States is the family system. The extended or consanguine unit is almost the only system sanctioned in the former and the latter has as the only established family system, the nuclear or the conjugal unit. Although black Americans seem to maintain some form of the extended family system, it is more diffused than the one prevailing in Ghana. For example, Jackson (1973) reports that family patterns among blacks in this country do not represent "a distinct subculture," and that within similar socioeconomic positions, both blacks and whites resemble each other. Though "matriarchy is more prevalent among blacks than whites," Crier and Cobbs (1968) maintained that "The black family is first of all an extended family. Relatives more readily share the responsibilities of child-rearing. Members of the family more often come to aid of a troubled member."

But they nevertheless recognized that "...The Negro family is weak and relatively ineffective... (in) protecting their members."

Added to these familial differences are other social and belief systems of the Ghanaian which are unlike those of the United States. For example, in the Euro-American society the inculcation of acceptable social behavior into the child, that is, discipline, toilet training, feeding and almost all the emotional needs of a baby are the sole responsibility of the
father and mother. In early and late adolescence, most children begin to or are encouraged by their parents to start thinking of leading independent and self-supporting lives. At age 18 years and up, most American children are independent of parental control or influence. Consequently, most infractions of the law, however minor, are handled through the judicial processes. The social characteristics or attitudes of the average American are therefore devoid of many parental influences.

On the other hand, the child in Ghana falls not much under the influence of his father and mother as he does under the grandparents, aunts, and other older relatives who tend to over indulge him; much of his knowledge and behavior patterns are also acquired from other older children and siblings with whom he plays. Thus, as Kidd (1906) says, "...children, when very small learn from their mother; when they cut the second teeth they ask the bigger boys questions; and the bigger boys ask the young men, and the young men ask the old men. In this way knowledge and information filter down through successive strata." Discipline and punishments for offenses (which occurs in late childhood through adolescence) are usually immediate and inflicted by any member of the parental generation who happens to be handy. In most cases, however, offenses involving other people or property (except serious ones such as homicide or those involving total strangers) are settled amicably between the offender and his family and the offended and his family.
The reader could see why older people in Ghana would be more revered and also have greater and more enduring influence over children than those in the United States. In fact, the influence is such that one hardly encounters a Ghanaian who will unhesitatingly call an older person by his first name without being chastised by the person being so addressed. In the same vein, one hardly encounters a high school or unmarried college student who is self-supporting and or does not live with his parents or relatives. Most youngsters (except those who travel to cities in search of jobs) continue to live home together with their siblings and parents until they get married; at which time they voluntarily move out to be on their own.

But living away from one's parents or family does not necessarily imply being totally free from the cultural practices which are usually protected and passed on to succeeding generations by the older ones. In Ghana, rituals such as the relatively minor affair of the naming of a newly born baby, the circumcision of a male child, and the much more larger ones such as the Homowo festival of the Ga people (Accra region) and the Oguaa Afahye (celebrated in the Cape Coast area) all command the full participation of both younger and older people, illiterates and literates alike, and involves the invocation of ancestral spirits and other deities for their participations and protection of the living. The intensity and institutionalization of these practices in the Ghanaian culture are only a few of the factors that inculcate a belief in the
supernatural in the average Ghanaian.

There are of course, numerous differences between Ghana and the United States, but for the purpose of this paper, the following two examples will suffice. First, in comparing the African Negro with the Western European, Westerman (1939) wrote of the African:

...Within his own circle he is never in a position where he does not know how to behave or what to do...work is not specialized in the same way as with us and therefore the non-expert "layman"...does not exist. The African is able to enlarge with ease on any subject...he does not suffer from social disabilities, for there is hardly any economic dependence, nor is there a distinction between servant and master, rich and poor. Hence nobody suffers from an inferiority complex....It is natural for him to express his real personality, for everybody knows everybody else, and no-one can therefore permanently conceal his nature.

A man does not plan, set himself an aim and exercise his strength in attaining it. The individual as such has no aim in life if his task is to become exactly like the rest....The motives for his actions are predominantly social, not individual, and are deeply influenced by public opinion....Personal responsibility is avoided wherever possible.2

While not in complete agreement with the above quotation, this writer believes that the substance of it is accurate and largely true today. Hence, unlike in the United States, creative innovation is not particularly institutionalized in the Ghanaian society.

Secondly, in the United States the prevalent view of the etiology of all sicknesses is the naturalistic notion. But in

Ghana, as Jahoda (1961) states:

The traditional cosmology has no room for a purely naturalistic notion of disease, because there is no clear-cut conceptual separation of the natural or physical world on the one hand, and the supernatural, magic or witchcraft, on the other.

The ideas and beliefs people in Ghana have about social stratification, systems of authority and illness—both physical and mental—are such that it will be fairly accurate to refer to the Ghanaian as one who views himself as being controlled by some powerful and debilitating external forces. For example, Jahoda (1961) has documented several cases dealing with a broad spectrum of the everyday life of the Ghanaian—from family relationships to contracting a venereal disease, from failing a school examination to the threat of losing a job, etc. He found that for every personal misfortune or illness, the individual explanation was a reference to some magical act.

**Purpose of the Study**

It is against the background of the absence of such attitudinal studies in Ghana or between the two countries, and the diversified belief systems, familial and social differences between the United States and Ghana, that the present study is being conducted. The aim is to explore comparatively social attitudes toward mental illness and the mentally ill in the two countries so as to determine: a) how much acceptance or rejection the mentally ill and the ex-mental patient encounter
in each society, and b) the differential effects—if any—of the different family systems, belief systems, etc. on social attitudes toward mental illness and the mentally ill.

The hope is that since social attitudes influence the care and prevention of mental illness, the accurate measurement of such attitudes, together with their sources of variations, will greatly help in planning and effecting meaningful programs to help those afflicted. This is very important—especially if Leighton’s (1939) observation is correct—for Ghana where there is at present a rapid acculturation taking place, but which has no adequate mental health facilities or programs to cater for the needs of those persons who may develop mental problems as a result of such social changes and their concomitant pressures on individuals.
Chapter II

REVIEW OF THE LITERATURE

Historical Perspective

In reviewing the literature about mental health and mental illness, there are at least two reasons for preceding the current thinking on the subject with a historical overview. One is that the history of psychopathology and its concomitant interplay of social attitudes and theories about mental illness depicts a series of remarkable patterns that could be very instructive for future educators, planners and leaders. The second reason is that it can be safely assumed that mental illness has always existed among people and that ascribed causes have in the past and continue in the present to determine the methods adopted for prevention and cure. Thus a historical overview not only provides us with a fit between the past and the present, but it also gives us a basis for comparing or measuring current achievements and progress in the field of mental health and mental illness.

Concept of Mental Illness in the Golden Age

Deutsch (1949) points out that in ancient Greece as well as in ancient Egypt or the so called "golden age", mental illnesses were viewed as divine or demonical visitations. The results of such views were the establishment of several
healing shrines and temples where possessed people were exorcised. For example, in Greece the temples of Aesculapius (the god of healing) located at Epidaurus and Cos are said to have numbered over three hundred healing shrines and temples. Similarly, Field (1960) reports that in Ghana, it is not uncommon to see shrines in villages and some towns that serve among other things the same purpose—healing or exorcising the "possessed."

From around the fourth century B.C. and through the great works of Hippocrates (460-370), the Greeks and Romans began to recognize diseases, including mental diseases, as being caused by natural phenomena. It must be noted that in spite of such advancements, insanity was generally viewed with fear, rejection, suspicion and as the work of the devil through the medieval period until the era of the Enlightenment.

The Birth of Moral Treatment

Caplan (1969) illustrates how the works of the Realists such as Balzac and Dickens and Gothic novelists influenced both European and American psychiatrists in the nineteenth century. According to Caplan, the view of the mutative powers of the environment depicted in both European and American literature had already gained popularity in America as a result of the eighteenth century philosophical thesis held by Benjamin Rush, the "father of American psychiatry," and other Jeffersonians. Their position was that, "because all men were created members of the same species, differences among them must stem from accidental causes of environment."
The birth of the "moral treatment" and its attendant cult of curability is seen in the works of Phillippe Pinel in France in 1792, the English Quakers led by William Tuke and Benjamin Rush in the United States. Also, the supposed insanity of George III of England and the rough treatment he received from his attendants gave an early impetus to moral treatment.

Caplan further notes that:

The essence of moral treatment was the belief that, because of this great malleability of the brain surface, because of its susceptibility to environmental stimuli, pathological conditions could be erased or modified by corrective experience. Therefore, insanity, whether the result of direct or indirect injury or disease, or of overwrought emotions or strained intellectual faculties, would be cured in almost every case.

This belief in curability coupled with the then pervasive sense of religious humanism gave the needed impetus to the then pioneers of moral treatment in this country, e.g. Dorothea Dix (1802-1887), to fight for and succeed in getting funds from the government and philanthropists for the establishment of several mental institutions within which the insane were managed and "cured."

The Demise of Moral Treatment

Though the intention of the movement was to model the institutions after the York Retreat in England, many factors worked against, and contributed to the demise of moral treatment. First, Deutsch (1949) explains that the "cult of curability," was based on reports of up to 90 percent cure rates from the institutions. This was later refuted by
statistics that indicated that the "cures" were nothing but successive releases of the same individual from several hospitals. Secondly, there was not enough money to cater for the needs of the larger populations now occupying the institutions. And thirdly, the hitherto middle-class population had been drastically changed to include paupers, and often people from prisons or very degrading circumstances who had no secure environment to return to should they improve.

Ironically, Benjamin Rush had by 1883 placed the seat of insanity in the blood vessels of the brain. He recommended confinement and total deprivation of the individual's liberty, blood-letting, restraining devices such as the "strait waistcoat," or the "tranquilizer" as the methods of treatment. As it will be shown later, the organic view adopted by the practitioners of the moral treatment is very important in many respects.

After a new pessimism influenced social attitudes toward the insane, all due to the factors mentioned above, mental institutions became explicitly custodial. Thus, and as Achenbach (1974) suggests, the works of Darwin, Origin of Species (1859) and Calton's Hereditary Genius (1869) coupled with the organic view taken by the practitioners of moral treatment did, if anything at all, "provide ammunition for hereditarian arguments in most of Western Europe. But, in America, it appears to have provided rationalization for a change in professional attitudes that had already occurred."
Whatever the arguments were, by the mid-nineteenth century the wild optimism had given way to bleak pessimism about mental illness. The social attitudes toward mental illness and the mentally ill remained unchanged until the advent of psychoanalysis, the mental hygiene movement, etc., around the end of the nineteenth century.

Contemporary Social Attitudes Toward Mental Illness

Succinctly, one can see that if anything at all, it is social attitudes that have continued to determine the methods of treatment of the mentally ill in all ages rather than any advances in medical knowledge. However, unlike the past patterns enumerated above, current social attitudes toward mental illness and the mentally ill are depicted in literature as falling into two separate camps—humanism or optimism versus custodialism or pessimism—all existing concurrently.

The Humanistic Orientation

That the public is more humanistic, more libertarian, and therefore more tolerant regarding deviant behavior is amply demonstrated by several studies during the last decade. Studies reporting such views indicate, among other things, that in this country the public now views psychiatric patients in more psychological and less moralistic terms. The public, according to this view, is now also more optimistic about the possibilities of patient recovery in a maximally therapeutic environment.

Prominent among this view are a series of studies in the
1960's by Lemkau, Crocetti and others. At the beginning of the
1960's, Lemkau and Crocetti (1962) conducted a survey of a
sample population drawn from Baltimore to find out about the
population's opinions and beliefs about mental illness. The
sample was poorly educated, with a median 9.7 years in school.
Forty percent of the sample was Negro, and the median family
income for the entire sample was $4,730. A randomly selected
sample of over 18 years old from the population were indi-
vidually interviewed by trained interviewers using question-
naires that had 3 of the 6 items used by Star (1950) in an
earlier study. The three questions involved descriptions of
a simple schizophrenic, a paranoid schizophrenic and an
alcoholic. After each story was read, the respondent was
asked, "Would you say this person has some kind of mental
illness or not?" The authors compared the findings with
those of Star and Cumming, showing that in each case more
people identified the person in the story as being mentally
ill than has been reported in previous studies. There was
also no significant correlation between the tendency to make
the correct identification and variables such as age, race,
marital status and urban or rural birth. But it was found
that the higher the income or the more educated, the greater
the likelihood of considering the case stories as representing
mental illness.

On the question of rejection, the authors indicated that
50% of their sample "could imagine themselves falling in love with someone who had been mentally ill," 81% "wouldn't hesitate to work with someone who had been mentally ill," and 62% disagreed with the statement that "almost all persons who have a mental illness are dangerous."

On the basis of these findings, the authors concluded that there is no evidence to support the concept of "denial" of mental illness on the part of the public. Furthermore, they found that pessimistic, isolating and rejecting attitudes on the part of the public toward the mentally ill reported by previous studies were not supported. Rather, the public were able to identify the case stories as mentally ill and showed more humane attitudes toward the mentally ill.

Evidence in support of this view is also furnished by the works of Crocetti, Spiro, and Siassi (1971). They studied the opinions and attitudes of blue-collar workers toward mental illness and compared them with Lemkau and Crocetti's (1962) Baltimore study. The sample consisted of 973 respondents from a population of 8,000 United Auto Workers members employed at the General Motors plants in Baltimore. The typical respondent was white, 40 years old, lived in a row house, was a high school drop-out and was born in Baltimore or lived there for many years. He had been married for over 17 years, worked at the same job for over 13 years, with a family income of close to $9,000 and had two children. The hypothesis tested was that "the preponderance of the public has attitudes toward the mentally ill
that are characterized by stereotyping, stigmatization, rejection and prejudice and regards them as incurable." From their findings on questions which examined willingness to work with, to live with, or to fall in love with an ex-mental patient, they drew these conclusions: 1) for at least a decade, the public has accepted mental illness as illness, 2) the public looks to the medical profession for the treatment of this illness, and 3) the majority are optimistic about the outcome of such treatment.

However, while the public may now be more able to correctly identify cases of mental illness than in past decades, a careful perusal of these studies cited suggests some revised conclusions. First, it is highly questionable to equate correct identification of case stories of mental illness with "favorable change in attitudes toward mental illness." In other words, the fact that one correctly identifies another as being mentally ill does not necessarily mean that one will be more tolerant of the mentally ill. Secondly, it must be noted that questionnaire items about rejection and isolation of the mentally ill dealt with the ex-mental patient and not the mentally ill. It therefore seems very erroneous to make any conclusions about the mentally ill on the basis of the questionnaire items used. The ex-mental patient and the present mental patient are not the same.

A replication of Lemkau and Crocetti's 1960 Baltimore study by Meyer (1964) found similar results. But he also
suggested that, contrary to Cumming and Cumming's (1951) findings, the public has in the last ten years developed a greater tolerance toward mental illness and is more rational and humane in its verbally expressed attitudes toward mental illness.

Another study supporting the optimistic view is that of Rootman and Lafave (1969). In their study, they compared current attitudes toward the mentally ill in a rural Canadian town with the findings of Cumming and Cumming (1951). The town, Saltwater, is in the same Canadian province as that in the study of Cumming and Cumming. With the exception of small differences in ethnic composition, the two populations—Saltwater and Blackfoot—were said to be more similar on all demographic indices than the Baltimore sample used by Lemkau and Crocetti (1962). It will be recalled that earlier, Lemkau and Crocetti (1962) had made a comparison between a sample of persons from Baltimore (an urban, industrialized city in the United States) and from Blackfoot (Cumming and Cumming, 1951), a rural, agricultural town in Canada on their attitudes toward mental illness, and concluded that the public was not as rejecting as Cumming and Cumming (1951) implied. The rationale for choosing Saltwater was that, to compare the Baltimore population (as was done by Lemkau and Crocetti, 1962; and Meyer, 1964) with that of Blackfoot would yield erroneous conclusions, since the two populations are markedly different in many respects. However, the findings of Rootman and Lafave also suggested a more
tolerant and "enlightened" attitude toward mental illness and the mentally ill than that of Cumming and Cumming (1951), thus lending support to the findings of the Baltimore study. However, both Rootman and Lafave (1969) and Meyer (1964) respectively warn that their findings must be interpreted with caution since comparison was made between only two rural communities and that they reflect only verbally expressed attitudes.

To this writer, the foregoing warning warrants more than "just being taken note of" in studies dealing with public attitudes. This is so because most of the previously noted studies seem to convey the impression that a change in stated attitude is synonymous to a change in behavior—a belief which La Pierre (1934) ingeniously demonstrated to be an illusion.

Another much quoted study that supports the optimistic view of public attitudes toward mental illness is that of Elinson, Padella, and Perkins (1967). In a survey of about 1,500 selected housing units in New York City, they explored public opinions about mental illness and attitudes toward the mentally ill. Conspicuous among their numerous conclusions were that "rejection of the mentally ill" involves at the very least a double standard of value. The public does not globally reject the mentally ill. On the contrary, the public does have hope for a favorable outcome to treatment of the patient...." For example, two out of three respondents (69%) in their study agreed with the statement that "mental illness is an illness like any other." Yet, more than three out of
four (77%) agreed that "unlike physical illness, which makes most people sympathetic, mental illness tends to repel most people." Only 16% admitted to being repelled by mental illness themselves, however. Thus, it seems that unlike about three decades ago, candid rejection of mental illness is now less socially acceptable to confess. Similarly, Edgerton and Bentz (1969 and 1971) report a more favorable attitude toward mental illness by the public. They reported that almost all respondents agreed that mental illness was like any other illness.

The public's equivocal stance toward accepting the mentally ill is further illustrated in the following findings of Elinson, et. al. Only two out of five (44%) respondents "would be willing to" have a former mental hospital patient as a boss on a job--although seven out of ten (73%) respondents would be willing to work next to such a person. An even fewer number--one out of four (23%)--would be willing to share an apartment, or "agree if someone in the family wanted to marry such a person," whereas 69% agreed "to live next door to him."

Though there have not been any studies of attitude toward mental illness done in Ghana, one could say that in some measure the culture fosters more tolerant attitudes toward mental illness. For example, Tooth (1950) wrote:

There appears to be little social stigma attached to madness; lunatics are well treated in their homes and even when shackled to a log in the traditional manner, the madman is seldom alone for long, is well fed and enjoys the company of his children and friends. This tolerant attitude accounts for the number of harmless lunatics at large:....
Similarly, Field (1960) wrote:

The rural patient is never taken to the mental hospital, not because of any associated stigma, but because the illness is regarded as supernaturally determined and hence, outside the province of hospitals. The only rural patients I have ever known to enter hospitals were sent there by the Police Magistrate after homicidal assaults.

Regarding belief in superstitions, it is not uncommon for one to encounter in Ghana, various testimonies to the existence of powerful jujus (voodoo) and witches. A more recent example of such testimonies are found in a Ghanaian Daily, "The Sunday Mirror" (May 6, 9, 30 and June 6, 1975) in which a self-professed witch has been sued by a couple for defamation. The woman accused the man and his wife of being wizard and witch respectively, and that the couple killed her daughter through their powers of witchcraft and wizardry. In her testimony she declared that "witches and wizards take the form of either animals or birds...but she, herself was a vulture." She attempted to prove the veracity of her accusations in court by asking permission "to transform herself into a vulture and to cause the plaintiffs to transform also." Her request was however refused on legal grounds.

To the outside observer, especially a foreigner, the above example of belief in superstitions might be dismissed on the grounds that the woman was probably mentally ill at that time, or that, being an illiterate, her thought processes are still primitive in nature. But such explanations are not adequate because such beliefs have been found not restricted to the
mentally ill nor the illiterate persons in Ghana. Jahoda (1970) found among university students in Ghana a strong belief in supernatural concepts: a belief which also correlated highly with their scores on Rotter’s I-E scale. Rotter (1966) was the first to describe systematically a dimension of locus of control of reinforcement within social learning theory. Briefly described, a person is "external" if he perceives events in his life as not being contingent upon his actions, but rather as the result of luck, or other forces beyond his control. "Internal" on the other hand, refers to someone who perceives that he has control over events that occur in his life. Higher scores on the I-E scale indicate greater externality.

While there is some validity to the findings of Tooth, Field and Jahoda regarding the Ghanaian attitudes toward mental illness, the former two writers seem to overlook some important elements in the culture that may account for the "social tolerance" observed. Three such elements--the functions of the family, position in the family and labeling--will be discussed later on in the paper. Suffice it to say that from the author's own experience (a Ghanaian born and raised in both villages and cities in Gold Coast, now Ghana), there is indeed a very strong stigma attached to mental illness in Ghana.

The Custodial or Pessimistic Orientation

Unlike the humanistic orientation, custodialism is saturated with pessimism, impersonalness, and watchful mistrust. Patients are conceived as irrational, insensitive to others,
unpredictable and dangerous. Mental illness is attributed primarily to poor heredity, organic lesion, punishment for sins, etc. For instance, both Tooth and Field indicates that in Ghana the etiology of mental illness is thought to be some form of magic, poisoning, witchcraft, "medicine" or offending some god. As Tooth further suggests:

In the forest zone, especially in Ashanti, the lunatic is more feared for his potentiality for evil than respected. Mental illness is regarded as a disaster which it is impolite to mention except in vague circumlocutory terms. An afflicted person is looked upon either as the victim of juju or a witch, and it is customary to subject him to fetish tests to determine whether he is the victim or the aggressor.

Similarly, along the coast and especially among the Fanti, occurrence of mental illness in the family is regarded as a disgrace and the patient is liable to be disowned by them especially if he wanders around in the community.

While the situation in the United States is somewhat different, there are still numerous studies documenting isolation, fear and rejection of the mentally ill in this country. An example is the early 1951 classic study by Cumming and Cumming (1957). In their 1951 study conducted in Blackfoot, a small rural agricultural Canadian town in the Saskatchewan Province, Cumming and Cumming found that the public's general attitude toward mental illness was that of fear and denial, isolation or segregation through hospitalization and rejection. Phillips (1963 and 1964), Sabrin and Mancuso (1972) all reported that people labeled as mentally ill are all reacted to with fear,
dislike and aversion that have characteristically and traditionally been manifested toward mental patients in American society.

Another study documenting the public's rejecting attitude toward mental illness was that of Phillips (1966). Responding to the optimistic views presented in the literature, Phillips conducted a study to document the negative effect on public attitudes of a history of psychiatric hospitalization. His sample consisted of 300 married white females living in the town of Branford, Connecticut, a southern New England town of about 17,000 population. Each respondent was given five cards (one at a time), on which were written five different descriptions of behavior. The first four—a paranoid schizophrenic, a simple schizophrenic, an anxious-depressed person and a phobic individual with compulsive features—were the same as those of Star (1950). The fifth description was that of a normal person. The people described on the cards were presented to the subjects together with the information that they have either never sought any professional psychiatric help or, alternatively, they have been in a mental hospital. Of the normal person, 98.3% of the respondents who were told that he had never sought psychiatric help would allow their children to marry him. One hundred percent would rent him a room, work with him on a job, have him in a club, or have him as a neighbor. Yet when the same case description was accompanied with the information that he had been in a mental hospital, only 16.7% would allow their children
to marry him, and 40% would rent him a room, thus clearly showing the stigmatizing effect of a history of psychiatric hospitalization. However, on methodological grounds, one could question the generalizability of the findings because of the sample—300 married white females—can not be viewed as representative of the population.

Earlier, Crocetti and Lemkau (1965) had criticized Phillips' two previous review papers dealing with the public's rejection of the mentally ill. They contended that Phillips had failed to substantiate his statement that "those identified as mentally ill are very much subject to rejection." Furthermore, that "current sociological work in this area tends to reflect theoretical presuppositions rather than the empirical reality of the mental illnesses." In a reply to these statements, Phillips (1965) argues that "The 'considerable contrary evidence' Crocetti and Lemkau say they have accumulated is in fact no evidence at all." He further argues that the findings of Crocetti and Lemkau "pertain to those who have been mentally ill, not those who are presently mentally ill." The failure to make a distinction between those who have been and those who are mentally ill "leads to their assertions (that the public is now more accepting of the mentally ill than it has been in past decades), which are totally unsupported by the data they present", he continued.

Pursuant to his response to Crocetti and Lemkau's (1965) criticism, Phillips (1967) also responded to Lemkau and Crocetti's
(1962) findings with a study in which he argues that the ability of the layman to identify certain behaviors as mental illness does not necessarily imply changes in the way he will act toward persons suffering from mental disease as suggested by Lemkau et al. In this study, 86 subjects were each presented with three of the Star descriptions of disturbed behavior. Each description was also followed with a social distance question about the person just presented. Each subject was later asked if the hypothetical person was mentally ill. As expected, respondents who identified the cases as mentally ill wanted to maintain greater social distance than those not making such judgments. Phillips then concluded that contrary to Lemkau and Crocetti's assumptions, the layman's ability to identify behavior as mental illness is associated with rejection, and not greater tolerance of the mentally ill. Johannsen (1969) also concluded, among other things, that a) the public is not misinformed but uninformed, b) both the public and the professionals have negative attitudes toward mental illness, c) the public looks upon the mental hospital as a means of maintaining social equilibrium, and does not generally desire the return of patients incarcerated, and d) when the patient is not labeled, society is likely to be tolerant of a great deal more aberrant behavior than professionals in mental health, often regarding symptoms as mere signs of eccentricity. Halpert (1969) also concluded his review of the literature by saying that even though people now express more enlightened attitudes toward
mental illness than in the previous decades, "It is not clear that this advance has been matched by greater acceptance of mentally ill persons." The Final Report of the Joint Commission on Mental Illness and Health (1961) also echoed the findings of several other studies such as Star (1950), Cumming and Cumming (1957), Whatley (1958), Nunnally (1961), Phillips (1963, 1964, 1966 and 1967) and Johannesen (1969): "a major lack of recognition of mental illness as illness and a predominant tendency toward rejection of both the mental patient and those who treat them."

A more recent example demonstrating public attitudes toward mental illness in this country was the affair of Senator Thomas Eagleton during the 1972 presidential campaign. Even though Science News (1972) presented the stigma as more a matter of political apprehensions and anticipations rather than actual expressed public attitudes, the fact still remains that the public did not regard his past illness as any other illness and therefore not cured. As a result, he became a political liability to Senator McGovern and had to withdraw from the ticket. This differentiation between physical and mental illness is also reflected in the study of Elinson et. al. (1967) in which 77% agreed that "unlike physical illness, which makes most people sympathetic, mental illness tends to repel most people."

**Equivocal Findings**

The relevant literature shows several variables as being
the sources of variations in the public's attitudes toward mental illness and the mentally ill. Some reports (Woodward, 1951; Whatley 1958; etc.) have shown that younger people have more enlightened and accepting attitudes toward mental illness and the mentally ill than older people. Some (e.g. Dohrenwend and Chin-Shong 1967) have reported findings of more pronounced negative feelings toward mental illness among lower-class groups than higher-status groups. Yet other reports indicate that better educated people tend to be more tolerant, enlightened, more humanitarian, and more scientific about mental illness.

Such observations were noted earlier by Ramsey and Siepp (1948) and later confirmed by Woodward (1951). Ramsey and Siepp reported in their 1948 Trenton, New Jersey study that the higher the educational and occupational level, and the younger the age, the more favorable the respondent's attitude toward mental illness and the more optimistic he was regarding chances for recovery. Similarly, Kanno and Edgerton (1969) reported that education appears to be an important determinant of the nature of responses given to questions concerning mental illness obtained from a Mexican-American Community. Freeman (1961) also reports a significant correlation between level of formal education and enlightened attitudes toward mental illness on the part of patients' relatives. But he also qualifies his findings by saying that the relationship is a reflection of differential verbal ability rather than a differential "ways of life" or social class status.
On the other hand, Nunnally (1961) and Freeman and Kassebaum (1960) found that education had little or no effect on attitudes toward mental illness. The same seems to be implied by the studies by Tooth (1950) and Field (1960) of the opinions and beliefs about mental illness expressed by both literate and illiterate Ghanians. Furthermore, Lemkau and Crocetti (1962) and Dohrenwend, Bernard, and Kold (1962) have revealed respectively a relatively high level of sophistication about mental illness in a poorly educated, low socioeconomic urban population, and a low mental health orientation of civic leaders who had had much contact with the mentally ill. Thus the relationship between level of formal education and extent of knowledge may be somewhat equivocal.

Added to the numerous factors (age, sex, race, education, etc.) mentioned in the literature as possible sources of variation is the concept of ego-involvement. Though its role in attitudes toward mental illness has not been extensively investigated, the concept does seem to have some potential effects worth noting, hence its inclusion in this review. The concept was first introduced in this context by Whatley (1958) in his study dealing with the social consequences of psychiatric hospitalization. Primarily, the study sought to reveal some of the social factors associated with avoidance reactions toward recuperating patients. He administered the Ego-Involvement Scale—which he had designed in 1956—to a stratified sample of 2,001 residents of Louisiana. The results showed 81% of
the subjects responding favorably to "It is best not to associate with people who have been in mental hospitals", an item ranked as being low with ego-involvement. In striking contrast, only 36% responded favorably to the statement, "I would be against any daughter of mine marrying a man who had been to see a psychiatrist about mental problems." Similar findings of differential avoidance of the ex-mental patient were found among the variables age, race, education, income, occupation and marital status. That is, most favorable responses were given by young, better educated, married white respondents who were engaged in well-paid clerical or professional occupations. Thus, not unlike some of the findings of Elinson, et. al., the present results also show that the average person does accept the recovered mental patients in some situations but not in others. The findings that acceptance of the ex-mental patients are inversely related to the proximity of ego values also led the author to conclude that, "Tendencies to shun or to restrict social interaction with ex-patients are most likely to be present in situations which involve important self values."

**Statement of the Problem**

That potentially there are big differences between Ghanaians and Americans in their general attitudes toward mental illness is very aptly suggested in the literature on the subject. For example, the Ghanaian attitude toward mental illness is said to be that of fear, rejection, superstitiousness and ignorance.
while the American, though somewhat rejecting, exhibits more enlightened attitude toward the mentally ill. For many illnesses, it is suggested that the fear of magic has functional primacy for the Ghanaian. The American on the other hand, sees natural causes as underlying almost all illnesses. Finally, the literature also suggests that the Ghanaian family system is more tolerant or supportive of deviant behaviors than the Western nuclear family.

These differences, the present author suggests, are mainly due to the following:

a) The extended family system in Ghana fosters among its members, a strong feeling of interdependency such that attitudes toward mental illness in this society will be strongly negative only in extreme cases of mental illness.

b) Because of the interdependency inherent in the extended family system, coupled with the strong belief the Ghanaian have in the control that "external or supernatural forces" has over the individual, Ghanaians will be more "external" than their American counterparts. Consequently, they will also perceive the causative agents of mental illness as being more of external sources such as voodoo, etc., than their American counterparts.

c) This interdependency creates a strong deference to authority (as observed in such acts as sanctions
against calling an older person by his first name) which in turn creates a much narrower perception of what behavior constitutes mental illness; such that only the "raving maniac" or the psychotic—who does not or cannot show deference to authority—will be the one most widely recognized as being mentally ill.

d) Once a person is labeled as mentally ill the interdependency is reduced; and since the labeled individual does not or cannot reciprocate the deference accorded him, the "respect" given him also diminishes. Consequently, attitudes toward the mentally ill will be less tolerant in Ghana than in this country.

e) Since perception of mental illness is restricted to the psychoses in Ghana, overall attitudes toward mental illness will be more negative among Ghanaians than their American counterparts.
Chapter III

METHOD OF INVESTIGATION

Subjects

Subjects consisted of 844 students, with subgroups shown in Tables 1 and 2.

Table 1

<table>
<thead>
<tr>
<th></th>
<th>AMERICANS</th>
<th>N=564</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>College Students = 267</td>
<td>High School Students = 297</td>
</tr>
<tr>
<td>Male:</td>
<td>136</td>
<td>Male:</td>
</tr>
<tr>
<td>Black</td>
<td>61</td>
<td>Black</td>
</tr>
<tr>
<td>White</td>
<td>75</td>
<td>White</td>
</tr>
<tr>
<td>Female:</td>
<td>131</td>
<td>Female:</td>
</tr>
<tr>
<td>Black</td>
<td>58</td>
<td>Black</td>
</tr>
<tr>
<td>White</td>
<td>73</td>
<td>White</td>
</tr>
</tbody>
</table>

Total by Sex:  Male = 285
                Female = 279

Total by Race: White = 295
                Black = 269
## Table 2

Breakdown of subjects by nationality, education, sex and race.

<table>
<thead>
<tr>
<th></th>
<th>GRAMAIANS</th>
<th>*N=280</th>
</tr>
</thead>
<tbody>
<tr>
<td>College Students</td>
<td>150</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>75</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>75</td>
<td></td>
</tr>
<tr>
<td>High School Students</td>
<td>130</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>75</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>55</td>
<td></td>
</tr>
</tbody>
</table>

Total by sex: Male = 150
Female = 130

*All subjects were blacks.*
The Californians were drawn from the University of California at Davis—about 18 miles from the state capital, California State University at Sacramento—the state capital—and three high schools all in Sacramento. The Ghanaians were also drawn from two of the three universities (one in Kumasi and the other in Accra) in the country and three secondary schools in Accra, the capital city.

Procedure

A total of 116 items selected from questionnaires developed and used by Nunnally, Jr. (1961) and Elinson, Padella and Perkins (1967) were used as one measuring instrument. Added to these items were statements descriptive of psychoneurotic and psychotic symptomatologies as outlined by Rowe (1972). Two newly arrived Ghanaians in the United States, a High School teacher and a High School graduate, helped in the formulation of some of the statements to make them more relevant and understandable to the Ghanaian High School students. An example was the inclusion of the work "juju", which is the most widely used Ghanaian word for voodoo. The questionnaire items were subsequently broken down into eight dependent measures: 1) Attitudes and opinions about mental illness; 2) Belief in demonic forces as causative agents of mental illness; 3) Attitudes and opinions about care; 4) News media as a source of information on mental illness; 5) Attitudes and opinions about the mentally ill and the ex-mental patient; 6) Family influence on attitudes and
opinions about mental illness and the mentally ill; 7) Knowledge of what behavior constitutes mental illness—psychoneuroses; 8) Knowledge of what behavior constitutes mental illness—psychoses.

An internal-external locus of control scale developed by Norwicki and Strickland (1973) was also included on the questionnaire, bringing the total number of dependent measure variables to nine.

Eight hundred of the questionnaires—each nine pages long—were mailed to three known Ghanaians, one a graduate student, another a secondary school teacher and the other, a lecturer at the University of Ghana at Legon. They were respectively instructed to administer the questionnaires to both male and female students between the ages of 16 and 30, none to form six students (form six—lower and upper six—is a two year preparatory program, beyond the regular five year high school program, for students intending to continue their education at the university level) nor graduate students. Instructions for the respondents were included as the first page of the questionnaire. The three were given money and instructed to mail or take the completed questionnaires to Legon from where they were bulk mailed to the author at the Psychology Department at California State University, Sacramento. The rest of the questionnaires, 700 total, were administered in class to students in the Sacramento area, the classes being randomly chosen. All subjects were told that the study was meant to
measure general attitudes toward mental illness and that they should indicate their best possible opinions or attitudes by marking "yes" or "no" against each item. They were also told not to write their names or make any identifying marks on the questionnaire papers. This, they were told, should enable them to freely answer each question without any thought of their being recognized by anyone. They were also told that participation was voluntary, and that anyone who did not want to take part was free not to do so.

After the questionnaires were completed, they were collected by the author and all questions by the respondents in regards to the just completed questionnaires were fully answered by the author.
Chapter IV

STATISTICAL TREATMENT OF DATA

Chi-Square Statistics

The 116 questionnaire items were broken into eight categories plus the I-E locus of control scale. Since the two population groups (Ghana and California) are independent, and the data are in terms of frequencies of "yes" and "no" responses, a chi-square was used as the appropriate statistical test to compare the overall attitude in each of the eight categories between the two nationalities.

In setting up the 2 x 2 contingency tables, the total number of yes and no responses to the combined items composing a category was calculated for each subject, and the scores for all subjects in a nationality group were combined for entry into the contingency table for that category. Percentages of total yes responses for each of the eight categories for each population group are also shown on the contingency tables. A summary of the results of the chi-square tests comparing the attitudes of the two nationalities on each of the first six response categories are presented in Tables 3 through 8.

The remaining two categories were analyzed in a three-way comparison between populations in Ghana, Sacramento, and New York City (the latter figures were obtained from the study by
Elinson, et. al. (1967).) These results are summarized in Tables 9 and 10.

Table 3
Category 1

Attitudes and Opinions About Care of the Mentally Ill
(19 Items)

<table>
<thead>
<tr>
<th></th>
<th>Sacramento</th>
<th>Ghana</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Yes</td>
<td>36.8</td>
<td>48.5</td>
</tr>
<tr>
<td># Yes</td>
<td>3939</td>
<td>2581</td>
</tr>
<tr>
<td># No</td>
<td>6777</td>
<td>2739</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 203.18, \text{ 1 df, } p < .0005 \]

Note: Agreement with an item signified less acceptance of and a less favorable attitude toward the mentally ill.
Table 4
Category 2

Family Influence on Attitudes and Opinions About Mental Illness
(17 Items)

<table>
<thead>
<tr>
<th></th>
<th>Sacramento</th>
<th>Ghana</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Yes</td>
<td>40.9</td>
<td>54.2</td>
</tr>
<tr>
<td># Yes</td>
<td>3919</td>
<td>2578</td>
</tr>
<tr>
<td># No</td>
<td>5669</td>
<td>2182</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 226.06, 1 \text{ df}, p < .0005 \]

Note: Agreement with an item signified greater family influence on attitudes and opinions about mental illness.

Table 5
Category 3

News Media as a Source of Information on Mental Illness
(3 Items)

<table>
<thead>
<tr>
<th></th>
<th>Sacramento</th>
<th>Ghana</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Yes</td>
<td>35.2</td>
<td>51.1</td>
</tr>
<tr>
<td># Yes</td>
<td>596</td>
<td>429</td>
</tr>
<tr>
<td># No</td>
<td>1096</td>
<td>411</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 57.85, 1 \text{ df}, p < .0005 \]

Note: Agreement with an item signified belief in the news media as a credible source of information on mental illnesses.
Table 6
Category 4

Demonic Forces as Causative Agents of Mental Illness
(8 Items)

<table>
<thead>
<tr>
<th></th>
<th>Sacramento</th>
<th>Ghana</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Yes</td>
<td>28.4</td>
<td>40.5</td>
</tr>
<tr>
<td># Yes</td>
<td>1280</td>
<td>907</td>
</tr>
<tr>
<td># No</td>
<td>3232</td>
<td>1333</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 99.89, 1 \text{ df, } p < .0005 \]

Note: Agreement with an item signified more belief in demonic forces as being causative agents of mental illness.

Table 7
Category 5

Knowledge of What Behavior Constitutes a Mental Illness - Psychoneuroses
(5 Items)

<table>
<thead>
<tr>
<th></th>
<th>Sacramento</th>
<th>Ghana</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Yes</td>
<td>47.4</td>
<td>49.6</td>
</tr>
<tr>
<td># Yes</td>
<td>1337</td>
<td>694</td>
</tr>
<tr>
<td># No</td>
<td>1483</td>
<td>706</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 1.66, 1 \text{ df, } p < .10 \]

Note: Agreement with an item signified greater recognition of psychoneurotic symptoms as being mental illness.
Table 8
Category 6

Knowledge of What Behavior Constitutes a Mental Illness - Psychoses (6 Items)

<table>
<thead>
<tr>
<th></th>
<th>Sacramento</th>
<th>Ghana</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Yes</td>
<td>66.5</td>
<td>78.0</td>
</tr>
<tr>
<td># Yes</td>
<td>2251</td>
<td>1311</td>
</tr>
<tr>
<td># No</td>
<td>1133</td>
<td>389</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 70.83, 1 \text{ df}, p < .0005 \]

Note: Agreement with an item signified greater recognition of psychotic symptoms as being mental illness.

Table 9
Category 7

Attitudes and Opinions About Mental Illness for the Three Populations (6 Items)

<table>
<thead>
<tr>
<th></th>
<th>Sacramento</th>
<th>Ghana</th>
<th>New York</th>
<th>Ghana</th>
<th>New York</th>
<th>Sacramento</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Yes</td>
<td>57.6</td>
<td>58.9</td>
<td>64.5</td>
<td>58.9</td>
<td>64.5</td>
<td>57.6</td>
</tr>
<tr>
<td># Yes</td>
<td>1952</td>
<td>989</td>
<td>2718</td>
<td>989</td>
<td>2718</td>
<td>1952</td>
</tr>
<tr>
<td># No</td>
<td>1432</td>
<td>691</td>
<td>1494</td>
<td>691</td>
<td>1494</td>
<td>1432</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 0.60, 1 \text{ df}, \text{n.s.}; 16.25, 1 \text{ df}, \text{p} < .0005; 36.85, 1 \text{ df}, \text{p} < .0005 \]

Note: Agreement with an item signified less acceptance of and a less favorable attitude toward mental illness.
Table 10

Category 8

Attitudes and Opinions About the Mentally Ill and the Ex-mental Patient for the three populations (6 Items)

<table>
<thead>
<tr>
<th></th>
<th>Sacramento</th>
<th>Ghana</th>
<th>New York</th>
<th>Ghana</th>
<th>New York</th>
<th>Sacramento</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Yes</td>
<td>37.6</td>
<td>57.9</td>
<td>49.7</td>
<td>57.9</td>
<td>49.7</td>
<td>37.6</td>
</tr>
<tr>
<td># Yes</td>
<td>1274</td>
<td>969</td>
<td>2094</td>
<td>969</td>
<td>2094</td>
<td>1274</td>
</tr>
<tr>
<td># No</td>
<td>2110</td>
<td>711</td>
<td>2118</td>
<td>711</td>
<td>2118</td>
<td>2110</td>
</tr>
</tbody>
</table>

$\chi^2 = 181.75, 1 \text{ df},$ $30.19, 1 \text{ df},$ $110.23, 1 \text{ df},$

$p < .0005$ $p < .0005$ $p < .0005$

Note: Agreement with an item signified less acceptance of and a less favorable attitude toward the mentally ill.
It can be seen in Table 3 that the Sacramento population has a more accepting and favorable attitude toward care of the mentally ill than the Ghanaians ($p < .0005$). This is consistent with the findings in Table 10 which shows, as predicted in hypothesis four, that the mentally ill were more likely to be rejected by the Ghanaians than by either the Sacramento ($p < .0005$) or New York ($p < .0005$) samples. As can be seen in Table 4, family influence on attitudes and opinions about mental illness was stronger for the Ghanaians than the Americans ($p < .0005$). Table 5 shows that the Ghanaians regarded the news media as a more important source of information on mental illness than did American counterparts ($p < .0005$).

The findings in Table 6 tend to confirm hypothesis two. That is, the Ghanaians believed more in "demonic forces as being causative agents of mental illness" than did the Americans ($p < .0005$). Knowledge of behavior patterns constituting psychoneuroses did not appreciably differ between the two populations (see Table 7), but the Ghanaians had a significantly greater knowledge of the symptoms of psychosis (see Table 8; $p < .0005$). These two findings suggest that the psychotic behavior patterns are more often recognized by the Ghanaians as indicating mental illness than the neurotic behavior patterns, thus supporting hypotheses one and three.

Table 9 shows no significant difference between Ghanaians and the Sacramento sample on attitudes and opinions about mental illness, though the New York population was significantly
more rejecting than either the Ghanaian ($p < .0005$) or Sacramento ($p < .0005$) samples.

Mean scores for "externality" were computed for the Sacramento ($\bar{X} = 22.31$) and Ghana ($\bar{X} = 28.54$) samples. As predicted in hypothesis two, the Ghanaians in this study were more external ($t = 18.03$, $p < .0005$). It will be recalled from Chapter I that Jaboda (1970) reported a significant relationship between "externality" and supernatural beliefs among Ghanaian university students.

Also of interest was the New York City study by Elinson, et. al. Although the present study deals primarily with comparison between students from California and Ghana, the New York study still offers the opportunity for a three-way comparison on some items in the questionnaire. Examples of some of the items the three have in common are presented in Tables 11 and 12. The percentage scores for items completed by the New York sample which fell into categories 7 and 8 were converted into raw scores and analyzed using the chi-square statistic, as explained earlier. The results presented in Tables 9 and 10 indicate that the Ghanaians and Californians in this study showed significantly more enlightened attitudes and opinions about mental illness than the 1967 New York City population. There was no significant difference between Ghanaians and Californians in their attitudes and opinions about mental illness. On attitudes toward the mentally ill and the ex-mental patient, Ghanaians showed more rejecting attitudes than both
the 1967 New York City population and the California population. The Californians were also more accepting of the mentally ill than the 1967 New York City population.

Table 11

Percentage Responding Yes to Items on Attitudes and Opinions About Mental Illness for the Three Populations

<table>
<thead>
<tr>
<th>Item</th>
<th>New York City N=702</th>
<th>Sacramento N=564</th>
<th>Ghana N=280</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Although they usually aren't aware of it, many people become mentally ill to avoid the difficult problems of everyday life.</td>
<td>77.1</td>
<td>52.1</td>
<td>45.7</td>
</tr>
<tr>
<td>2. Unlike physical illness, which makes most people sympathetic, mental illness tends to frighten most people.</td>
<td>77.4</td>
<td>74.5</td>
<td>87.9</td>
</tr>
<tr>
<td>3. Most people feel very helpless about mental illness.</td>
<td>71.5</td>
<td>61.3</td>
<td>84.3</td>
</tr>
<tr>
<td>4. A mental illness can happen just because it runs in the family.</td>
<td>43.6</td>
<td>46.1</td>
<td>52.1</td>
</tr>
<tr>
<td>5. Mental illness is an illness like any other.</td>
<td>68.7</td>
<td>60.1</td>
<td>39.6</td>
</tr>
<tr>
<td>6. One of the main causes of mental illness is lack of moral strength or will power.</td>
<td>49.0</td>
<td>52.0</td>
<td>43.6</td>
</tr>
</tbody>
</table>
Table 12

Percentage Responding Yes to Items on Attitudes and Opinions
About the Mentally Ill and the Ex-mental Patient
for the Three Populations

<table>
<thead>
<tr>
<th>Item</th>
<th>New York City</th>
<th>Sacramento</th>
<th>Ghana</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To become a patient in a mental hospital is to become a failure in life.</td>
<td>17.1</td>
<td>17.7</td>
<td>21.1</td>
</tr>
<tr>
<td>2. Anyone who is in a hospital for a mental illness should not be allowed to vote.</td>
<td>39.6</td>
<td>20.9</td>
<td>71.8</td>
</tr>
<tr>
<td>3. Although patients discharged from mental hospitals may seem all right, they should not be allowed to marry.</td>
<td>21.4</td>
<td>21.5</td>
<td>30.4</td>
</tr>
<tr>
<td>4. A mentally ill person who stays in the community is in danger from rude and unkind people there.</td>
<td>80.1</td>
<td>67.0</td>
<td>81.8</td>
</tr>
<tr>
<td>5. Patients in mental hospitals are in many ways like children.</td>
<td>76.1</td>
<td>48.6</td>
<td>78.9</td>
</tr>
<tr>
<td>6. If a mental patient is treated in a general hospital instead of a mental hospital, it will help to lessen his being despised or looked down on.</td>
<td>64.1</td>
<td>50.2</td>
<td>62.1</td>
</tr>
</tbody>
</table>
Chapter V

DISCUSSION AND CONCLUSIONS

Discussion

Some procedural problems were encountered in gathering the data. For instance, it is possible to argue that some of the Sacramento population (e.g. the Davis students) represented a group with a much more sophisticated background in psychology than the rest of the Sacramento population. Therefore, their inclusion in the sample might have caused the Sacramento sample to become an atypical group, which could in turn have caused systematic bias in the results. However, the large number of subjects sampled should have minimized whatever effects the relatively few respondents from Davis—a total of 67 undergraduate psychology and other social science majors—could have had on the results.

Also, the mailing of questionnaires to and from Ghana was considerably delayed in transit, and many of the potential respondents could not complete them because the arrival of the forms coincided with their final examination week. Another problem later encountered was that more than 300 questionnaires had to be rejected on the methodological grounds that the subjects did not adhere fully to the instructions, thus reducing the final total of subjects from the goal of 600 each to 564 for the Americans and 280 for the Ghanaians.
Finally, it is also possible to argue that since the Ghanaians consistently gave a higher percentage of "yes" responses in almost all the categories than the Sacramento sample (see Tables 3 - 10), the differences noted between the two groups may be due to what Campbell, Siegman, and Rees (1967) called "direction-of-wording" effects. In other words, the differences between the two samples might have been due to a "yes-saying" set in the Ghana sample rather than differences in attitudes toward mental illness between the two populations. However, in view of the findings of no significant difference between the two sample groups on attitudes and opinions about mental illness, it could also be argued that the "direction-of-wording" effects could not have accounted for all the differences noted. Despite these problems, the results reveal several areas in which some tentative conclusions may be drawn.

For example, that the students from the two countries differ markedly in their overall attitudes toward mental illness seems to have been clearly demonstrated. The Ghanaians' strong beliefs in "demonic forces" as being causative agents of mental illness not only support the observations of other researchers in this area, it also supports the hypothesis of "externality" advanced in this paper.

It seems likely, however, that an "external" belief system may postpone the labeling process and its attendant social rejection and stigma, thereby permitting the continuation of
family support and acceptance of the mentally ill. As an example, 71.1% of the Ghanaian respondents agreed that a person is mentally ill if he shows a behavior pattern of being "very talkative, often exhibiting incoherence of speech, and going about claiming to possess supernatural powers." Yet only 48.6% of them will commit a relative with such psychotic symptomatology. It must be noted that for many Ghanaians, supernatural powers are a desirable possession, though not many (especially the literate population) would openly admit a belief in the existence of such powers. While it could be argued that family loyalty rather than the desirability of demonic powers accounts for this difference, consider the response to the following statements: About 76.1 percent of the Ghanaians agreed that a behavioral pattern of "hearing non-existent voices and or seeing non-existent objects" is indicative of mental illness. An even larger number, 82.5 percent, will commit a relative with this symptom to a mental hospital. So belief in supernatural powers should not lead to commitment while hearing non-existent voices may. The family may act to postpone the labeling process until symptoms become obviously socially undesirable.

Another important outcome of this study—though unexpected and not adequately explored—was the finding that Ghanaians more than their American counterparts, viewed the news media as a very important source of information on the subject of mental illness. It is very unlikely that the beliefs in
"demonic forces" are propagated through the news media or encouraged in the schools in the country. Traditions and family influence must maintain these beliefs. This raises the likelihood that the media may be a countervailing source of information on the subject of mental illness; since the news "must come from the leaders" it therefore must be credible.

The finding of no difference between the two groups on attitudes and opinions about mental illness, in spite of the strong rejection of the mentally ill by Ghanaians, calls for some explanation. One should also note the findings in Table 11 and Table 12 which show respectively that of the Ghanaians, 60.4 percent disagreed with the statement that "Mental illness is an illness like any other"; 78.9 percent agreed with "Patients in mental hospitals are in many ways like children"; and 71.8 percent agreed with "Anyone who is in a hospital for a mental illness should not be allowed to vote." By contrast, responses from Americans were, respectively, 39.9 percent, 48.6 percent, and 20.9 percent.

The three elements—the extended family system, position in the family, and labeling—suggested in Chapter II as the probable reasons for the reported "social tolerance" toward the mentally ill in Ghana could possibly account for this seemingly inconsistent finding.

First, not only does the extended family in Ghana provide its members with materials and a wide range of emotional
supports against societal pressure; the extended family also encourages strong interdependency among its members. For instance, a person could leave his place of residence to live with any relative—be he an uncle, a "distant" cousin, or aunt—for weeks without having to worry about rent, etc. In the village especially, one can move from relative to relative for months, working with them and sharing in their daily lives. If such a visitor is not gravely ill or psychotic and even only marginally productive, it will be nearly impossible for him to be thought of as being mentally ill by his relatives.

Second, the appanages (that is, the rights and privileges accruing from birth or station) of a family member—especially an older one—not only include the legally sanctioned rights such as inheritance, right to marriage, etc. They also include being respected for one's age, position in the family, wealth, knowledge, etc. Labeling of a relative (for whatever reason short of a legal one), is therefore never even suggested by a younger person nor is it the perogative of any individual family member. It is arrived at through a very long process—in part as a result of the above mentioned family functions and also due to the appanages just enumerated—such that mental illness remains only an abstraction until in many instances the person has engaged in psychotic behavior; then the community may label him as mentally ill. Thereafter mental illness becomes a concrete phenomenon to be dealt with and all necessary and available sanctions are brought against the person so labeled.
Until he is labeled, he is accorded all due "respect and privileges" no matter how minimal his current contribution to the family has become.

Such reasoning becomes even more tangible when one compares the following responses from the Ghanaian sample. Majorities representing 52.3% and 57.5% of the Ghanaians respectively disagreed with the statements "People are usually the last to recognize the signs of a mental illness in members of their own family"; and "When a mental illness happens in a family, it is wise to keep it a secret as far as possible", an even greater proportion would consider it as disrespectful for an individual to publicly or openly refer to an uncle or father (66.5%), or an aunt or an older relative (77.1%) as being mentally ill. Yet over 89 percent of them agreed to the statement that "A relative who walks about nude and throws stones at people should definitely be sent to a mental hospital."

Thus, even though the occurrence of a mental illness in the family is recognized and not denied, "moralistically", the family influence is such that the label "mentally ill" or "crazy", is applied only when the person is overtly psychotic and/or unmanageable. At this stage, many families would have already contacted several medicine men for help in curing the patient, the reason being that a more powerful voodoo man should be able to remove a "curse" put on someone by one less powerful. If no improvement in the health of the patient is noted after exhausting all aids that could possibly be obtained
from medicine men, the beliefs in the curative powers of the voodoo men gets somewhat dissipated and the patient may be rejected by the family. Hospitalization (which Field, 1960, has noted is not considered by Ghanaians to be the proper place for a mentally ill person) then becomes the last hope for the patient whose behavior has by this time caused the role relationships hitherto existing between himself and the extended family to be terminated.

Finally, some of the Ghanaians responses also suggest that Whately's (1958) concept of ego-involvement previously mentioned in Chapter II may be a very important factor in attitudes toward mental illness. It also raises the possibility that the concept may have cross-cultural validity. For example, though 57.9 percent agreed to the statement, "The family name is always put to shame when mental illness occurs in the family", only 25.0 percent will consent "If someone in your family wants to marry such a person." Moreover, even though 62.5% of the Ghanaians will be willing to work next to an ex-mental patient, only 46.8% agreed "To hire such a person, if you could?"; an even lesser number (31.1%) would be willing "To have him or her as your boss on a job?"

Conclusions

The conclusions derived from the data of this study are that, as far as the present population in this study is concerned, the trend in attitudes and opinions about mental illness and the mentally ill in this country could be viewed as being
progressively accepting of the mentally ill. The Ghanaians on
the other hand, seem less optimistic in their attitudes and
opinions about the mentally ill than even the 1967 New York
City population.

A need for educating the Ghanaian student about mental
illness and its etiology is strongly suggested by the findings
of this study if "enlightened" attitudes toward mental illness
and the mentally ill are to be achieved. In this regard, the
family and the mass media could play very important roles
since they are viewed as credible sources of information on
this subject by the Ghanaian student. Furthermore, for both
countries, the findings suggest a pressing need for more
research to delineate the extent of the family's influence
on overall attitudes toward mental illness as well as the
effects of labeling or lack of it on the mentally ill and
the ex-mental patient.
REFERENCES


SCIENCE NEWS, August 5, 1972, p. 85.


WITTKOWER, E.D., and FRIED, J. A cross-Cultural approach to mental health problems. American Journal of Psychiatry,

INSTRUCTIONS

Please read the following instructions very carefully.

You are being asked to participate in a study of mental health problems. Your participation will supply valuable information which may help to generate more useful research work in the area of mental health.

On the following pages you will find among other things, a number of statements about mental health problems. We want to know whether you agree or disagree with each of the statements. To the right of each statement you will find one of the following response scales:

<table>
<thead>
<tr>
<th>Agree</th>
<th>Disagree</th>
</tr>
</thead>
</table>

or

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

The use of the scale can be illustrated with the following statement:

"A person can get malaria from mosquito bites."

If you agree with this statement you would place an 'X' mark in the first column. If you disagree with the statement, you would place an 'X' mark in the second column.

You will probably feel that you do not know the answers to some of the statements. When this occurs please make the best guess that you can. Also, please note that for the purpose of this study, the terms mentally ill, crazy, mad, and insane, all refer to the same condition and are therefore used interchangeably.

Please make sure that your marks are exactly in the middle of the boxes and NOT on any of the lines dividing the boxes.

Also, please make sure that you make a mark for each statement. Leave none of the statements blank and make only one mark for each. You should not spend more than a few seconds marking each statement. If it is difficult for you to make up your mind, make the best guess that you can and go on to the next one.
Please continue on the next page after completing the following:

Birthdate ______/______/______  Age _______ Years
Month    Day     Year

Race _____

Present level of Education ___________  Sex _____
(e.g. Form 4, 9th Grade, or undergraduate).
1. Mental illness is now the most serious health problem in this country.

2. Most people feel very helpless about mental illness.

3. There really are supernatural forces that can make someone sick which only a witch-doctor, an astrologer, a priest, or a voodoo man (juju-man) would know about and be able to deal with.

4. Unlike physical illness, which makes most people sympathetic, mental illness tends to frighten most people.

5. Mental illness is mostly caused by the effects of juju (voodoo) or evil spirits.

6. It is easy to recognize someone who once had a serious mental illness.

7. Mental illness is an illness like any other.

8. A mental illness can happen just because it runs in the family.

9. Insanity is brought on as punishment for sins.

10. The mental illness of many people is caused by a lot of fighting and quarreling between their parents during childhood.

11. One of the main causes of mental illness is lack of moral strength or will power.

12. The mental illness of many people is caused by the separation or divorce of their parents during childhood.
13. Insanity often grows out of a tough or difficult situation that a person gets into and cannot handle.

14. Although they usually aren't aware of it, many people become mentally ill to avoid the difficult problems of everyday life.

15. Kindness and understanding from others can usually head off a mental illness.

16. People would not become crazy if they avoided bad thoughts.

17. The mentally ill are usually harder to take care of when there is a full moon than at other times.

18. Mental illness is usually caused by some disease of the nervous system.

19. Not much can be done for a victim of mental illness.

20. No one should ever go to any hospital unless there is just no other way to take care of him properly.

21. It is necessary to use mental hospitals for keeping people out of the way.

22. When a doctor tries to treat a person with little education, neither one really understands the other.

23. Unhappy people should go to a psychiatrist for help.

24. Everyone should be trained in school to recognize the early signs of mental and emotional trouble.

25. The most important source of information about mental illness is the news media.
26. Many of the people who go to psychiatrists are made worse by the treatment they get.

27. It now appears that many types of mental illness can better be treated by jujumans (voodoo men) than by psychiatrists.

28. The type of treatment for mental conditions that relies mainly on talking is probably useless.

29. No one should ever go to a mental hospital unless there is just no other way to take care of him properly.

30. Newspapermen are doing a very good job in reporting what the mentally ill actually do in the community.

31. To become a patient in a mental hospital is to become a failure in life.

32. Patients in mental hospitals are in many ways like children.

33. The family name is always put to shame when mental illness occurs in the family.

34. Without the newspapers, TV, and radio, most of us would not know about the causes of mental illness.

Most people will consider their friends or other people with any of the following behavioral patterns as being mentally ill:

35. Very strong feelings of inferiority and guilt.

36. Absence of anxiety or being indifferent to a disabling illness.

37. Feelings of restlessness, dread, or fearfulness with no apparent external cause.
38. Always suspicious and falsely accusing others of planning to harm him.

39. Hearing non-existent voices and or seeing non-existent objects.

40. Strong and persistent fear of darkness.

41. Feelings of inadequacy and or showing exaggerated attention to their bodily organs and functions.

42. Very talkative, often exhibiting incoherence of speech, and going about claiming to possess supernatural powers.

43. Completely and always isolates himself and shows lack of interest in his surrounding as well as difficulty in thinking.

44. Eating spoiled food from trash cans or garbage containers.

45. Walking about nude and throwing stones at people passing by.

How would you feel about a person after finding out that he has been a patient in a mental hospital? Would you then be willing:

46. To work next to him or her on a job?

47. To tell your friends that he is your relative if that is the case?

48. To hire such a person, if you could?

49. To have him or her as your boss on a job?

50. To live next door to such a person?

51. To share an apartment or room with such a person?
52. To agree, if someone in your family wants to marry such a person? [Yes No]

53. To live with him or her together with your family in the same house? [ ]

54. To be in the same classroom with him? [ ]

55. Do you believe that you can stop yourself from catching a cold? [ ]

56. Are some people just born lucky? [ ]

57. Do you believe that if somebody studies hard enough he or she can pass any subject? [ ]

58. Do you feel that most of the time parents listen to what their children have to say? [ ]

59. Are most of the other people your age stronger than you are? [ ]

60. Do you feel that most of the time it doesn't pay to try hard because things never turn out right anyway? [ ]

61. Do you believe that wishing can make good things happen? [ ]

62. Most of the time do you find it hard to change a friend's (mind) opinion? [ ]

63. Do you feel that when you do something wrong there's very little you can do to make it right? [ ]

64. Do you believe that most people are just born good at sports? [ ]

65. I would object to having a mental health clinic set up near my home. [Agree Disagree]

66. To protect those who are not insane, the mad person should be locked up in a mental hospital and never released. [ ]
67. Most women who were once patients in a mental hospital could be trusted to take care of other people's children (baby sitters).

Agree | Disagree

68. Many people who have never been patients in a mental hospital are more insane than many hospitalized patients.

69. Being nervous most of the time usually is due to some kind of mental illness.

70. People are usually the last one to recognize the signs of a mental illness in members of their own family.

71. Telling your friends that your uncle or father is insane is not a respectable thing to do.

72. Most people will consider their mother or father as being crazy if the mother or father always falsely accuses people of planning to harm her or him.

73. When a mental illness happens in a family, it is wise to keep it a secret as far as possible.

74. Referring to an aunt or an older relative as being mad will be considered disrespectful by most people.

75. Most mad people continue to show signs of their illness long after they leave the hospital.

76. Mental illness is often a punishment, the cause of which can be traced to a crime or offense the individual has one committed against the ancestral spirits or some god.

77. The only time one can use juju (voodoo) to make a person go crazy is when that person has offended the one using the juju (voodoo).
78. Once crazy always crazy.  

79. A relative who walks about nude and throws stones at people should definitely be sent to a mental hospital.  

80. Flirting with someone's wife is a sure way of leaving yourself open to the effects of juju (voodoo).  

81. A mentally ill person who stays in the community is in danger from rude and unkind people there.  

82. Anyone who is in a hospital for a mental illness should not be allowed to vote.  

83. A relative who always show obsessive fear of darkness is insane.  

84. Most people will not hesitate to commit either their father, mother, or any relative to a mental hospital if either of them is suspected of being mad.  

85. Although patients discharged from mental hospitals may seem all right, they should not be allowed to marry.  

86. Most people will consider a brother or a cousin with pronounced feelings of inferiority and guilt as being insane.  

87. The mentally ill person should stay in the same community with native doctors (voodoo men) because they are best qualified to treat such cases.  

88. Only people who don't respect their parents will send their parents to a mental hospital if the parents show any indications of hearing non-existent voices or seeing non-existent objects.
89. If a mental patient is treated in a general hospital instead of a mental hospital, it will help to lessen his being despised or looked down on.

90. The mentally ill pay little attention to their personal appearance.

91. Mental disorder is not a helpless condition.

92. The real cure for mental illness will take the form of a pill or an injection.

93. Most people will try to prevent their ex-crazy sister from getting married.

94. The best way to mental health is by avoiding joyless thoughts.

95. Anyone who has been committed to a mental hospital before should never be allowed to associate with children.

96. If a relative such as a sister, grandfather, mother, etc., is very talkative, claims to possess supernatural powers, and or often show incoherence of speech, he or she must definitely be committed to a mental hospital.

97. Do you believe that when bad things are going to happen they just are going to happen no matter what you try to do to stop them?

98. Do you feel that you have a lot of choice in deciding whom your friends are?

99. Do you feel that when a person your age is angry at you, there's little you can do to stop him or her?
100. Do you think that people can get their own way if they just keep trying?  
101. Do you feel that it's easy to get friends to do what you want them to do?  
102. Do you usually feel that you have little to say about what you get to eat at home?  
103. Do you feel that when good things happen they happen because of hard work?  
104. Do you feel that when somebody your age wants to be your enemy there's little you can do to change matters?  
105. Did you feel that it was nearly impossible to change your parent's mind about anything?  
106. Do you think it's better to be smart than to be lucky?  

In your opinion, what are some of the reasons people with mental or emotional troubles don't go for help? Because they:

107. Are afraid of what people will think or might say.  
108. Are afraid to find out if it is serious.  
109. Don't recognize the trouble.  
110. Are too shy.  
111. Are afraid of being locked up in a mental hospital.  
112. Don't realize that they are sick.  
113. Believe it will bring shame to their family as well as themselves.
<table>
<thead>
<tr>
<th></th>
<th>Agree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>114.</td>
<td>Don't know where to go for help.</td>
<td></td>
</tr>
<tr>
<td>115.</td>
<td>Can't afford to pay for the costs involved in treatment.</td>
<td></td>
</tr>
<tr>
<td>116.</td>
<td>Don't have beliefs in the treatments available.</td>
<td></td>
</tr>
</tbody>
</table>