International Review of Psychiatry, December 2010; 22(6): 589–598

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healthcare

Common understandings of women's mental illness in Ghana: Results from a qualitative study

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Abstract

Despite the high rates of depression and anxiety disorders amongst women, the mental health of women is a neglected area, particularly in Africa. This study sought to explore what key stakeholders perceive as the main causes of mental illness in women in Ghana. Using qualitative methods, 81 semi-structured interviews and seven focus group discussions were conducted with 120 key stakeholders drawn from 5 of the 10 regions in Ghana. The analysis was undertaken using a grounded theory approach. Respondents attributed mental illness in women to a number of causes. These included women being the weaker sex, hormones, witchcraft, adultery, abuse and poverty. Explanations could be clustered under three broad categories: women's inherent vulnerability, witchcraft, and gender disadvantage. The way in which women's subordinate position within society may underpin their mental distress needs to be recognized and addressed. The results from this study offer opportunities to identify how policy can better recognize, accommodate and address the mental health needs of women in Ghana and other low-income African countries.

Introduction

Health research amongst women in low- and middle-income countries, particularly in Africa, has tended to focus primarily on maternal and reproductive health issues, with the neglect of mental health concerns (Avotri & Walters, 1999, 2001; Moultrie & Kleintjes, 2006). Notwithstanding the importance of these issues, the sidelining of women's mental health has meant that there is a paucity of reliable gender-disaggregated prevalence and incidence rates available in developing countries (WHO, 2000). Furthermore, the determinants of mental illness in women have remained unexplored, and gender-sensitive mental health services and interventions underdeveloped in these regions (Patel et al., 2006; Sellers, 2004). This marginalization has dire social development and public health implications, given growing global evidence that common mental disorders (CMDs), such as anxiety disorders and depression represent an increasing and disproportionate burden amongst women.

For example, Patel, Araya, de Lima, Ludermir, and Todd (1999), who studied four low- and middle-income countries (Zimbabwe, Chile, Brazil and India), found that common mental disorders were significantly associated with female gender. Results from studies in the developed world indicate that women have on average about a two-fold increased risk for depression and anxiety disorders over men (Belle & Doucet, 2003; Nolen-Hoeksema & Keita, 2003). This gender-skewed picture has been shown in clinical and general population samples, independent of location, method of assessment, diagnostic system, race and ethnicity (Bebbington, 1996; Somers, Goldner, Waraich, & Hsu, 2006).

How do we explain this gender-skewed epidemiological picture? Proponents of social and gendered models of health have argued that in addition to individual factors, the social, economic and cultural contexts in which women live play a role in women's increased vulnerability to common mental disorders (WHO, 1993, 1997). It is argued that the gender inequality and oppression that women experience in their public and private lives are fundamental determinants of their distress (Desjarlais, Eisenberg, Good, & Kleinman, 1995).

Globally, poverty disproportionately affects women, who account for 70% of the world's poor (UNDP, 1997, cited in WHO, 2000). Women also tend to have less access to economic and political

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ISSN 0954–0261 print/ISSN 1369–1627 online © 2010 Institute of Psychiatry
DOI: 10.3109/09540261.2010.536150

power and are more likely to be unemployed or working in the informal sector (Patel & Kleinman, 2003). The unequal and precarious economic situation is heightened amongst women in Africa, where the intersection of colonialism, food shortages, the debt crisis and structural adjustment programmes have precipitated large-scale urbanization and migration, disrupting family and community ties, and exacerbating poverty and inequality (Lawson, 1999).

There is much epidemiological evidence from middle- and low-income countries to suggest that common mental disorders are strongly associated with poverty (Amin, Shah, & Vankar, 1998; Lund et al., 2010; Patel et al., 1999; Patel & Kleinman, 2003). Recent studies point to poverty and its associated variables of adversity, insecurity, rapid social change, social exclusion, reduced access to social capital and malnutrition, as increasing the risk for CMDs (Flisher et al., 2007).

Research also shows a strong relationship between common mental disorders and exposure to domestic violence (Fischbach & Herbert, 1997; Patel et al., 2006). This strong relationship exists possibly because violence against women encapsulates humiliation, subordination and entrapment (WHO, 2000), which are associated with depression. The high rates of CMD in women may not be too surprising, given the contemporary global epidemic of gender-based violence. The World Health Organization's (1997) review of studies from the developing world indicate that lifetime prevalence rates of domestic violence range from 16% in Cambodia to 42% in Kenya.

Despite the strong association between gender and mental illness (particularly common mental disorders), and the increased risk for mental illness among women living in poverty, little is known about local perceptions of the causes of mental illness in African countries. The aim of this study in Ghana was to explore what key stakeholders perceive to be the main causes of mental illness in women in Ghana. It drew on qualitative data that was collected as part of a situation analysis of the current status of mental health policy, legislation and services in Ghana which was conducted as part of the first phase of the Mental Health and Poverty Project (MHaPP). The MHaPP, which is being conducted in four African countries: Ghana, South Africa, Uganda and Zambia, aims to investigate the policy level interventions that are required to break the vicious cycle of poverty and mental ill-health, in order to generate lessons for a range of low- and middle-income countries (Flisher et al., 2007).

Methods

This particular study focuses on the qualitative data obtained from the MHaPP situation analysis. Eighty-one interviews and seven focus group discussions were conducted with policy makers, health professionals, users of psychiatric services, teachers, police officers, academics, and religious (Christian and Islamic) and traditional healers drawn from five of the ten regions in Ghana. The interviews and focus group discussions were conducted with 122 respondents, who were purposively sampled from among the major stakeholders in mental health at the national, regional and district levels. Thirty-five interviews were held at the national level and 23 at the regional level. Sampling was conducted according to principles of maximum variation, in order to capture the opinions of as wide a range of stakeholders as possible.

Interviews were transcribed verbatim, translated into English by a bilingual speaker, and were cross checked by another. The analysis was undertaken using a grounded theory approach (Strauss & Corbin, 1998). The objective is to build and expand, rather than test theory, and is useful in undertaking local research where it may not be wise to transfer theory generated in more western settings onto an African context (Pidgeon & Henwood, 1997). A coding list was created by the study team, where all transcripts were entered into NVivo7 for coding and analysis.

Ethical approval was granted by the Ghana Health Service Ethics Committee, the Institutional Ethics Board at the Kintampo Health Research Centre, and the Ethics Committee of the Faculty of Health Sciences, University of Cape Town. Informed and voluntary consent was obtained of all participants who participated in the study. The names and other identifying features of the respondents have been omitted in order to ensure confidentiality and protect respondents' privacy.

Results

There was almost unanimous agreement amongst the participants outside of the mental health care sector that women in Ghana are more affected by mental disorders. In answer to the question, 'Do you think that males or females are more prone to having mental illness', there were ubiquitous responses such as 'Well, everybody is talking about the women having more of this thing than the men', 'When you go to the hospitals, you can see that, the majority of the mental patients are the females' and 'It is indisputably women'.

Other respondents, mainly from the health care sector, were of the view that women may be more prone to 'hidden' mental disorders such as depression or milder forms of psychosis, whereas more

severe cases may be overrepresented by men. As one senior health research explained:

> I will say that the obvious mental cases are more common in the men. But I think the ones that are not obvious, the ones that may be hidden like depression, psychosis, at the lower level are common in women. . .so if you look at it at that level may be it could tilt even towards more women.

It is thus clear that almost all respondents, across all the different stakeholder groups believed that women were more affected by mental illness, particularly common mental disorders such as depression.

Discussions amongst both women and men respondents around the possible causes of mental illness in women revealed a number of divergent explanations. Issues related to being the weaker sex, hormones, requiring too much love, witchcraft, adultery, physical abuse, infertility and poverty were all linked by respondents to the varying ways in which mental illness could occur amongst women. Proceeding inductively, it became clear that understandings could be meaningfully clustered under three broad categories: inherent vulnerability, witchcraft, and gender disadvantage. Each of these categories will be explored in more detail.

Category I: Inherent vulnerability

Women are more prone to mental health problems, because of their make-up. Women were described by numerous respondents, particularly male respondents, as naturally and essentially predisposed to mental illness. As one female psychiatric nurse said:

> Women are prone to mental illness more than men. This is because they have weak constitution. Their make-up is much weaker than men.

Other respondents provided more specific supposed 'innate' factors that increase women's susceptibility to mental illness. Some respondents mentioned that women 'cannot solve problems by themselves' while others spoke about women being 'dependent' on men or 'less self-reliant' than men as key natural contributory factors. Women's inability to deal with stress was also a common emergent theme. For example, when explaining why mental illness affects women more, one district hospital administrator articulated:

> You see women cannot cope with certain situations, for example woman cannot cope with stress as a man can . . . we have to educate the women how to cope with stress.

This view was reiterated by a primary health care officer:

> Women can't manage frustrations . . . We were at [psychiatric hospital] and you could clearly see that. The women inmates were more than the men and if you ask all the women there, it was due to ill-management of stresses.

Other respondents felt that women were unable to handle difficult situations, or 'because of nature, women normally can't deal with a lot of things'. This was most aptly expressed by one police officer when he explained:

> Women by their nature are feeble, they are weak, that is why they are called the weaker sex. The kind of resistance the man has to certain external condition, the woman's resistance is not up to that level, so the least thing affects her, she thinks about it, takes it in, treasures it in her in such a way that it affects her, it breaks her down and eventually that leads to mental problem.

Through this detailed explanation, this respondent insinuates that women are not strong enough, or what other respondents described as 'not good at problem-solving' or 'not exposed to enough hardships' to be able to deal with difficult circumstances in life. Other respondents spoke more explicitly about the way in which women internalize problems, and how this leads to mental illness. One teacher during a focus group discussion explained:

> Women normally, feel the pain inward, they take it in, and we men tend to be outward so when something happens, the way the women will receive the impact and how it will affect her, you know it wouldn't affect the man up to that level.

Other respondents highlighted that women naturally anticipate too much from marriage and relationships, and these expectations can only lead to disappointment and distress. For example, one government official outside of the Ministry of Health described that women require too much love for men to fulfil within the context of permissiveness:

> You see the women need love so much that it is almost impossible for men to provide this kind of love so if for example you go from one woman to the other, then they will start thinking and then hysteria will set in and then it can lead to the mental problem.

This government official appears to hold two assumptions: that women inherently require too much love, and that men are naturally polygamous

or flirtatious. Similarly, a director of a general health clinic, said:

> I think women maybe expect too much from marriage. It is just the way that they are I think. But, our African men, you see, our traditional way of marrying, sometimes you marry about three women . . . that may lead to mental illness because majority of the cases come from this point.

Once again, the assumptions of women's inherent marriage expectations and men's innate unfaithfulness are clearly revealed. A final specific 'innate' factor attributed to women's supposedly natural vulnerability relates to women's gynaecological constitution. A common theme, particularly amongst policy makers outside of the Ministry of Health, was the fundamental role that women's hormones play in their mental illness; 'I think it is because of their hormones' and 'you know, women's hormones, particularly at certain times, can make them mad'. The contributory function of women's hormones in their mental illness was most pertinently captured by a policy-maker in a sector outside of health:

> Because females, during their menopause time, their behaviour changes . . . they change, they become not quite right. Yesterday, I went to somebody's office, she was screaming off her head and I said 'wait a minute this is a bit abnormal, this is insane' I think when women are on their menopause they became crazy sometimes.

Many respondents shared this man's sentiments about the role played by the menopause and hormonal changes. It is thus clear that many respondents thought women's increased vulnerability to mental illness was because of innate aspects of women's make-up, particularly their biological constitution.

Category II: Witchcraft

When exploring dominant understandings of the causes of mental disorders in women, there was a great deal of agreement among respondents that common community attitudes tend to understand mental illness in both genders as 'the work of witches' or 'the doing of witches' or 'women causing damage with witchcraft'. None of the respondents reported holding such views themselves, but that such perceptions are dominant within the general community. For example, one programme manager elucidated:

> People don't really understand the causes, so they attribute it to witches, and to women who they think meddle with things like witchcraft. I think women in this way become a kind of scapegoat, because of the lack of knowledge.

Sharing the views of many others, this respondent thus indicates that given great uncertainty surrounding mental illness aetiology, women are often blamed. These sentiments were most clearly and concisely expressed by another teacher when she said:

> People see madness, epilepsy and witchcraft as all the same. They see mental illness as the doing of witches and their curses.

Similarly, a general health nurse explained that when mental illness occurs, a woman may be singled out, and accused of having caused it:

> When someone goes mad in a neighbourhood, people will often turn to a woman in the community, and point fingers at her and say that she is a witch and caused the damage with her witchcraft. People will say she caused the mental problems in so and so.

Some respondents explained the harrowing consequences such accusations can produce. It was highlighted that in many circumstances, women who are suspected of using witchcraft to cause mental problems are separated, or expelled from the community, particularly in northern Ghana. They are forced to move to designated places, or 'witch-camps'. As one government official highlighted:

> The cultural belief in bewitching is very strong. Women who are believed to be witches, and practice witchcrafts are thought to cause a lot of the mental problems, so they will separate these women . . . They have a special place for them.

One of the respondents interviewed was a traditional healer who stayed at one of these so-called witches camps, in the area around Gambaga, which was established by the chief of Gambaga in the 1940s to accommodate women accused of witchcraft. He stated that this camp provides a safe place for these women who are protected by the Gambaga chief. In these camps, they undergo 'cleansing' rituals to rid them of witchcraft. These women have to fend for themselves, isolated from their friends and families. This extract depicts how women come to reside in the camps, and the new life they are forced to assume:

> Sometimes, the community brings them to the camps. Other times, they are chased out by their people that are going to kill them. So they run away to the camp . . . Now at the camp, certain rites have to be performed to kick off this witchcraft power before they go. They have to weaken the powers of the witchcraft so they

> can't cause any more problems. Some of them have to stay forever though. There are some we knew when we were kids and they stayed here till they died.

It is thus clear that women are frequently blamed for the mental illness in the community, and are consequently 'pathologized' and relegated to a life of rejection and isolation.

Category III: Gender disadvantage

Some stakeholders, from the varying groups interviewed, appeared to hold certain perceptions about women's vulnerability to mental illness that are situated within a more social and gendered model of health. Within this category that we have termed 'gender disadvantage', women's susceptibility to mental illness was discussed, for the most part, with three overlapping levels of meaning: polygamy, physical abuse and poverty. However, polygamy associated with possible female mental illness was an overriding concern.

Polygamy

> Polygamous marriage . . . It all stems from that.

A recurring theme was the contributory role played by either extramarital relationships or polygamous relationships by men.

When asked what they thought the major causes of mental illness in women may be, many respondents spoke about 'marriage problems' or 'frustrated relationships' or 'the stress from marital problems'. As one NGO member exclaimed:

> I think the women they have a larger proportion of mental problems because, for women, it's marriage, marriage problems. It can make a woman go mad. It turns her upside down.

Phrases and comments such as these recurred frequently in the interviews. When probed further, it became clear that amongst other issues, marriage problems and frustrations appeared to be synonymous with polygamy and extra-marital relationships. This was most aptly highlighted when a programme manager was asked to expand on what he means when he says that marriage problems are the main cause of mental illness in women. He replied, most categorically:

> Polygamous marriage . . . It all stems from that.

Similarly, a community psychiatrist spoke about how most of the women he sees talk about marriage issues being at the centre of their depression. When the interviewer inquired about what 'marriage issues' they talk about, the psychiatrist answered:

> The most predominant is inter-personal relationship in the home . . . They get depression and people think that well it's their own problem. But it's actually because of our societal values. Our polygamous societal values. You know, we have this polygamous society which breeds a lot of problems, a lot of troubles for women. You get married to somebody then your eyes will turn, and then before you realize, you are having three and more women with children who are all not cared for properly. Naturally the mother will get disturbed, get depressed.

This psychiatrist alludes to the neglect that polygamy generates, and the consequent mental problems such neglect induces. Polygamy was said to have other consequences, such as shock. For example, this programme manager explained:

> Women get shocked as a result of an unexpected action by the husband, when he starts having all kinds of other relations.

These views were further confirmed by a woman on admission at a psychiatric hospital for depression. She was asked why she was depressed. She adamantly responded:

> Because of my husband, the way he handled me. It reached a time my husband was womanizing so much, I nearly killed myself . . . You know, you men like chasing here and there. You know, if somebody has love for a man and you demean it, it is very painful, very, very painful and . . . we go off the rails. We give everything to you, everything, and with that . . . he is trying to share that love with somebody else, another woman. It is so very very painful.

This woman's narrative movingly highlights the pain and suffering a betrayed trust may produce for women.

Physical abuse

> Women suffer a lot of abuse . . . and it affects them.

A common theme amongst many respondents related to the widespread physical abuse women experience, and the implications this has for their mental well-being. From the respondents' narratives, it seems that 'marriage problems' is not only synonymous with polygamy, but also relates to the frequent domestic abuse women face.

Many other respondents spoke about the domestic abuse women face, and the consequences it brings

for their mental health. This senior public health nurse alluded to the contributory role abuse has for women, and the silence around such domestic abuse:

> We see a lot of sexual assault with the woman being treated in barbaric ways. But they cannot say anything to the men, because they always say women are wrong . . . We tell them to report it but of course most of them will not because if they do, the men will divorce them and they fear divorce. So they keep it to themselves and before you realize it, they have developed hysteria, they get stroke, and they get postpartum blues. So there is a lot of stress for women.

This nurse indicates that women's abuse frequently goes unreported, due to the repercussions such reporting could entail. The silence around abuse was confirmed by a police officer, who said that 'we actually have a lot more rape cases than you would imagine, but they never follow through with it.'

The silence surrounding abuse has severe consequences for women's mental health. Respondents stated that 'keeping it to themselves' may play a major role in causing women's mental distress. Indeed, other respondents spoke about, for example, the way abuse 'remains inside her until it eats her up inside.'

Other participants highlighted that the shame and humiliation caused by domestic violence plays a role in women acquiring mental illness, as reflected by one teacher's remark:

> Women suffer a lot of abuse . . . and it affects them. That is why women are the majority when you go to mental houses. Like men, those who have been beating their wives, you look at it to be normal, but due to anger, they beat them to the nonsense point and whenever anybody sees the women, they will say who did that? You see, it leads to an insult and that really affects a woman, emotionally.

The comment that 'you look at it to be normal', implies that domestic violence is to some degree normalized. One is also struck by the remark that a woman is doubly insulted and ashamed when the results of abuse are obvious to all.

A few respondents raised the issue of female genital mutilation (FGM). It is again striking how women's victimization becomes the cause of their humiliation and consequent distress. For example, when asked to provide more concrete examples of the effect of abuse on mental well-being, a government official responded:

> An example is FGM. You see sometimes in the community, some of the girls may not be willing to go through that practice but maybe they will force them and abuse them. After the child has been forced into this act, if it is detected at school, others point fingers at her. She then becomes frustrated and that leads to her not being able to cope.

Other respondents spoke about the 'psychological effect' female genital mutilation has on young girls, and how this practice 'will cause fear and anxiety in the person and if the girl doesn't take care, she will become mad in the course of time or depressed.'

Poverty

> Women who become mad easily are those who are not working and depend completely on the man.

A final theme, very common amongst all stakeholder groups, is the way in which poverty intersects at many levels with gender to induce mental illness in women. On one level, many participants highlighted that family economics are dominated and organized by men, significantly denying women control and agency over their lives. This in turn was seen to create mental problems for women, as suggested by this school teacher:

> In most cases, it is the men who have the upper hand when it comes to the money. So, the man will refuse money, clothes and other things. When this happens, the woman can start thinking and worrying that she won't be able to get what she needs, and you know when you think too much your mental state gets affected.

Other respondents spoke about poverty for women in the context of broken or unhappy marriages, and the different ways in which women's economic dependence on men affects mental well-being. This programme manager spontaneously highlighted the gendered dimension of deprivation:

> You see, many women depend on men for survival. So if their husband abandons them, she really will then have nothing, no house to live in, they have to struggle to be able to eat. So, you know they stress out. That alone can give them some mental disorders. So poverty and mental health, they are related particularly for women.

Many participants stated that poverty also limits women's ability to leave a marriage if they wish to, and this entrapment can cause mental illness. It was emphasized by many respondents that when a woman 'is not the breadwinner of the family' or 'don't have any source of income', they 'depend completely on the man' and are consequently 'then stuck in the marriage' which in time, 'will make them mad'. A few respondents spoke about the

conundrum that many women face: staying in an unhappy marriage or leaving and having no livelihood, both of which could generate stress. Of this a medical superintendent said:

> If a woman has money and can take care of herself and the husband is misbehaving, she can leave him. But, you see, because of poverty most women can't leave, and have to stay in a bad marriage. Either way, she becomes mad. Either she stays, and gets stressed or she leaves and gets even more stressed.

There were other aspects of poverty and women's mental health that were discussed. In both individual interviews, as well as focus group discussion with school teachers, it became clear that poverty plays a major role in the well-being of adolescent girls. It emerged that a common phenomenon within Ghanaian society is for young girls who come from poor families to forge relationships with older men who provide them with material goods and money. Many teachers provided firsthand accounts of how this frequently leads to various mental and behavioural problems in young girls, as this interchange between two female focus group participants suggests:

> For some girls, it [mental problems] is mainly because of poverty because there was a situation where a girl came to school with no food, no money, so in this case she has to look for money to buy food, to eat in school and buy things like text books. So this resulted in getting this older boyfriend for extra money . . . and it caused all kinds of behavioural problems for her . . . you see it in school. (Teacher 1)

> To add to what our colleagues have just said, to be frank they don't do it willingly. They do it because their situation is forcing them to do it . . . When a young girl doesn't have anybody to support her and they come across some men who are prepared to help if they agree to be their sex partners. It creates all kinds of mental problems for them. (Teacher 2)

Many other teachers recounted detailed stories about girls they had taught or knew, who were forced through poverty into these kinds of relationships, resulting in drinking and drugs and at times pregnancy. They spoke with candour about the mental distress and behavioural problems that occur amongst their students following such activities.

In conclusion of this final category of understandings of women's mental disorders, which we have termed the 'gender disadvantage' grouping, the words of one male hospital administrator seems to most appropriately tie together the different perceptions of this category:

> I think that gender plays such a big part due to the male dominance of society, you know, gender disparity. Women are so often seen as lesser beings than men. They are so often not empowered enough to be able to enjoy their rights, they are so often suppressed and oppressed, and out of frustration from all of this they get mentally sick.

Discussion

This study provides qualitative insights into common perceptions surrounding the main causes of women's mental illness in Ghana. These were explored with a range of key stakeholders in health and the allied professions. To our knowledge, this is the first large-scale study in Ghana assessing how people comprehend mental distress in women.

The results revealed a multiplicity of divergent perceptions surrounding mental illness in women with surprisingly few distinct gender differences. Although a few more men spoke about women's supposed 'weaker nature' predisposing them to mental illness, some women also appeared to draw on these discourses. Most certainly, the fact that more men than women held such views may point to the way in which such gender roles and stereotypes are developed and maintained more dominantly by men. More studies however, are needed to generate more conclusive results.

A striking finding from this study was that many people, including mental and general health practitioners, women and men, attributed women's mental illness to factors supposedly intrinsic or natural to women's composition. Talk of women being 'the weaker sex' due to their supposed inherent dependence and embellished need for love, their depleted problem-solving skills and their inability to manage stress was widespread. Many respondents also saw women's mental distress as a result of their hormonal and reproductive make up.

This tendency to attribute women's mental disorders to essentialist causes is not uncommon, being shown in a number of studies from high-income countries (Avotri & Walters, 2001; Chadwick, 2006; WHO, 1993, 2000). Most certainly, these perceptions are not new, but come out of a long history of scientific discussion and investigation which consistently positioned the very physiology of womanhood as pathological, attributing women's distress to their bodies (Chadwick, 2006; Ussher, 2003). For example, during the nineteenth century, neurasthenia and hysteria were theorized by scientists to derive largely from a multitude of disturbances related to women's

reproductive systems such as the hormones, childbirth, or dysmenorrhoea (Ussher, 2003).

In spite of these perceptions, contemporary controlled studies on physical determinants of mental illness in women have produced inconclusive and often contradictory results, and have failed to adequately explain the gender disparities in affective disorders (Nolen-Hoeksema & Keita, 2003). Most certainly, biological factors do play a role in mental disorders in women (Stein & Seedat, 2007), but all too frequently too much emphasis is given to these factors, with limited attention placed on the contribution of more social and structural conditions (WHO, 2000). There is thus a need in Ghana to start critically examining and unpacking the essentialist meanings attributed to women's mental disorders, and interrogating their oppressive underpinnings.

The findings from this study also revealed that in the general community, mental disorders in women (and men) are commonly attributed to the work of 'witches', who are almost always women. Such dominant community beliefs have been reported in other studies in different African countries (Badoe, 2005; Hewson, 1998; Jahoda, 1979). In her research amongst women residing in a 'witches camp' in Gambaga in the northern region of Ghana, Badoe (2005) showed that women most frequently accused of witchcraft are those who have transgressed and challenged the patriarchal order, in a context where women are supposed to be subject to male authority. Examples include those who are economically successful in the public domain, head their own household, or choose not to marry and reproduce. Many stakeholders in this study confirmed that such patriarchal dynamics do occur in Ghanaian society.

There is also a need to start reflecting on the gendered nature of 'traditional' African culture. What may be required is the acknowledgement that 'cultures' are not static, and all have progressive and oppressive dimensions. Those damaging aspects need to be challenged if the mental health of women in Ghana and other African countries is to be improved.

There were other causes attributed to women's mental disorders. Some respondents spoke about the pain, neglect, shock and frustration caused by multiple extramarital relationships as playing a major role in women's distress. Ghana's traditional ethnic societies accept polygamy, as in many other African societies (Avotri & Walters, 1999, 2001; Marcus, 2002). More studies are needed which explore the mental health implications of polygamy, given its widespread practice in many African countries.

Other respondents emphasized domestic violence as a fundamental causative factor for women's mental illness. These perceptions are supported by controlled epidemiological studies, which have highlighted the dire mental health consequences domestic violence has for women (Campbell & Lewandowski, 1997; Fischbach & Herbert, 1997; Patel et al., 2006). Violence against women has received very little attention in Ghana, with the burden of the problem being under-appreciated (Ofei-Aboagye, 1994). Given the possible relationship between domestic violence and mental illness in women, there is a need for gender-based violence to be placed high on the political priority list in Ghana, and other developing countries.

An additional finding, related to the abuse of women, was the negative effects of FGM on young women's mental health (Amoako, 2004; Bikoo, 2007). The extreme psychological trauma that this practice can invoke has received very little attention in the literature. Since 2000, the International Action Against Female Genital Mutilation (INTACT) has been offering practitioners loans to stop performing the practice in Ghana, in the hope that by 2005, FGM would no longer be practised in the country. However, the results from this study reveal that this practice may still occur, and may have detrimental psychological repercussions for women. Only a few respondents raised this issue in the interviews, and interviewers did not probe further, with the consequence that more information is not available from the results of this study. Given the seriousness of this matter, further research in this area is urgently required.

Finally, many respondents highlighted how women's economic vulnerability and dependence on men, and the consequent lack of agency and inability to leave unhappy relationships pose major risks for women's mental well-being. These perceptions are consistent with results from other studies in developing countries, which have shown a strong relationship between poverty and mental health (Flisher et al., 2007; Lund et al., 2010), particularly amongst women (Avotri & Walters, 1999, 2001; Patel et al., 1999, 2006).

A somewhat unexpected finding from this study relates to the way in which poverty may be a significant risk factor for mental and behavioural problems in young women. It was described that poor young women are sometimes forced into sexual transactions with wealthy older men as they provide them with the resources they need for survival. This phenomenon has received much attention within the HIV/AIDS literature, highlighting how such relationships make such young women extremely vulnerable to HIV-infection (Amoako, 2004; Poku, 2001). There appears, however, to be a dearth of research and interventions on the mental health effects of such transactions.

More studies are needed to confirm whether poverty is an important risk factor for mental illness in women, and the mechanism at play in this possible relationship. This is essential in Ghana, as poverty disproportionately affects women. In Ghana, women are less likely to be employed as wage earners, their average per capita income is considerably lower than men's and they are more likely to work as street vendors or petty traders, with more than two thirds of women's primary income-generating strategies falling within these two categories (Levin et al., 1999).

Conclusion

The findings of this study indicate that improving women's mental health in Ghana and other low-income countries may require intersectoral work and policies that prioritize gender mainstreaming in order to improve the economic, cultural and social status of women. In the field of mental health specifically, there is a need for policy and legislation to be more gender-sensitive, recognizing and addressing the specific mental health needs of women. In Ghana, a new mental health law has recently been drafted and is pending submission to parliament to be enacted into law. Findings from this study support the need to incorporate and apply a gender-based analysis and framework to the new law. There is also a need to provide appropriate services that prevent mental health problems in women, and support the attainment of optimum recovery and functioning for women with mental health problems. All of these steps are essential if we hope to recognize and address the key factors that lead to, constitute and maintain women's mental ill-health in Ghana and other low-income African countries.

Acknowledgements

We would like to acknowledge the support of the Ghana Health Service. We gratefully acknowledge the assistance of Kenneth Ae-Ngebise and Daniel Awenva in the data collection and analysis.

Declaration of interest: The Mental Health and Poverty Project (MHaPP) is a Research Programme Consortium (RPC) funded by the UK Department for International Development (DfID)(RPC HD6 2005–2010) for the benefit of developing countries. The views expressed are not necessarily those of DfID. RPC members include Alan J. Flisher (Director) and Crick Lund (Co-ordinator) (University of Cape Town, Republic of South Africa (RSA), Mwanza Banda (University of Zambia), Therese Agossou, Natalie Drew, Edwige Faydi and Michelle Funk (World Health Organization), Arvin Bhana (Human Sciences Research Council, RSA), Victor Doku (Kintampo Health Research Centre, Ghana), Andrew Green and Mayeh Omar (University of Leeds, UK), Fred Kigozi (Butabika Hospital, Uganda), Martin Knapp (University of London, UK), John Mayeya (Ministry of Health, Zambia), Eva N. Mulutsi (Department of Health, RSA), Sheila Zaramba Ndyanabangi (Ministry of Health, Uganda), Angela Ofori-Atta (University of Ghana), Akwasi Osei (Ghana Health Service), and Inge Petersen (University of KwaZulu-Natal, RSA).

This research was funded by the UK Department for International Development (DfID)(RPC HD6 2005–2010) for the benefit of developing countries. The views expressed are not necessarily those of DfID. The authors alone are responsible for the content and writing of the paper.

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