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Double Tragedy: Examining the Effects of Mental Health Stigma on Help Seeking Behaviour among Deaf People in Ghana

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Abstract

Background: Globally, mental health is recognized as one of the major public health issues, and mental health stigma is one of the main barriers to mental healthcare. While several studies have been conducted on the stigma associated with mental health, very little is known about the mental health stigma experienced by deaf persons with mental health conditions in Ghana. This study examines the experiences of double stigmatization by deaf people with mental health conditions in Ghana. **Methodology:** A descriptive, mixed method data collection was used for seventy-nine (79) participants. The paper presents findings from the only qualitative component of the study. **Results:** The findings from the study showed that deaf people with mental illness experienced double stigma, namely being stigmatized for being deaf and for having mental illness. This hindered access to mental health services for deaf people with mental health condition. **Conclusion:** Deaf people with mental health conditions experience double stigmatization which discourages them from seeking professional psychiatric care. This implies that efforts to reduce mental health stigma and create awareness on deafness should be improved upon. It is recommended that, in view of the impact of stigma on the provision and use of mental health care services, strategies to improve access to mental health care, should seriously consider concerns about stigma.

Keywords

Accessibility, Deaf People, Mental Health, Interventions, Stigma

1. Introduction

Mental Health remains a major dimension of public health globally and all

countries are affected. Estimates of the WHO indicated that 13% (970 million) of the global population lived with mental illness (as at 2019), out of which 82% lived in developing countries [1]. Mental health stigma has been found to be a major challenge for the management of mental health conditions as stigma exists at all levels and significantly impacts patient treatment and care [2]. According to the [1], 71% of persons with mental illness do not receive treatment and lack of knowledge about mental health and mental health stigma play a role in limiting access. Mental health stigma increases isolation, hopelessness, and delays or prevents mental illness treatment [3]. In Ghana, studies have reported mental health stigma not only among ordinary members of public but also among highly educated persons and health professionals [3] [4].

1.1. The Stigma of Hearing Loss

There is a complex link between mental health conditions, deafness, and mental stigma [5]. Hearing loss stigma is real and widespread in many societies around the world-The major reasons for hearing loss stigma are misconceptions about deafness, stereotypes, and negative social portrayal of deaf people [6]. Deaf people experience "otherness" among hearing people because of their unique communication and accessibility needs. Sign language, which is the mode of communication for many deaf people, is different from spoken language and unfamiliar to many hearing people [7]. This communication system is often not recognized as a language because of the premium placed on spoken language and most hearing people consider sign language as disruptive to social interactions [8].

Deafness is traditionally seen as an impairment, or a condition that creates hardship, and deprivation, and isolates individuals who are deaf, rather than a sociocultural phenomenon that could be used to create identity [9]. Communication barriers and negative attitudes often make it difficult for deaf people to participate in social activities including family conversations and, thus, isolate them. Consequently, many deaf people experience significant isolation from their family members and friends. This limits interaction with and knowledge about deaf people, which is a major source of prejudice and stigma against them [10] [11].

Ghanaians are phonocentric, a "belief that spoken word is the ultimate communication" ([12], p: 14). This perception is based on the view that sounds and speech are intrinsically superior (or more "natural") to the written language, and that the spoken language is richer and more intuitive than other languages such as sign language. This assumption has created the impression that language is spoken, and erroneously associates deafness to a lack of speech [13]. The logic then is that speech is language and since deaf persons lack speech, they lack language. Taking this logic further, Brueggemann (1999) cited in [13] described the relationship as follows: "Language is human; speech is language; therefore, deaf people are inhuman…" (p. 11). Phonocentrism is thus often the basis of stigma-

tizing deaf people and justifying injustice and discrimination against them [13].

In Ghana, as in many countries around the world, one's human status is acquired at birth and social status is acquired later in life. As such, until deafness in the child is noticed, the child retains all the human characteristics and has the opportunity of attaining any social status. The child is given a name; a name that often comes with the child. When one's deafness is detected, one's name either disappears or is used in combination with a label signifying one's new social identity, an identity that devalues and stigmatizes one and put one in a situation that would forever limit one's chances of attaining a status equivalent to one's hearing peers [14].

Once deafness is detected, the deaf person becomes, a "mumu", an offensive, derogative, and collective label for deaf persons in Ghana. This label symbolically alludes to the sound made by an animal, cattle. The "mumu" is now a person without language, and with what [8] called a spoilt identity. They are stigmatized and derogatively labelled as slow learners, who cannot handle or manipulate complex problems due to their "limited" intelligence. Analysing the effects of negative labelled on disabled persons in Ghana, [15] noted that labels influence the way we perceive disability (deafness), guide our decisions, perceptions, and choices, and create impressions that distort reality. For deaf persons, their "mumu" status and the association of speech and eloquence to intelligence have adversely affected their attaining high social status and integration of mainstream society.

1.2. Deafness and Mental Health Stigma

There is an intricate association between hearing loss and psychiatric disorders. Deafness is a complex condition with serious effects on the social, emotional, and cognitive development of affected persons. As explained in the previous section, deaf people struggle with stigma due to their hearing loss, prejudice, and communication issues daily [16]. In addition, deafness, for many people, is associated with social exclusion, discrimination, and reduced educational attainment and employment opportunities. The consequences of these on the mental health status of deaf peoples are well known and documented by several studies for example [17]. They are also more likely to be victims of physical, emotional, and sexual abuse, but unable to report these abuses, thus increasing their vulnerability to mental health problems [18] [19] [20].

Several studies have confirmed that mental health problems are more prevalent among deaf people than the general population [21] [22] [23]. Mental health disorders among deaf people are higher than the hearing population; about 40% of deaf children have mental health conditions compared to 25% of hearing children. Similar trends have been observed among adult deaf persons from different countries [24]. Anxiety, schizophrenia, depression, phobias, psychoses, antisocial behaviours, and low self-esteem and wellbeing have been found to be very common among deaf people [6] [25] [26].

Even though the stigma associated with mental illness is prevalent among both the deaf and the general population, stigma among deaf people with mental illness is likely to be severer and more pervasive [21] [27] [28]. They experienced simultaneous stigmatization of mental illness and deafness, which is intensified by concerns about their privacy and confidentiality when seeking mental health services. Mental health patients are worried about using interpreters. They think interpreters will leak information about their mental state to others in the community and negatively label and stigmatize them [28] Thus, using a third party, such as interpreters and family members, though could break the communication barrier, could also be problematic. According to [28] and [25], the prevalence of mental health stigma discouraged deaf people from seeking professional mental healthcare using interpreters. As a result, deaf persons prefer the services of deaf mental health professionals or hearing professionals who are proficient sign language, since such therapeutic relationships does not require the involvement of sign language interpreters, who may breach their privacy and stigmatize them [28] [29] [30] [31].

Thus, although deaf people are at higher serious mental health problems than hearing people, they face more barriers accessing health care services due largely to stigma [32]. According to [33], the deaf "grapevine" illustrates how stigma works in the deaf community and cautioned service providers to be wary of it when working with deaf people on issues that are very sensitive. The deaf "grapevine" explains how word quickly travels among members of the deaf community. While this can be beneficial at times, the phenomenon can adversely influence the help-seeking behavior of deaf persons with mental health. The deaf "grapevine" creates an atmosphere in which rumors spread quickly compelling some deaf people not to seek counselling or other mental health treatments for fear that word of their condition would spread quickly within the deaf community and beyond, and they may be stigmatized, mocked, or shunned [33].

This may be worsened by being deaf and having a mental health condition—one experiencing stigma associated with mental illness and hearing loss. The cumulative effective of this stigma during the life time of deaf people contributed to self-stigmatization and mental vulnerability, hindering their access to and use of mental health care services; when they seek care, it was often inadequate and not customized to meet their needs [32] [34].

Besides stigma from the general population, deaf people with mental health conditions also face stigma from within the deaf community itself. Inadequate education on mental health issues among deaf people often leads to misunderstanding of mental illness. As a result, the community heavily stigmatizes their colleagues with mental illness, labeling them "crazy" people. This is heightened by the small size of the deaf community, where information about others' mental illnesses quickly spread.

Deaf people with mental illness therefore experience multiple stigma—self-stigma, public stigma, social stigma and institutional stigma. Self-stigma is in-

ternalizing negative perceptions about oneself and this is manifested in poor outcomes, such as failure to continue with treatment, low self-esteem, reduced self-efficacy, and low quality of life [35] [36]. Public stigma on the other hand, is the negative attitudes toward persons with mental illness held by the general public due to misconceptions, fear, and prejudice [37] [38]. This could lead to discrimination at workplaces and public institutions [34]. Professional stigma is related to health workers' attitudes toward their patients with mental illness. This is often caused by fear or misunderstanding of the causes of mental illness, or the stigma experienced by health workers from the public or their colleagues due to their association with stigmatized persons [37]. Institutional stigma refers to policies or cultural organization that promote negative attitudes and beliefs toward stigmatized persons, such as persons with mental health conditions [37] [38] [39]. Deaf people with mental illness are vulnerable to all the four categories of stigma because the general public, including health professionals, stigmatized them due to lack of understanding deafness and their communication needs. This is often reinforced by institutional practices that discriminate against deaf people. Deaf people in turn tend to internalize these negative views about them [40].

Although other persons with disabilities may also encounter similar experiences, deaf people are likely to have different experiences requiring different remedies because of the nature of their disability. Whiles studies elsewhere have confirmed that deaf people with mental health conditions encounter multiple stigma which adversely affected their help seeking behaviour [18] [19] [20] much has not been done on this in Ghana. Thus, this calls for more studies to understand the situation among this subgroup. This study, therefore, explored how mental health stigma affected the use of mental health services among deaf people with mental health conditions in Ghana. Specifically, participants' perceptions of mental health stigma in Ghana, mental health stigma among deaf people, and the effects of mental health stigma on help-seeking behaviour among deaf people in Ghana were assessed.

2. Methodology

This paper has been developed from a larger study that assessed the knowledge of mental health issues among deaf people in Ghana and the barriers they encountered accessing mental health services. The paper assessed the extent to which double stigma, that is, the stigma associated with deafness and mental illness, impacted on the help seeking behaviour of deaf with mental conditions. A descriptive mixed method design was adopted for the study, but only the qualitative component is presented in the paper. The study was conducted in four of the 16 regions of Ghana which were the Northern, Central, Upper West, and Greater Accra Regions. The four regions were chosen because of the difference in geographical features, culture, and variation in the level of development within the Deaf community. The study explored participants' experiences relating to mental health stigma among deaf people.

2.1. Study Population, Sampling and Sample Size

The study population comprised deaf persons without mental conditions, mental health professionals, representatives of Civil Society Organizations (CSOs) working in the mental health sector, deaf persons with mental health conditions, and their caregivers. In Ghana, CSOs play an important role in the provision of mental health care through advocating for equal access to mental health care and providing support services, but little is known about if and how their activities benefit deaf people. Their inclusion in the study is therefore to help understand the extent to which these CSOs have targeted deaf people and their experiences working with this population. The study participants were selected through purposive and convenient sampling. A total of 487 participants were involved in the study, but 79 participants participated in the qualitative study. These were 40 deaf persons without mental health conditions (10 from each project region), 8 representatives of CSOs, 12 mental health professionals, 8 deaf persons with mental health conditions, and 11 caregivers of deaf persons with mental health conditions. The health professionals included heads of regional health directorates and regional mental health coordinators. Also, included were mental health nurses. The participants were selected through the assistance of the executives of the Ghana National Association (GNAD) in each of the four regions.

Recruitment of Field Assistants

A total of 12 field assistants were recruited and trained to assist with the data collection. They were made up of eight deaf persons, who worked with deaf participants, and four hearing persons who worked with the hearing participants. Each of the four project regions had three field assistants (comprising two deaf persons and one hearing person) who worked with participants in the region. All the field assistants were fluent in the Ghanaian Sign Language, had at least a first degree or diploma and also had experience working with deaf people.

Three reasons guided the selection of the field assistants. First, they were selected based on their previous experience in (research) conducting focus group discussions (FGDs), personal interviews and administering questionnaires. Second, they were selected based on their fluency in the Ghanaian Sign Language. The third criterion for selection was residence in the project regions to ensure easy follow up on participants. A one-day workshop was organized to train the field assistants in disability research with emphasis on the peculiarities of working with deaf people.

2.2. Data Collection

Data were collected through one-on-one interviews and FGDs. Interviews were conducted with eight deaf persons with mental health conditions, the eight representatives of CSO, 12 representatives from the Ghana Health Service, and the 11 caregivers. Each interview lasted about 50 to 60 minutes. Four FGDs were held, with one in each region. Each FGD comprised 10 deaf participants. Each

focus groups lasted about two hours. The interviews and FGDs with the deaf participants were video-recorded, whereas the personal interviews with hearing participants were audio-recorded. There were debriefing sessions to assess the interviews and FGDs to ensure that they were on track. The interview guides and FGDs general covered issues relating to knowledge of mental health conditions among deaf people, sources of information on mental health issues and mental health support services, challenges deaf people face accessing mental services, and challenges health workers encounter working with deaf people.

2.3. Data Analysis

The analysis of the data followed the six-step thematic analysis proposed by [41]. The process consists of (1) familiarizing with the data, (2) developing codes, (3) generating themes, (4) reviewing themes, (5) defining and naming themes, and (6) writing the final report. Both the audio and video recordings of the FGDs and the interviews were transcribed verbatim into word format. After transcription, the transcribed notes were read through repeatedly in order for the researchers to be familiar with the data. The second phase involved assigning codes to our data. These are brief descriptions of participants' responses on mental health stigma and access to mental health care. Phase three involved generation of themes, which are broader and attempted to interpret the codes and the data. Our next step, phase four, consisted of reviewing and refining the themes that were identified in phase three to make them clearer and meaningful. At the fifth stage, we named and described each theme to capture what is being said by the participants. The main themes were perceptions of mental health stigma in Ghana and mental health stigma among deaf people. Our final stage was using the themes to develop the report.

3. Ethical Consideration

The Ethical Review Committee (ERC) of the Ghana Health Service granted approval to conduct the study. In compliance with ethical principles of the ERC, approval was also obtained from the Regional Directorates of the Ghana Health Service in the project regions. Informed consent was sought from all the study participants. The participants were informed of the purpose of the study, duration of the interviews and FGDs, their right to voluntary participation, and their right to withhold information they deemed confidential. The participants were also informed that they were free to withdraw from the study.

The deaf participants were informed that their refusal to participate in the study would not adversely affect their relationship with the GNAD. Interviews were conducted at locations chosen by the participants. The FGDs were conducted at the usual places where the local deaf associations' people have their meetings. These places were considered convenient by the deaf participants. For the interview participants, the interviews took place at their offices (health works and CSOs) and homes (caregivers).

4. Findings

4.1. Demographic Characteristics of Study Participants

With regard to the socio-demographic characteristics of the respondents, the age group with the highest representation (44.3%) was between 30 and 40 years. More than half (51.9%) were Christians, and more than half (58.2%) had basic education. However, for marital status, 43.60% of the male were single compared to 40% of females who said they were singles. Also, 38.5% of male participants were self-employed compared to 20% female respondents (Table 1).

Table 1. Socio-demographic characteristics of participants.

Variables	Male		Female		Total	
	n = 39	%	n = 40	%	n = 79	%
Age group						
15 - 29	6	15.4	4	10	10	12.7
30 - 40	14	35.9	21	52.5	35	44.3
41 - 60	10	25.6	11	27.5	21	26.6
Above 60	9	23.1	4	10	13	16.5
No response	0	0.0	0	0	0	0.0
Religion						
Christian	15	38.5	26	65	41	51.9
Muslim	18	46.2	14	35	32	40.5
Others	6	15.4	0	0	6	7.6
Educational Level						
Basic education	21	53.8	25	62.5	46	58.2
Secondary	11	28.2	6	15	17	21.5
Tertiary	7	17.9	9	22.5	16	20.3
Marital Status						
Married	13	33.3	15	37.5	28	35.4
Single	17	43.6	16	40	33	41.8
Divorced	2	5.1	1	2.5	3	3.8
Widowed	3	7.7	2	5	5	6.3
No response	4	10.3	7	17.5	11	13.9
Employment						
Employee	21	53.8	27	67.5	48	60.8
Self-employed	15	38.5	8	20	23	29.1
Unemployed	2	5.1	1	2.5	3	3.8
No response	1	2.6	4	10	5	6.3

4.2. Perception of Mental Health Stigma in Ghana

Mental health stigma was described by the participants as very serious in Ghana and this, according to the participants, is caused by erroneous notions about the causes of the condition, such as linking the condition to supernatural forces, and negative lifestyle, as in the quotation below:

> The stigma comes from various sources where some feel that people with mental health conditions are suffering as a result of spiritual reasons, others feel they may have lived a certain lifestyle that is causing them to be in such conditions, such as drug abuse, and others think it is genetic (Accra, CSO 2).

Some participants indicated that people whose conditions were believed to have been caused by spiritual forces, were avoided for fear of being "infected". One participant was particularly not happy with the way people with mental health conditions are treated. He described the situation as "very bad. People maltreat mental health patients because of stigma. Nobody wants to be associated with them. They are not given proper care because they are considered a cursed or have bad life styles (Upper West, P01). Supporting this view, another participant said, "Mental health stigma is a widespread canker in Ghana where persons with mental illness are labelled, stereotyped and discriminated against all over. The situation is really bad" (Upper West, P02). Because of the stigma, "people distanced themselves from people who are mentally ill for fear that they may contract the mental illness from them, which affects their treatment" (Northern, P01). A participant elaborated:

> So, all these factors will determine how a person with mental health condition will be treated. For instance, persons who abuse drugs are not shown any consideration and stigmatized because they feel they brought it upon themselves. Also, when they feel your condition is caused spiritually, it is difficult for people to associate with you because they fear by associating with you, they will also contract the condition. So, the stigma by society is based on what they believe is the causative factor (Accra, CSO 2).

Mental health stigma is so pervasive that even renowned mental healthcare facilities are stigmatized to the extent that people are discouraged from seeking treatment from such facilities:

> Because of stigma, an individual may not seek treatment. For example, the name Ankaful (one of the biggest mental healthcare facilities in Ghana) alone is some sort of stigma. So, telling someone to go to Ankaful that individual may not want to go, but thank God there are mental health units at other hospitals as part of the mainstream treatment and care, so it has reduced the stigma associated with some facilities (Cape Coast, MHN02).

4.3. Mental Health Stigma among Deaf People

Participants described mental health stigma among deaf people with mental

health conditions as more serious than what is experienced by their hearing counterparts. A participant, who was a health worker from Accra, explained that "I think 'mad' people, who are deaf roam the street, are seriously stigmatized, have difficulty getting good food to eat, poor clothing and no proper shelter, and we are unable to target them in our programmes" (Accra, MHW 02). A deaf participants agreed with this assertion and indicated that deaf people who have mental illness encounter "great" stigmatization from their communities; "they were seriously stigmatized, maltreated, evicted from their homes and were poorly fed, and this made it difficult for them to have a stable livelihood that will enable them to effectively manage their condition." A participant with mental illness from the Upper West Region concurred and said: "Deaf people with mental health conditions suffer serious social stigma. For example, I was sacked from my rented home, I am poorly fed, whipped with no justifiable reason." He added that:

> Sometimes, they (deaf people with mental health conditions) are forced and tie their legs on wooden materials. They can't hear what we tell them about the pains we experience when we are chained. They don't think we are human being because we can't speak. We have stigma on us. We can't even think about getting a cure when we don't have a place to sleep and food to eat (Upper West, P01).

On whether deafness worsened the situation for deaf people with mental health conditions, majority of the participants agreed, as explained by a deaf participant from the Upper West Region, who said, "Deafness contributed greatly to the attitude of society towards the deaf with mental health conditions. Yes, deafness contributes in a negative way because deafness is stigmatized because many deaf people can't speak and mental health is also stigmatized. Being 'mumu' and mad is not easy" (Upper West, P02).

In fact, some participants described mental health stigma among deaf people as "highly unacceptable." One participant, describing the situation in the local communities, for example, mentioned that, "deaf people with mental illness endure a unique form of labelling and prejudice rooted in local perceptions of witchcraft and spiritual curse as the major underlying cause of having both deafness and mental illness at the same time" (Upper West, 2). A participant in the northern region narrated the experiences of mental health stigma among deaf people with mental conditions in the region in the following words:

> People distance themselves from people who are mentally ill for fear that they may contract the mental health condition from them, which affects their treatment. And if you are deaf, your situation could be worse because deaf people are stigmatized already and if the person has mental health issues, you can imagine what will happen to him or her because of people thing deafness and mental illness are both inherited or cursed" (Northern Region, DP 01).

The above assertion was supported by a representative of CSO who said the situation among deaf people could be worse because of cultural and religious factors, perceived negative lifestyle, and the perception that deafness and mental illness are inheritable:

> The stigma comes from various sources where some feel that deaf people with mental health conditions are suffering as a result of spiritual reasons such as being cursed. Others feel they may have lived a certain lifestyle that is causing them to be in such conditions such as drug abuse. They don't expect a deaf person to engage in such a practice, whiles others think deaf and mental illness are genetic and can be inherited (Accra, CSO 03).

According to a deaf participant from the Upper West Region, some families "abandon their deaf children with mental conditions at prayer camps and others hide them in the house and wish nobody should know that they have mental health patient in their family" (Upper West, DP 01). It also emerged that most spouses divorced their partners after they acquired mental health conditions because of embarrassment and the perceived difficulty in caring for people with mental illness. Although this does not only affect deaf people, it could worsen the condition for them—increase their isolation, and reduce their ability to seek health care.

The views of CSOs were not different from views expressed by the other participants that deaf people with mental health conditions were more likely to experience greater stigma and social rejection than their hearing counterparts. For example, a CSO representative from Accra noted that:

> If you are deaf person and have a mental health condition, you are worse off. There is a general negative attitude towards people with mental health conditions, so if the person is deaf and also, has a mental health condition, the attitude becomes more even from the family members and they internalize this, which make them feel devalued (Accra, CSO 2).

Some of the CSO representatives described the situation for deaf people as a "double tragedy," meaning deaf people already experience stigma and rejection in society as a result of their hearing loss, and this is worsened by acquiring a mental health condition. Commenting on this, a participant from the Upper West Region said: "Yes. It will likely be different. The hearing people with the condition would be seen as normal mental health patients, but deaf people with the condition will be seen different because of prejudice" (Upper West, CSO 2). Another participant agreed, and said, "Yes! Since they have additional disability, they will have more stigma than hearing people, and people may not want to work with them" (Tamale, CSO 2). The comments below provide more explanation on this issue.

> Stigmatization that is the way people or society see persons with disabilities, and it will be a double or even a triple disaster for deaf people with mental

> health conditions because hearing loss is serious stigmatized in Ghana and you have contracted a mental health condition will make it worse for the person (Accra, CSO 1).
>
> Already people do not want to be associated with persons with mental health conditions. They are mostly rejected by society and they are not involved in normal social life. Once deafness is added, it compounds the situation, and most people hate them, and would not want to associate with them (Upper West, CSO 1).
>
> Generally, people with mental health conditions are worse off with attention and if you are someone who is a deaf person and with a mental health condition, this will only mean that the person is worse off within the family and society. So, there is a general negative attitude towards people with mental health conditions, so if the person is deaf and also, has a mental health condition, then, I would say this attitude will be more negative attitude from families and I have seen this before (Accra, CSO 2).

Although there was some disagreement among the caregivers as to whether deafness worsened the situation for deaf people with mental health condition, majority (82.1%) of them said deafness greatly worsen societal attitudes towards deaf people with mental health conditions. Deafness "makes the situation worse since they have multiple disabilities, people pity them, stigmatize them, and do not want to be associated with them" (Northern, P02). For example, people "sometimes laugh at deaf people thinking they are mad, so when they have mental illness, you can image the situation" (Central, P03). Another caregiver lamented and said people "look down on them [deaf people with mental health conditions] because they have double conditions and they tagged and labelled deaf people with mental health conditions because they are deaf and at the same time mentally ill" (Northern, P02).

The findings revealed that deaf people with mental illness did not only experience stigma from the hearing population but also from colleagues in the deaf community, as exemplified by the following comments from two deaf participants from Accra: They [deaf people with mental health conditions] "become withdrawn, isolated, sad and lonely", compelling some to have "suicidal thoughts" "…because their deaf friends shunned them that sadness may engulf them" (Accra, MD2). "Even some of their own deaf friends stopped visiting them immediately after they acquired mental illness, "some friends stopped visiting them, and their friendship slowly died because of their condition" (Accra, DP2).

The narratives of all the participants also revealed self-stigma among deaf people with mental health conditions. Participants cited various cases of how deaf persons with mental illness were treated in the local communities, and how this became internalized and consequently affected their use of mental health services. According to some of the participants, deaf people with mental health conditions experienced low self-esteem and this affected their quality of life, which one participant described as, "…very poor. This is because no one values

deaf people who are mental health patients and they internalized this, which has reduced their quality of life to the barest minimum and can't receive medical care" (Upper West, P04). They are also "unable to live to their full potential and use medical services and have low self-esteem and cannot mingle with other deaf people" (Cape Coast, P03). Confirming this, a participant who has mental health condition indicated that:

> For a better quality of life, I need to mingle with other people, including my own people (deaf people). But I am not able to do that because I can't compare myself to other people without this condition. I feel low because of my mental health conditions, which affect my everyday life. I am even unable to seek care (Accra, P01).

As noted above, mental health stigma against deaf people with mental health conditions has adversely affected their access to mental health services. Some participants identified fear on the part of health workers to work with deaf people with mental health conditions on one hand, and fear among deaf persons with mental health conditions to come out, on the other hand, due to stigma as major factors affecting access to health care. As a participant put it:

> I can't mention names but I know health workers who don't feel comfortable working with deaf people generally… and deaf people with mental health conditions don't want to come out due stigma, so the situation is likely to be worse for deaf people with mental illness. They are unlikely to receive the needed treatment or they get it late, and not always" (Accra, CSO 3).

A caregiver complained that her child would not allow them to take him to the hospital due to self-stigma. She explained that although "… medication is free under health insurance, but he [the deaf person with mental illness] doesn't allow us to take him there [mental hospital] because he feels shy or something" (Cape Coast, P01).

Mental health stigma against deaf people with mental health conditions appears to be institutionalized, which has further aggravated the situation. Responses from deaf participants, for example, suggest that deaf people with mental health conditions faced discrimination and suffered undue delays at healthcare centres due to communication barriers and the negative attitude of healthcare professionals. For example, Participant 3 from Cape Coast explained that when health workers "…identify that the mental health patient is also deaf, they ignore the person, pretending there were looking for interpreters, but these deaf persons don't go to the hospital alone. This takes a lot of time and delays attending to them." Confirming this, a participant said once they found that the patient is a deaf person, "they will ask him/her to wait, wait, wait because they claim they can't communicate with him or her and then soon forget about the deaf patient…" (Accra, P04). Also, some of them would "pretend and act as if they are too busy to attend to the person with mental health condition but shun them"

(Accra, P06). Some healthcare professionals corroborated that the attitudes of some of their colleagues were somehow negative. They, however, blamed this on their inability to communicate with deaf people, which caused them to sometimes ignore deaf people with mental health conditions:

> The attitude of some health care workers is somewhat negative towards deaf people with mental health issues because we don't understand them well. Their sign language and all that, is problematic. If we receive one right now, I will find it difficult to interact with them and this may affect their access to the right treatment (Accra, MHN 2).

According to some participants, because of fear that they will be stigmatized, some families delayed treatment, which worsened the person's condition. For example, Participant 3 from Accra, alleged that "their [deaf people with mental health conditions] treatment and care are often delayed. But some people tried to send them to the hospital for treatment but because of the stigma that is associated with their families, they delayed. Another participant from Accra added that "It is not easy to get early treatment for them [deaf people with mental illness], but some are not sent for early treatment because of stigma" (Accra, P05), and as a result, their condition "deteriorates and "become worse" (Tamale, P02).

They may also not seek professional mental healthcare at all, with some hiding from mental healthcare providers, while those who sought treatment tended to withdraw from the treatment process. Two mental health nurses corroborated the quotes below:

> In our communities, the stigma is too much and this is worse for deaf people. It's not easy. We hear they have the condition but it is not easy to get them because they will be hiding. Sometimes you visit clients in their homes, and they tell you how the community makes it difficult for them to go out (Upper West, MHN 2).
>
> Well, the public attitude is not about mental health alone. For instance, if someone is an HIV patient, the stigma alone is something. So, if somebody is in the community and is having mental health issues, and also deaf, they would want to withdraw from the person and even some families do so. When they see you talking with someone who has a mental health illness, they say he is not sound and tell you to ignore them. For deaf people, even their interpreters don't want to accompany them to hospital and this affect their access to treatment" (Accra, MHN 2).

Another important finding regarding mental health stigma and the use of mental health services by deaf people with mental illnesses is privacy. Since mental illness is stigmatized, the privacy of mental health patients should highly be observed. However, for deaf people, this is difficult to observe because of communication barriers. There must always be someone around to interpret for them during a consultation and this, according to some participants, may breach the privacy of deaf persons with mental health conditions, especially if the inter-

preter is not a family member.

> I know many deaf people with mental health conditions who wants to visit the psychiatric hospital, but are unable to do so because their family members cannot sign and if they employ an interpreter, their issue will be exposed and so they will not like to go to the hospital (Accra, MHN 03).
>
> Some deaf people do not go to the hospital on time to check their condition for early intervention. If they suspect they have mental health illness, they have to go to the hospital early to confirm this but they fear this will be done before an interpreter and before you are aware, everyone is aware of the condition and this delay early intervention and their condition gets worse (Accra, DP 01).

All the representatives of the CSOs unanimously agreed that mental health stigma greatly affected the ability of deaf people to seek help, receive treatment and care on time, because of "rejection and isolation." Some participants reported that mental health stigma affected treatment since "some avoided treatment all together because of stigma. And also, because most are rejected by their own families, it makes them hopeless and that will even not make them seek for treatment services" (Accra, CSO 2). Similarly, "stigma will affect their care because they would not be listened to or be urged to say what is affecting them for the right diagnoses to be done" (Accra, CSO 1). This may be worse for deaf people "… because less care is provided to them due to being deaf and having a mental health condition, as having a communication that is not common" (Northern, P02).

5. Discussion

Mental health is a major public issue in Ghana that affects the individual's physical and social wellbeing. It also has a negative impact on families, people who are connected to the affected persons, and the overall productivity of the country. However, there is a treatment gap for mental health conditions, estimated to be more than 98 percent [42]. Although the cost of mental health is a major factor, mental health stigma significantly hinders access to and use of mental health services. This study investigated mental health stigma among deaf people with mental health conditions in some selected regions in Ghana and how this affected their help seeking behaviour.

While mental health stigma is a global issue, the situation among deaf persons is likely to be worse since deafness and mental illness are both stigmatized. The findings of the study suggest that mental health stigma among them could be serious and complicated, and this could severely hinder access to mental health services for deaf people who are in need. These findings also support most studies on mental health stigma in Ghana. For example, [2] and [3] reported mental health stigma as a major barrier to mental health care, which needed urgent attention. Stigma causes grief and isolates the affected persons. It also makes it dif-

ficult for patients with mental health conditions to seek help and induces a feeling of dependence, and hopelessness [3].

Deaf people face discrimination, prejudice, and communication issues [16], as such, mental health stigma would have significant repercussions on their uptake of mental health care services and overwhelming effects on their wellbeing. However, their needs are often invisible for policy making and service delivery due to a lack of research on this population. This conclusion is consistent with findings from a study conducted by [25] who reported that despite the prevalence of mental health stigma among deaf people, they remain invisible and an underserved population. And as noted in the study, even some health professionals did not treat deaf people with mental health conditions well, which is likely to further exclude them from mental health care services. Some studies suggest that misconceptions about the etiology of mental health among deaf persons contribute significantly to stigma and biased psychiatric evaluation and treatment of deaf patients. It has been reported that even though deaf and hearing patients have similar psychiatric symptoms, the deaf patients were given more dosage of medication, had longer stay in the hospital, and more clinical supervision than their hearing counterparts, which also contribute to stigma [43].

Their distinct mode of communication complicates the situation for the deaf community. Studies have found that lip-reading is inadequate and skilled interpreters are often scarce [23]. The communication issue could come from several angles, namely, the inability of health workers and family members to use sign language. It is also important to note that not all deaf persons are fluent in sign language and this is complicated for deaf persons with mental health conditions. The lack of speech and misconceptions about sign language are also important drivers of stigma [6], which could limit access to mental health care. Further, their "mumu" status, which presents deaf people as not truly "human" and negative labelling by deaf people against their colleagues with mental health conditions increase their isolation and reduce their access to mental health care services [14].

Although interpreters could address the communication needs of deaf people, the sensitive nature of mental illness makes the use of interpreters under certain conditions inappropriate. For example, it could prevent deaf people from providing information that could be important for early detection and intervention due to the fear of the interpreter leaking the information to members of the community [30] [31]. The deaf community is closely knitted and information spreads easily through what is called the "deaf grapevine" [44].

Mental health conditions would have great impact on wellbeing of deaf people with mental health conditions, as low literacy and unemployment, and begging could make it hard for them to cope with mental health stigma. For many people, including those who are deaf, meaningful work and being able to provide for oneself and one's family are vital to a sense of well-being, identity, and quali-

ty of life. In many societies, working and contributing to household income and the wider community is an important attribute in gaining social status and respect. The inability to live a productive life could be demeaning and induce self-stigma. The consequences of self-stigma are well known. For example, it can have adverse effects on treatment and recovery, increase depression, reduce self-esteem, devalue individuals, and make them vulnerable to discrimination [45].

5.1. Limitations of the Study

A limitation of the study relates to the interview guides for deaf participants. Deaf people, generally, provide short answers to questions. So, in a qualitative interview, a lot of probes are required to "compel" deaf participants to provide detailed responses. The initial interview guides, therefore, had a lot of probes, which made them lengthen. However, during the ethical review process, the ERC of the Ghana Health Services thought the guides should be shortened. There was no opportunity for the researchers to explain why the interview guides had many probes, so, many of the probes were deleted. Although the research assistants were informed to probe for more responses, most of them could not do this effectively. Responses from deaf participants were thus brief, without enough details, and the researchers had made a lot of inferences from some of the responses. Some of these inferences may not be valid although efforts were made to avoid mistakes.

As expected, it was not easy interviewing deaf participants with mental health conditions because many of them could not articulate their views, while others were not willing to participate in the study or could not be interviewed at a session. Several sessions were needed to clarify responses and to complete interviews for some of the participants. But because of the limited time at our disposal, we could not organize more interview sessions for some. Responses from some participants were not useable and had to be discarded.

5.2. Implications

Ghana has made moderate gains in mental health care and management. The government has adopted a number of interventions to increase access to mental health services. Notable among them is the passage of a National Mental Health Act (846) and Mental Health Policy and the subsequent establishment of a National Mental Health Authority to oversee the implementation of the Act. One of the main objectives of the Act is to protect the human rights of persons with mental health conditions; protect them against discrimination and stigmatization [46]. Almost ten years after the enactment of the Act, mental health stigma is rife affecting universal access to mental health services, especially to deprived populations, such as the deaf community, thus living them behind in mental health care.

One shortcoming of the Mental Health Act is that, it does not provide effec-

tive strategies on how discrimination and stigma against different sub-groups could be addressed. Deaf people with mental health conditions experienced multiple stigma which requires multidimensional and multisector approach that include relevant government ministries such as the Ministry of Gender, Children and Social Protection, the non-government, traditional leaders, and service user and professional groups to deal with the situation. This has the potential to deal with discrimination through a coordinated and multi-sectoral programme of action that will promote the social inclusion of deaf people with mental conditions, and reduce stigma. Specifically, targeting this population and customizing interventions to suit their needs and empower them will leverage their self-efficacy to fight stigma and increase access to mental health care.

It will also be important to target healthcare professionals, as their attitude can reinforce discrimination and stigma against deaf people with mental health conditions. As discovered in the study, some mental healthcare staff exhibited negative attitude towards deaf people with mental health conditions. Several studies have reported ignorance about deafness and people's needs among healthcare workers. Prejudice and discrimination against deaf people have also been observed in some studies [10] [11]. Mental health workers can therefore be a source of stigma and may not be in the best people to champion awareness creation to destigmatize mental illness [47]. However, they cannot be left out on in the campaign to reduce mental health stigma. With proper preparation and training, they can be a vital resource to reducing mental health stigma and help to improve access. Provisions in the Persons with Disabilities Act, 715, requiring health training institutions to introduce topics on disability in their curriculum [48] should be enforced. Mental health stigma could also be an important topic in the curriculum of continuing professional development for mental health professionals.

The findings of the study also called for urgent measures to implement other important provisions in the Mental Health Act (846). These provisions are decentralization of mental healthcare, universal coverage and equitable access to mental healthcare, and protection of the rights of persons with mental health conditions against discrimination and stigmatization [46]. This means scaling up mental health treatment to ensure universal coverage should be a priority project. There are shortcomings of the Mental Health Act which must be addressed to make its implementation effective. For example, the Act does not address the specific concerns of other categories of persons with disabilities. This implies that policies and guidelines formulated on the basis of the Act are not likely to address the concerns of persons with disabilities, and for that matter, deaf people. An instance is the peculiar challenges relating to the communication barriers that deaf persons often encounter when accessing healthcare. Therefore, deaf people with mental health conditions are likely to face challenges accessing mental health care services. Although the current economic situation could make this difficult, it is not impossible to achieve this. It must be noted

that although the potential harm in term of loss of productivity caused by the impact of mental illness among deaf people on the overall economy may seem irrelevant, they cannot be overlooked as healthcare is a right and the principle of living no one behind applies equally to everyone, irrespective of the person's status.

On the basis of the findings of the study, it is recommended that efforts should be made to strengthen mental health literacy among the deaf population. This could be developed and deployed through social media handles in Ghanaian sign language. Additionally, efforts should be made to educate the public on mental health conditions to reduce the stigma associated with mental health. Improving knowledge on mental health conditions will improve attitude towards people with mental health conditions and then reduce stigma.

6. Conclusion

Mental health is an important component of overall wellbeing, and there is also growing evidence that it will be difficult to achieve many of the Sustainable Development Goals without making mental health a priority in the government's development agenda. However, mental health stigma in Ghana is having adverse effects on mental health treatment and management. And it seems to be reversing the gains that have been made so far. This study sought to ascertain how deafness and mental health stigma interact to impact on the uptake of professional mental healthcare among deaf people with mental health conditions in Ghana. The findings shed light on the stigma and social exclusion of deaf people with mental health conditions, and how these experiences affected seeking professional mental healthcare. The study has improved our understanding of mental health stigma among deaf people with mental health conditions and deaf people's vulnerability to mental health problems. It is imperative to note that this is a population that has often been excluded from healthcare programs in general. The study thus calls for the need to develop group-specific mental health programmes and support systems that can drive current efforts at improving access to mental health care and leveraging hope for the future.

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Conflicts of Interest

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