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Social and Cultural Considerations in Accessing Mental Health Treatment in The Gambia, West Africa

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SOCIAL AND CULTURAL CONSIDERATIONS IN ACCESSING MENTAL HEALTH TREATMENT IN THE GAMBIA, WEST AFRICA

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ABSTRACT

SOCIAL AND CULTURAL CONSIDERATIONS IN ACCESSING MENTAL HEALTH TREATMENT IN THE GAMBIA, WEST AFRICA

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This study examines the social and cultural considerations in accessing mental health treatment in The Gambia, West Africa. Participants were recruited from The Gambia for a qualitative study that included semistructured interviews (N = 17). A team of analysts identified five themes. The results highlighted social and cultural conceptualizations of mental health and mental illness, sociocultural determinants of health, interventions, barriers to care, and the legal framework to support mental health change. These findings are important for counselors to understand different perceptions of mental health and mental illness and the associated stigma. Furthermore, several opportunities for advocacy in The Gambia have resulted from this study. This dissertation is available in open access at AURA (https://aura.antioch.edu) and OhioLINK ETD Center (https://etd.ohiolink.edu).

Keywords: mental illness, mental health, The Gambia, Africa, stigma

Dedication

I dedicate this lifetime achievement to my mother, Abbey Nyang, who believes in me and in my capacity to learn.

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I would like to acknowledge my children, Abu, lamin, Sulay, and Jatou, as well as to my 10 grandchildren who give me a constant source of joy.

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To the people of The Gambia who struggle with mental health, I hope this piece of work has relayed your voices in a way that it can bring change.

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CHAPTER I: INTRODUCTION

Statement of the Problem

The Republic of The Gambia, commonly called The Gambia, is a former British colony, which gained independence in 1965. It has a democratic system of government with three branches: the legislature, the judiciary, and the executive. The president of the Republic is the head of the executive branch and is assisted by a vice president and a cabinet of ministers. Gambia is one of the smallest countries in the world, with an estimated population of 2.2 million people (Global Burden of Disease [GBD], 2018; World Health Organization [WHO], 2018). According to The Gambia Bureau of Statistics (GBOS), 2013, more than half of the population is female, and more than 63% are youths (GBOS, 2013). Approximately 50% of the population live in rural regions, which comprise 60% of the country (GBOS, 2013). The Gambia is also one of the poorest countries in the world, with an estimated gross domestic product per capita of US $773.00 in 2020 (World Bank Group, 2022).

The exact prevalence of mental illness in The Gambia is unknown. A situational analysis of mental health in The Gambia in 2012 by the Mental Health Leadership and Advocacy Program (MHLAP, 2012) revealed that from a then-estimated population of around 1,478,000 million, approximately 120,000 had a mental disorder (MHLAP, 2012). The size of the population has almost doubled, but no recent studies exist on the prevalence of mental illness. Recent statistics from the Global Burden of Disease (GBD, 2017) illustrate that more than 34% have depressive disorders and 35.9% have anxiety disorders. Mental health stigma has also been identified as a significant factor that affects people with mental health problems in The Gambia. Stigma is a pervasive condition that often discredits the individual, leaving them feeling lesser and negatively unequal to others (Abdullah & Brown, 2011; Goffman, 1963; Monteiro, 2015).

The plethora of emerging research on mental health stigma in low- and middle-income countries (LMICs) speaks to the role of culture and cultural differences in both the conceptualization and understanding of mental health (Amuyunzu-Nyamongo, 2013; WHO, 2012, 2014). In The Gambia, explanatory beliefs about causes and attributions of mental health and the labels that are attached to them are stereotypical, isolating, discriminating, and stigmatizing toward those with mental health issues. This may result in mental health stigma. Empirical studies have provided a foundational understanding of the scale, nature, and lack of access to necessary mental health service (Barrow, 2016; Barrow & Faerden, 2022; Coleman et al., 2002). These studies have touched on the need for information on the role, association, and impact of stigma in both care-seeking attitude and stigma as a deterrent in service utilization. An investigation into the lived experience of mental health stigma would generate important findings for and be resourceful to the Gambian government, which provides the implementation and planning of services, and the nongovernmental organizations and institutions that provide mental health services. This investigation could address the treatment gap, which was estimated to be 90% (MHLAP, 2012).

MHLAP (2012) indicated that it did not examine mental health stigma specifically, but this stigma is likely a factor that influences service underutilization. With many needs, it is important to prioritize those that are the most fundamental to health, including access to treatment and addressing stigma. Mental health in The Gambia is rooted in culturally nuanced concepts and understanding. These cultural understandings significantly impact the social

identity of people with mental health. Furthermore, they define the treatment pathways and modality for mental health care and create public stigmatization of mental health issues.

The globalization and decolonization of mental health in Africa has influenced researchers and scholars with a call for action for the extension of the bio-psycho-social framework of assessment, diagnosing and treatment of mental health in Africa (Monteiro, 2015). The bio-psycho-social model has long been used in the contextual approaches to mental health interventions in low- and middle-income countries in systematic response to a need to address factors that determine or increase mental health (Engel, 1977). Research speaks to the systemic and structural factors of mental health, such as lack of funding, limited health care infrastructure, lack of mental health policy and laws, and mental health stigma and discrimination (Akinsulure-Smith & Conteh, 2018; Becker & Kleinman, 2013; Monteiro, 2015). Although such a model has increased the overall status of mental health in low- and middle-income countries, mental health is still a stigmatized and neglected area of health and wellbeing in these countries. Furthermore, due to its widespread prevalence, mental health has been described as an epidemic in low- and middle-income countries (Hohenshil et al., 2015; Monteiro, 2015). The Gambia, as a low- and middle-income country, shares the same systemic and structural problems that face many other African countries in terms of prioritizing mental health and its delivery (Akinsulure-Smith & Conteh, 2018).

Theoretical or Conceptual Framework

A useful perspective for examining mental health care and access is the ecological systems theory (Bronfenbrenner, 1977). Ecological systems theory of human development considers the influences of multiple systems at different levels that interact to influence the lived experiences of the individual and current systems surrounding that individual (Crawford, 2020).

According to this theory, human development results from interactions between developing human organisms and environments at five significant levels: microsystem, mesosystem, exosystem, macrosystem, and chronosystem. The microsystem consists of the person's immediate environment and includes an individual's personality, beliefs, and temperament. The mesosystem is the connection between the different microsystems. For example, elements of the microsystem interact to affect the individual's experience (e.g., how school and home may interact). Both microsystems and mesosystems must include the individual. Systems that affect environments at the meso level but do not include the individual comprise the exosystem, which consists of microsystems that interact with each other, but at least one of the microsystems does not include the individual at the center of the system. For example, the workplace of a parent does not include the child, but they could be affected by characteristics of the parent's workplace (e.g., the parent is required to work long hours or is stressed from work). However, because the child is not part of the parent's work environment, the workplace is not part of their micro or mesosystems. The macrosystem influences the characteristics of the interactions among the different systems or, in other words, it influences the "social design" for the broader culture or subculture. For example, family culture develops within the family in the microsystem, which is influenced by the mesosystems and exosystems of each family member. All of these systems are then affected by the broader society and culture. Bronfenbrenner lends special emphasis to the importance of cultures within the groups and the patterns of exchange both within and among groups. This theory emphasizes reciprocal effects of these different systems on personality development and social and psychological outcomes (Crawford, 2020). Ecological systems theory provides an important perspective in investigating West Africa and access to mental health care and any associated stigma. This study begins with a collection of individual

perspectives and identifies themes through a phenomenological interpretive analysis. These themes are viewed through ecological systems theory as part of the discussion on the findings to provide perspective on how different levels of frameworks interact in the context of one's life.

Statement of Purpose

The purpose of this qualitative phenomenological study is to explore and understand the lived experience of adults seeking mental health treatment and the role of mental health stigma in The Gambia, West Africa.

Research Questions

RQ1: What is the lived experience of mental health amongst adults in The Gambia? RQ2: What is the lived experience of mental health stigma amongst adults in The Gambia? No hypotheses were made due to the qualitative nature of the study.

Significance of the Study

The significance of this study cannot be underscored enough in examining opportunities for mental health advocacy in The Gambia. Firstly, as a low -to -middle income country, mental health should be a public health priority for The Gambia. Mental health is a global pandemic and the treatment gap for mental illnesses is between 76% to 85% in low to middle income countries as opposed to 35% to 50% in high-income countries (Barrow, 2016; Evans-Lacko et al., 2012). There are no recent data on the prevalence of mental illness in The Gambia, but the latest available data indicate a treatment gap of 90% (Barrow, 2016; MHLAP, 2012). This wide treatment gap necessitates investigation of factors impacting this disparity.

Secondly, to breach this treatment gap, Patel and Prince (2010) investigated the intersection of treatment outcome and care-seeking behavior. They posit that current interventions utilized in mental health care in Africa will not be effective without behavioral

change. Furthermore, Summergrad (2016) stated the need for early intervention to avoid a knock-on effect not only on general health goals but also, particularly, on socioeconomic development. Therefore, both qualitative and quantitative research are greatly needed to understand the nature and scale of the problem (Barrow & Faerden, 2022). Hence, this counseling, advocacy, and social justice focused research could help provide understandings of how mental health is experienced and could therefore inform interventions.

Thirdly, although The Gambia government has acknowledged mental health care as a priority, the framework for development of a viable system has not yet been implemented. The Gambia has developed a mental health policy 2021-2030, and also validated a mental health bill in 2019 to legislate mental health laws, but this has not yet been implemented or enacted. The extant mental health legislation is the Lunatic Act (1964). Findings from this study could, therefore, prove useful in informing mental health policy development and bringing The Gambia in line with obligations under the Convention on the Rights of Persons with Disabilities (2008), which it ratified.

Fourthly, mental health care interventions must be decolonized in The Gambia. This counseling and social justice research aims to reflect the cultural and social understandings of the research phenomena and facilitate closer understanding, empathy, and more interactions with people with mental illness. This study is well poised for this facilitation, through its inquiry into the social and cultural factors that impact mental wellbeing. Approaching the study with cultural humility, as coined by Tervalon and Murray-García (1998), behooves health practitioners to exercise restraint in the application of previously acquired cultural knowledge to avoid the perpetuation of the power imbalance in the therapeutic setting (Zhu et al., 2021). Thus, the aim

of this qualitative phenomenological study is to explore and understand the experience of mental health and the role of mental health stigma amongst adults in The Gambia.

Definition of Terms and Operationalized Constructs

Mental Health is defined as a state of optimal wellbeing that incorporates physical and mental health (WHO, 2014). Mental health stigma is a socially constructed identification that "a social group creates of a person or group of people based on some physical, behavioral, or social trait perceived as being divergent from group norms" (Goffman, 1963, p. 54). Additionally, adults are defined as persons aged 18 years or older. These are the terms most relevant to the central research question.

Assumptions and Limitations

It was assumed that this research could provide insight into mental health care in The Gambia. Furthermore, the study sought to understand how mental health stigma could, be a deterrent to service utilization. Foreseen limitations were that qualitative research can yield rich data but is not generalizable. Additionally, the small sample size of qualitative research presents a limitation, even though it carries the conversation forward regarding mental health in The Gambia. After the review of literature, design considerations are further discussed as part of Chapter III.

CHAPTER II: LITERATURE REVIEW

Introduction to the Literature Review

Ecological systems theory is the foundation of the study as it provides a valuable perspective of the framework created by Bronfenbrenner that allows one to conceptualize the current state of The Gambia. Furthermore, multicultural counseling considerations are incorporated in the study in an effort to avoid colonizing practices. Additionally, mental health help seeking is explored in literature from The Gambia, among other regions. Traditional [to The Gambia] healing practices are included along with an examination of mental health stigma in an effort to respect the beliefs of the culture while also finding opportunities to incorporate practices to promote mental health.

Theoretical Orientation

Ecological systems theory was selected for this study because of the systems approach that could be useful for consideration in The Gambia. Bronfenbrenner developed a theory of human development related to multiple systems at different levels that influence the lived experiences of the individual, or ecological systems theory (Crawford, 2020). Furthermore, human development results from five significant levels: microsystem, mesosystem, exosystem, macrosystem, and chronosystem. This theory lends special emphasis to the importance of cultures within the groups, and the patterns of exchange both within and among groups. This theory emphasizes reciprocal effects of these different systems on personality development, social and psychological outcomes (Crawford, 2020). Furthermore, ecological systems theory

provides a useful perspective in looking at access to mental health care and any associated stigma in the Gambia.

A phenomenological study was conducted to explore mental health stigma amongst law students (McCue, 2016). Ecological systems theory was utilized to explore the lived experience of the participants. Data were collected from eleven participants from across the US. In-depth interviews were used, and the data were analyzed through the lens of Bronfenbrenner's ecological systems theory. The research findings revealed that participants with mental illness encountered stigma, microaggressions, and other obstacles in their journey to becoming a lawyer. Moreover, because of the competitive nature of law school, students with mental illness feared speaking publicly about it. The stigma further distressed students when mental health questions were asked as part of the character and fitness application for entry into the profession. Additionally, ecological systemic dynamics, such as family, romantic partners, friends, other law students with mental illness, and faculty, were found to have influenced participant development (McCue, 2016). While this study took place with law students in the U.S., it gives an example of how ecological systems theory can inform research.

Another study considered the experience of African Americans who live in rural U.S. communities and have numerous health disparities rooted in race and rural geography (Scott & Wilson, 2011). This study used ecological theory as a lens for exploring the social determinants of health in rural U.S. communities. It included a blend of community-based approaches with ecological theory to identify potential social determinants of health among African Americans living in the rural Deep South, from their own perspectives. Using purposeful sampling, in-depth interviews were conducted with rural Deep South African Americans who represented a wide range of perspectives. The interview guides were structured around five ecological levels:

individual, relational, environmental, structural, and superstructural. A content analysis of the transcripts and field notes, using an "editing approach," identified potential social determinants of health. Triangulation and member checking were used to ensure the quality of the data and results. Possible determinants of health were identified at all five levels of the ecological framework. A lack of engagement with personal health and health promotion was a recurring theme at the *individual level*, and participants demonstrated minimal engagement with preventive health activities and education. A lack of social capital emerged at the *relational level*, with estrangement between the younger and elder generations and fractiousness among churches as potential sources. At the *environmental level*, the community-built environment was an area of concern in that it provided few opportunities for physical activity and access to healthy foods. The local job environment was also identified as a potential social determinant of health because of the strong associations between income and health. Cronyism and nepotism favoring Whites in access to jobs emerged at the *structural level*, including those where local policies and funding allocations were made, such as funding for the local health department. Participants perceived that the educational system was structured to discourage African Americans from university education, and at the *superstructural level*, potential social determinants were high rates of poverty and racism. Reports of persistent stress from poverty and racism were significant, and such stress creates health risks through physiologic pathways. Moreover, the social determinants of health that were identified have the potential to affect a variety of health behaviors and outcomes. The results demonstrated the value of the ecological approach for conducting rural community-based research and highlighted the need for quantitative studies in this area as well as the development of interventions that address multiple ecological levels (Scott & Wilson, 2011). This study influenced the selection of ecological systems theory as the basis for the

present study. Ecological systems theory helps examine the various systems at play when incorporating mental health services for a specific population. This theory is considered as part of the methodological design and discussion of the findings.

Review of Research Literature and Synthesis of the Research Findings

Multicultural Counseling

Counseling is an emerging field in The Gambia. As expounded by Akinsulure-Smith and Conteh (2018), a framework for multicultural counseling is imperative in the decolonization of mental health to recognize the causal explanatory beliefs and the essence of cultural identity. It is, thus, an important aspect of counseling to have in mind when analyzing stigma and mental health services in The Gambia.

One study sought to investigate the efficacy of cognitive processing therapy with female victims of sexual violence in the Democratic Republic of Congo (Bass et al., 2013), which is a low-income, conflict-affected country where sexual violence occurs frequently. The study sought to identify salient mental health problems of these sexual violence survivors. The setting for the study was a cluster of 16 villages that were grouped into blocks of two to four villages on the basis of proximity and shared language and were randomly assigned to provide cognitive processing therapy or individual support. Four hundred and ninety-four women were screened for eligibility, and 402 (93%) agreed to participate. Participants presented with clinically significant distress at baseline. According to the results, cognitive processing therapy, when compared with individual support alone, was effective in reducing post-traumatic stress disorder symptoms and combined depression and anxiety symptoms. Furthermore, it improved functioning in female survivors of sexual violence in the eastern Democratic Republic of Congo. Benefits of treatment were large and were maintained 6 months after treatment ended.

Participants who received therapy were significantly less likely to meet the criteria for probable depression or anxiety or probable post-traumatic stress disorder. The findings suggest that this evidence-based treatment can be appropriately implemented and effective even if there are challenges with illiteracy and ongoing conflict. Limitations of this treatment include baseline differences in symptom severity between study groups that may limit comparability. Interestingly, randomization was performed in blocks of two to four villages that were grouped on the basis of language and proximity. It was assumed that villages close to one another would be similar however, this assumption was not supported with the data. Future research could compare results with additional villages and participants (Bass et al., 2013).

A recent qualitative content analysis (QCA) explored the extent to which current evidence-based practices in counseling apply knowledge that is relevant to social justice counseling competencies, which stress the importance of applying such knowledge to practice (Clark et al., 2022). A QCA of 22 peer-reviewed counseling journals was conducted to examine how professional counselors measure social justice and advocacy outcomes of interventions. Full volumes of journals were reviewed by reading the abstracts, introductions, and method sections to identify articles that met inclusion criteria that was related to social justice issues and provided empirical outcome measures. The social justice issues of interest were intersecting identity factors, increased access, or issues related to minoritized and marginalized groups. A coding framework was then used to identify the year each article was published, journal name, constructs that were operationalized, sample population, data type, application to the field, and whether the study followed a systemic focus. The literature search yielded 35 articles that were coded using a QCA framework. The analysis revealed that of the 22 journals reviewed, 11 published articles that met the selection criteria. These were published between 2010 and 2020

and the number of publications increased somewhat each year, mostly due to articles on special issues in social justice. Overall, substantial diversity existed among the methodologies, assessment protocols, and topics that appeared in the reviewed studies. Marginalized communities were in nearly half of the articles (12), and social justice and advocacy issues were in 10 of the 35 articles. However, education and vocational issues appeared less often (five articles), and most were not systemic in nature (five articles). Notably, there was a lack of evaluation of systemic change over time across the articles reviewed. Between 2010 and 2020, the focus of multicultural-social justice outcome research in these journals was on the individual or microsystemic level, indicating that change in individuals was assessed through counseling interventions that were based on social justice principles. Overall, the content analysis indicated that the constructs assessed across the 35 outcome studies fit within five categories: (a) the needs of marginalized populations, (b) multicultural and social justice competence, (c) training and competence specific to working with LGBTQ populations, (d) self-concept and identity issues, and (e) educational and vocational issues. Based on the analysis, practitioners and scholars still lack empirically driven systemic and community-based interventions to meet the needs of marginalized communities. The study is limited with respect to the period studies and the QCA method. However, future research could design measurements and methods to fit a definition of social justice that meets the needs of individual members from marginalized communities (Clark et al., 2022). In conclusion, the importance of collaboration is emphasized among researchers, practitioners, and communities in designing community-based participatory studies and interventions that integrate a systemic focus and change into outcome research. Additionally, it is

important for future counseling researchers to incorporate social justice and advocacy in their interventions.

Mental Health Help Seeking

In a historical cross-sectional investigation of epilepsy in The Gambia, Coleman et al. (2002) sought to understand the lived experience of primary-level management of epilepsy in a rural setting. The study examined local access to the effective treatment of epilepsy, community awareness of and clarification on the use of preventative treatment, and integration with available local and traditional treatment modalities. In particular, the study investigated knowledge and beliefs about causation, treatment, health-seeking behavior, experience, socioeconomic circumstances, family history of epilepsy, and etiology. The sample was drawn from a cluster of 40 villages around Farafenni in the northern region of The Gambia, which lies on the Trans-Gambia highway that links Senegal and The Gambia in the north of Gambia. The sample, drawn from the household registration system, consisted of 3,223 people from the area population of 16,400. Approximately 25% of the sample presented with active or inactive epilepsy. Half the sample lived in poverty, on under US $150 annually, 95% of whom were Muslim. The data collection methods included semistructured interviews and group discussions conducted by trained and supervised fieldworkers. An interview protocol was utilized, and group discussions included community members and interest groups. The groups included teachers, religious leaders, traditional healers, and biomedical health care workers. The discussions that took place supplemented the interviews and established connections for the later dissemination of the results. The findings showed that the continuous treatment rate was less than 10%, with 90% not receiving continuous treatment. The choice of treatment was largely shaped by beliefs in an external spiritual cause of epilepsy. This was commonly expected to be curative but not

preventive. While treatment seldom led to the control of seizures, when control was achieved, the level of community acceptance of people with epilepsy did increase. Participants utilized both biomedical and local/traditional systems for treatment of their illness. Of the 69 participants that had active epilepsy, 42 (61%) indicated a preference for preventive biomedical treatment if it were available in the local community. Recommendations were that primary-level epilepsy care could be integrated into a bio-medical chronic disease program, such as a program for diabetes, asthma, and mental health (Coleman et al., 2002). Primary prevention could be achieved through early intervention in maternal and child health services.

A recent study examined the barriers to accessing mental health services in The Gambia (Barrow & Faerden, 2022). The study setting was in the Brikama region, situated west of The Gambia and 40 km from the capital city, with a population of 37.2% of the national population. The purpose of the study was to examine factors that deter access to mental health services in The Gambia. Participants were mental health service patients and their family members within the community under study. Participants were adults aged 18–70 years who were capable of giving informed consent. Furthermore, they were recruited through convenience and purposive sampling. In-depth and focus groups interviews were conducted with the participants. Two pretested interview protocols were used for data collection, and interviews were recorded and translated into English. Findings from the study reported a plurality of beliefs about the causes of mental illnesses among participants in the study. They indicated that families support patients financially to access treatment and therefore are the decision makers in when and how patients access treatment. It was noted that since family members' decisions are dependent on their perceived view of causes of mental illness, most people needing treatment do not access services at all or in a timely manner. Another reported deterrent factor was the cost of treatment as a

barrier to accessing services. It went on to say that the average annual salary is around US $1,000 after taxes, the cost of traditional healers is around US $187, and the cost of biomedical interventions for injections and medications is around US $9–12. This high cost and disparity in costs was cited as a cause of treatment divergence in other African countries. The study acknowledged the importance of social and political factors in mental health/illness and advocated for increased availability of bio-medical services for mental health care nationwide, easier access to such mental health services, and family and community education on the causes of mental illness to improve access to services (Barrow & Faerden, 2022). This was a recent study on access to treatment in The Gambia and provided background information on the status of mental health care service utilization and a perspective of mental health and stigma in The Gambia.

Tuazon et al. (2019) investigated the specific cultural and social characteristics that are related to mental health help-seeking behavior among Filipino Americans because such behavior is typically low in this population. This correlational, cross-sectional study examined how colonial mentality, ethnic identity, acculturation, and social support are related to mental health help-seeking attitudes. Colonial mentality was described as a form of internalized oppression that involves internalized ethnic or cultural inferiority and a tendency to prefer American values and behavior while rejecting cultural aspects that are Filipino. Ethnic identity, acculturation, and social support are variables that probably act independently and interact with colonial mentality to influence help-seeking behavior. The study sample consisted of 410 participants between the ages of 18 and 77 who self-identified as Filipino Americans. Data were collected through an online survey, utilizing a battery of questions related to colonial mentality, mental health, ethnic identity, and social support. The results indicated that colonial mentality was negatively related

to ethnic identity development (meaning internalizing and exploring Filipino ethnicity) and social support. Moreover, higher levels of colonial mentality were associated with negative mental health help-seeking attitudes above and beyond ethnic identity, acculturation, social support, and demographic variables. Furthermore, higher levels of Filipino cultural tendencies (i.e., less American acculturation) were related to lower levels of colonial mentality. Similarly, higher levels of ethnic identity achievement were related to lower levels of colonial mentality. Another unique finding was that higher levels of social support were significantly predictive of more positive mental health help-seeking attitudes for Filipino Americans. Filipino Americans may need the support of friends and family to pursue mental health services. Because Filipino Americans with colonial mentality tend to denigrate Filipino culture, a negative relationship exists between colonial mentality and social support. This finding may also address the isolating effect of colonial mentality, which can lead one to reject Filipino culture and discriminate against other Filipinos, which, in turn, can lead to isolation from other Filipinos. Clinical practice recommendations suggest that counselors need to develop an understanding of their cultural environment to successfully work with Filipino Americans and to increase the use of mental health services through the use of outreach strategies to help build relationships with Filipino communities. Limitations of the study are that it did not include groups such as gender or collect data across varying communities. Additionally, it was noted that the survey methodology involved a controlled environment. Furthermore, it was suggested that broader ethnographic and qualitative studies with other populations would serve to further understand how colonial

mentality, ethnic identity, and social support interact to influence mental health help-seeking behavior (Tuazon et al., 2019).

Another study examined the effectiveness, efficiency, and client dropout rates of mental health counselors providing services to adults experiencing mental disorders in an integrated health center (Ulupinar et al., 2021). A quasi-experimental, pre-post design was utilized. Participants were purposively sampled, referrals being from primary care staff and faculty. Twelve licensed mental health counselors with more than two years post-master's experience were identified in the integrated college health center. The setting for the study was an integrated college health center in the mid-Atlantic region of the US. Outcome questionnaires were used to assess session-by-session progress in client psychosocial functioning. Results showed that gender, theoretical orientation, and years of experience were not associated with therapeutic outcome in the sample. Furthermore, clients seen by the counselors showed a wide range of improvement rates, achieving clinically significant pre-post changes. Variability between mental health counselor efficiency and early client dropout rates were seen. A limitation was variance in the therapeutic outcome, which must not be attributed solely to counselor performance as factors such as experience of the primary care provider and role of the psychiatrist as a consultant and provider might be moderators. Other stated limitations were that apart from counselor theoretical orientation, not much information was disclosed about the counselor or data on client diagnoses, and client assignment was random (Ulupinar et al., 2021). It is useful to consider mental health counselors working within an integrated system of both physical and behavioral health and positive therapeutic outcomes using culturally sensitive and strengths-based orientation, which could be useful to socially disadvantaged people.

Traditional Healing Practices

When working with different populations, it is important to consider traditional healing practices because of the relevance to the population of focus for this dissertation. In a qualitative ethnography, Krah et al. (2018) sought to gain an understanding of traditional healing practices and beliefs in Ghana, West Africa. The study also aimed to explore the opportunities and challenges for integrating traditional with biomedical systems to improve outcomes in community health care and was conducted in two regions in Ghana. Data collection spanned over a 6-month period, with more than 20 in-depth interviews and focus group meetings conducted. Purposive and snowball sampling techniques were also used. The findings indicated that there are opportunities and challenges for integrating systems of care. Of great significance was the wide acceptance and popularity of traditional medicine, with 80% of Ghanaians relying on its methods for primary health care, translating to a ratio of 1:200 (one traditional healer to 200 people). The popularity of traditional healers is also based on the infrastructure of the field. The study reported that traditional healers were easily accessible to individuals seeking care and within the financial means of these individuals. Most importantly, the study revealed that an important factor for the sustainability of traditional medicine is that it is rooted in local customs and belief systems and that providers are trusted within communities. Some of the challenges that emerged from the data include a lack of understanding of traditional medicine, discrimination from the mainstream biomedical system, a lack of equipment and declining interest in healing as a profession, especially from young people, which has implications for the future of the field. The study concluded that given the popularity, accessibility, and ratio of use of traditional healers, integrating them into the national health care system should be a priority,

as integration would provide greater accessibility and improve outcomes for many people (Krah et al., 2018).

In another qualitative ethnography, Ae-Ngibise et al. (2010) explored the factors motivating the popularity and wide use of traditional and faith healers in the delivery of mental health care in Ghana. The study also sought to understand factors supporting or inhibiting collaboration between traditional/faith-based healing and public mental health services in Ghana. Eighty-one semistructured interviews were conducted along with seven focus group discussions with 120 key stakeholders who were drawn from five of the 10 regions in Ghana. The results revealed that traditional and faith healers were favorable for reasons such as the cultural perceptions of mental disorders and the psychosocial support afforded by such healers. Furthermore, availability, accessibility, and affordability were identified. Some of the identified barriers hindering collaboration were human rights and safety concerns, skepticism around the effectiveness of "conventional" treatments, and traditional healer solidarity. Recommendations were that mutual respect and bidirectional conversations were necessary for successful collaboration and greater understanding (Ae-Ngibise et al., 2010). This mutual respect and collaboration are helpful for planning the design of the current study.

A historical study on alternative mental health services analyzed the role of the Church and clergy in the collaboration and provision of mental health services (Blank et al., 2002). This qualitative cross-sectional study aimed to investigate the needs and preferences of rural religious leaders in forming collaborative relationships with mental health professionals. The setting for this exploratory qualitative study was a cluster of 12 southern states in select Christian churches in rural Central Appalachian communities. The White churches were drawn from the same geographic areas and zip codes as the Black churches. A computer-assisted telephone interview

system and a survey instrument that had been developed and tested were used to collect data. Participants came from 269 churches, 181 of which were predominantly Black and 88 of which were predominantly White. There were 95 churches in urban areas, while 174 were in rural areas. The findings showed that Black churches were providing many more services than White churches. This finding held true even when comparing urban and rural churches. However, there were few links between churches and formal provider system (Blank et al., 2002).

A more recent qualitative investigation which looked at the gap between religion and helping professions was aiming to help improve rural mental health. Interviews were conducted with clergy in the region to explore needs and preferences. The findings suggested that clergy were aware of mental health needs and had a desire to collaborate. Moreover, clergy mentioned some existing relationships with mental health providers and indicated there may be mistrust between the two fields. However it was also identified that it was a professional responsibility for the two fields to collaborate (Smith et al., 2018). This is further illustrating that in many populations, a connection through churches might help bridge a gap for mental health services.

In a cross-sectional study, Ndetei (2013) sought to correlate the types of mental illnesses treated by traditional healers, investigate the validity of the diagnosis that traditional healers made, and document the treatment modalities used by traditional healers in the treatment of mental health/illness. The research sites included three informal settlements in Kibera, Kawangwara, and Kangemi, which were chosen for the rich multicultural and multiethnic background of the population. The samples were representative of all ethnic groups in Kenya. The participants were drawn from traditional healers and patients who resided in the three locations. The methodology used in-depth interviews and focus group meetings. Traditional healers participated in both in-depth professionals but interviews and focus groups, whereas the

other participants engaged only in in-depth interviews. The findings indicated that traditional healers recognized specific mental disorders, with psychosis being the most easily identified. Furthermore, they indicated that community members consult with traditional healers for mental disorders and that these practitioners successfully recognize some mental disorders, especially those involving psychosis. However, the diagnostic skills of these practitioners are limited, particularly in regard to common mental disorders that are less extreme. Thus, the findings suggest a need to educate traditional healers in identifying various types of mental disorders and making appropriated referrals to other practitioners when patients fail to respond to traditional treatment (Ndetei, 2013). Some additional important observations are as follows. First, traditional healers treat a large clientele in this region, so they must not be ignored. Instead, it is more productive to engage them constructively in advancing awareness and competencies regarding understanding and identifying mental illness and providing referrals when needed. Second, this article notes that traditional healers offer counseling for mental illness, although resources can be limited (Ndetei, 2013). However, counseling and the associated personal contact helps patients feel appreciated. Finally, traditional healers might be willing to collaborate with other healers and health services, so efforts to create channels of communication and referral support are likely to be embraced and helpful.

Mental Health Stigma

Cultural differences in the stigma of mental illness have widely been the focus of this study (Krendl & Pescosolido, 2020). It was useful to consider the possibility that cultural differences in attributions about the etiology of mental illness may have contributed to differences in stigma (prejudice and discrimination) between four Eastern and seven Western countries. The sample consisted of 11,004 noninstitutionalized adults over the age of 18, drawn

from representative samples of adults in 16 countries (at least one country on each inhabited continent). The study used quantitative methodology and data from the Stigma in Global Context – Mental Health Study, a cross-national study that was developed and funded by the National Institutes of Health. Face-to-face interviews were conducted by trained interviewers, which included demographic variables and 75 questions about mental health and illness. The instrument was modified to account for country differences, such as the presence of cultural idioms for illness. According to the results, individuals in Eastern countries reported more mental illness stigma of all types—both across all six core aspects of prejudice and for discriminatory potential—than individuals from Western countries. Moreover, individuals in Eastern countries ascribed more moral attributions to mental illness, which played a critical role in increasing discriminatory potential. Data revealed an unexpected cross-national differential in the effects of mental illness type. For instance, in Eastern (compared with Western) countries, higher stigma—both prejudice and discrimination potential—toward individuals with depression was particularly pronounced. Additionally, the nature and magnitude of cultural differences in mental illness stigma was influenced by target race/ethnicity. More individuals in Western countries (compared with Eastern) endorsed higher stigma (prejudice and discriminatory potential) and made more moral attributions when the target was a minority (as compared with a majority) group member. While analyses in Eastern countries revealed a similar pattern for schizophrenia, the results for depression were unexpected. That is, more individuals in Eastern countries endorsed stigma toward majority, in-group members when compared with minority, out-group members. A limitation was that it was not possible to delve deeper into any one country's cultural idioms.

Other factors, such as global economic status contributions, cannot be ruled out and should be further investigated (Krendl & Pescosolido, 2020).

A community-based, cross-sectional study focused on beliefs regarding mental illness in different populations in Al-Ahsa, Saudi Arabia (Firdos et al., 2021). Eight hundred and forty participants aged 18–75 completed an online demographic questionnaire using the beliefs toward mental illness scale, which is a 21-item survey that is rated on a 6-point Likert-type scale that measures negative stereotypes surrounding mental illness, such as dangerous, socially dysfunctional, incurable, and embarrassing. The results indicated that participants who were older than 30 years had more negative views regarding people with mental illness, including beliefs that such disorders are dysfunctional, embarrassing, and incurable. Furthermore, unemployed people reported more negative views toward mental illness than students or working people, and white-collar professionals expressed more negative views than health care professionals. Within families, older generations (grandparents) expressed more negative views than other family members. Overall, the findings suggest that participants' lack of knowledge and understanding, religious beliefs, and subjective views regarding mental illness created obstacles to awareness and that they facilitate mental health stigma. Future research could examine anti-stigma interventions to increase awareness and understanding regarding individuals with mental illness (Firdos et al., 2021).

Another study on mental health stigma was conducted by Alamer et al. (2021). The study setting was also in Al-Ahsa in Saudi Arabia and investigated the stigmatization of people with mental illness and the dehumanizing effects it has on people. The study noted that individuals with mental illness have often been associated with dangerousness, unpredictability, and the inability to communicate with others, and they are often blamed for their illness. This

cross-sectional study assessed the mental illness stigma among members of the Al-Ahsa region. Participants aged 18–65 completed the community attitudes toward mental illness scale, with four subscales (authoritarianism, benevolence, social restrictiveness, and community mental health ideology), each with 10 questions that were rated on a 5-point Likert-type scale. For the subscales, authoritarianism is related to whether people with mental illness are inferior and in need of supervision. The benevolence subscale is related to kindness toward the mentally ill. The social restrictiveness subscale assesses whether individuals with mental illness are believed to be a source of danger to society, and the community mental health ideology includes people with mental illness in the community. Seven hundred and fifty-eight participants completed the study. The results indicated a positive relationship between age and stigma scores. Furthermore, health care professionals showed lower levels of stigma, as did people who were multilingual. Overall, most of the population (91.96%) had a low to medium-low stigma score. Stigma scores were most influenced by age, career, number of spoken languages, mental illness diagnosis, and knowing someone with a mental illness. It was suggested that mental health stigma has significant consequences for those who are affected, including preventing people with mental health issues from seeking help, social isolation, and suicidal ideation. Campaigns targeted at mental health stigma were encouraged (Alamer et al., 2021).

Mental illness stigma in the context of public stigma was also the subject of a recent study in India (Bharti et al., 2021). The study participants were aged 18–60, able to read English, and willing to complete the study. Participants were excluded if they had a history of mental illness or cognitive deficits or refused to give informed consent. Nonprobability snowball sampling was utilized to conduct an online survey that included basic sociodemographic data and the Reported and Intended Behaviour Scale (RIBS), which is an 8-item survey that measures

people's mental health stigma-related behavior toward persons with mental illness in various life domains: living with, working with, living nearby, and continuing a relationship with a close friend with a mental health problem. Descriptive and inferential statistics were utilized to determine the relationship between reported past behavior and intended future behavior, including the Mann–Whitney test and Kruskal–Wallis test for ordinal data. Six hundred and eighty-four responses were eligible for the data analysis. The general results indicated that most participants did not live with, work with, or live near a person with mental illness or have a close friend with a mental illness (range = 66.4%–79.8%), and many of the participants responded with "don't know." However, most responded that they would continue a relationship with a friend with a mental illness (strongly agree = 34.5%). Significant differences ($p < .05$) emerged with respect to intended behavior. For example, health care workers and those who had interacted previously with a mentally ill person were more willing to interact with individuals with a mental illness. Moreover, most people did not intentionally stigmatize the mentally ill, and exposure to individuals with mental health issues was related to more willingness to interact with people who have such issues. The study, however, recommended the education and outreach initiatives to increase awareness of mental health issues (Bharti et al., 2021).

Another cross-sectional community study was carried out in Worabe Town, Ethiopia (Bedaso et al., 2016). Data were gathered through interviews with 435 adults who completed the Community Attitudes toward the Mentally Ill tool to assess their attitudes toward people with mental illness. Multiple linear regression analysis was used to find predictors of the Community Attitudes toward the Mentally Ill tool scores. Farmers had the highest mean scores on the social restrictiveness subscale, indicating that they hold more socially restrictive views and have less humanistic attitudes toward those suffering from mental illness. According to the findings, those

with more knowledge of or exposure to mental health issues scored significantly lower on the social restrictiveness subscale and were less authoritarian toward mentally ill people. Participants with a higher level of education (college or university) reported more social constraints. Respondents over the age of 48 scored significantly lower on the community mental health subscale. Overall, the findings showed that residents of Worabe Town had a high level of social restrictiveness but a lower level of authoritarianism toward those with mental illnesses. The presence of negative attitudes toward the mentally ill across all four subscales suggests that strategies are needed for reducing negative mental illness stigma in Worabe Town. Future research could investigate other areas to see if the results are consistent (Bedaso et al., 2016).

Another phenomenological study analyzed participants in the Lahu community's lived experience of mental health service utilization (Keovilay-See, 2016). The study examined participant beliefs about mental health treatment and services for the community. A qualitative phenomenological design was utilized, and a sample of five Lahu individuals over the age of 18 were involved in this study. The materials consisted of an English version and a Lahu version of the demographic questionnaire and a phenomenological question that was designed to elicit experience. The results suggested that there were barriers to seeking mental health services in the Lahu community. Participants reported a preference for seeking support or assistance for emotional needs from family or friends (Keovilay-See, 2016). Future research could further explore barriers to seeking mental health services in diverse communities.

One qualitative study examined individual factors that influence experiences of stigma and discrimination toward people with mental illness in Ghana (Gyamfi et al., 2018). The sample was purposive and restricted to participants who were already attending mental health services and who were able to articulate symptoms and answer open-ended questions. Although positing

that stigma and discrimination of people with mental health are universal concepts, what might differ are specific types of discriminatory behaviors and legislated policies that prevent overt discrimination. The findings expressed a need for further research to establish whether individual experiences and perceptions of stigma can be attributed to individual factors alone. A limitation of this study was the nongeneralizability of the findings, which should be viewed, according to the study, in the context of Ghana (Gyamfi et al., 2018). This study helps provide perspective for examining mental health and stigma in The Gambia because it looked at another African nation.

One qualitative study sought to assess the impact of cultural beliefs on mental health among selected communities in western Kenya (Amunga, 2020). The study utilized a descriptive survey design to present data in the perception of the participants. A purposive sampling technique was utilized to select the participants for focus group discussions, a document review, and an interview schedule. The findings suggested ethics help maintain law and order by adhering to given rules and regulations. These rules and regulations come in the form of taboos, which contain the "dos and don'ts" of a given society. The study concluded that mental illness is attributed to a breach of rules and ethical principles that govern behavior in the given community and that cultural beliefs have both a negative and positive impact on mental health. This implies that most Africans are subjected to a choice between the good that should be done and the evil that should be avoided. Breaking some of these rules may cause a person or family member to develop a mental illness. Anxiety and trauma from broken taboos and norms can lead to mental illness, but the performance of rituals can create peace, psychological contentment, and mental wellbeing. The African way of dealing with mental illness has a positive side, which acts as a check and balance on people's morals, behavior, and conduct. Therefore, such culturally informed ways should be preserved and may be modified to assist in dealing with the challenges

of mental illness. Recommendations were that cultural beliefs that lead to mental wellbeing should also be preserved. This study is useful for increasing knowledge on the research literature on alternative forms of belief and conceptualization of mental health (Amunga, 2020).

Rationale

The globalization of mental health has provided opportunities for the decolonizing of mental health in The Gambia. Although mental health care is at an infantile state, there is hope that a viable mental health system can be achieved to serve the population's needs. The literature review shows that a combination of interventions is required to address the social and cultural factors impacting mental health. This study is relevant because it examines the experience of Gambian adults in the community. Furthermore, the social cultural norms that instigate mental health stigma were examined from the lens of community, and lessons from these experiences could provide a perspective that is culturally nuanced. Perhaps this research could in time help to reduce the wide treatment gap. The findings could aid research in counseling and professional development, effective interventions, and modalities to increase access to services and reduce stigma and discrimination. This could help The Gambia meet their targets under the WHO Comprehensive Mental Health Gap Action Plan 2013–2030, which include a target of increasing service coverage for mental illnesses by 2030 (WHO, 2012). Moreover, generating information regarding effective interventions to reduce stigma and discrimination has become an important mental health priority worldwide (Semrau et al., 2015). Therefore, more information needs to be collected regarding the lived experience of mental health stigma amongst adults in The Gambia.

CHAPTER III: METHOD

Research Questions

The first research question seeks to address the lived experience of adults seeking mental health treatment in The Gambia. The second research question asks, What is the lived experience of mental health stigma amongst adults in The Gambia?

Study Design

The philosophical ideals underpinning this study are grounded in phenomenology and social constructivism and assume that there are no absolute realities. Rather, realities are constructed through subjective experience shaped by environment and social interactions (Moustakas, 1994). A phenomenological approach recognizes the subjectivity of participants with their own interpretation of truth, not what is attributed to or imposed on them by the researcher (Moustakas, 1994). Therefore, the following steps took place to gather data qualitatively, after institutional review board approval was granted.

Study Context

No intervention was undertaken as this was a qualitative study that focused on the lived experience of participants. Rather, data collection consisted of demographic questions via Survey Monkey and a scheduled one-on-one Zoom interview. This assisted with ease of participation and the anonymity of the participants.

Participants

The population of focus included adults from The Gambia who are over the age of 18. Additionally, the informed consent, demographic questions and interview process required an eighth-grade level of English. Participants were a sample of convenience and were recruited through a variety of means (e.g., email and social media). Furthermore, snowball sampling was

utilized, which aims ideally for 8–14 participants, or to the point of saturation, which is standard for qualitative research.

Data Sources

Demographic data were collected via Survey Monkey. Demographic questions included the following: Do you live in The Gambia? Which age range do you fit into? What is your gender? What is your marital status? What is your level of education? How many people live in your household? What best describes your religious or spiritual beliefs? Which dates and times would you be available for a 30-minute Zoom interview regarding mental health in The Gambia?

Additionally, a semistructured interview was conducted via Zoom with each participant and was audio recorded through Zoom and saved to the researcher's password-protected computer. The Zoom interview questions included the following: What do you know about mental health or mental illness in The Gambia? How do you think people feel about mental health/illness in The Gambia? What is your understanding of how people see mental health? What is the meaning of mental health in your language/cultural group? How might people get help for their mental health issues in The Gambia? What is your experience in seeking local and traditional healing for mental health? What is your opinion about why mental health services might be underutilized in The Gambia?

Data Collection

In order to collect data, a recruitment message was shared which included a link for Survey Monkey. On Survey Monkey, interested individuals reviewed the informed consent form and demographic questions and had the option to list times they would be available for a Zoom interview. Then, the researcher connected with them via email to confirm the Zoom interview time. During the Zoom interview, the researcher followed a semistructured script with questions.

First, participants were reminded that the interview is audio recorded. Next, the purpose of the study was provided, followed by a set of open-ended questions. Upon conclusion of the interview, participants were thanked for their time. Audio was transcribed, and any identifying information was removed. The audio recordings were stored on a password-protected computer for the duration of the study.

Data Analysis

Demographic data were evaluated using JASP, a statistical analysis program that calculates the frequencies and percentages of participant information. The qualitative data were then analyzed after the interviews were transcribed. In phenomenological studies, researchers are expected to bracket feelings, assumptions, biases, and judgments about the phenomenon under study to have the true essence and a deeper understanding of the lived experience of the participant (Moustakas, 1994). Bracketing allows researchers to process the identification of the research questions, data collection, data analysis, and understanding of the essence of the lived experience (Creswell, 1998). Furthermore, bracketing is used as a practice to enhance trustworthiness. Data collected from the interviews was analyzed using a verbatim transcription of data. First, a team of three analysts, including the principal researcher, developed an understanding of the data through reading and note taking. Data was then coded, and a matrix was utilized to chart identified commonalities across analysts. The primary researcher also collaborated with available participants to review the data and how it was being interpreted in an effort to achieve triangulation and saturation and to help provide some checks and balances.

Ethical Considerations

Throughout the course of study, the American Counseling Association Code of Ethics was utilized (ACA, 2014). First, it is important to maintain confidentiality in research (ACA,

2014; G.1.b.). Therefore, only email addresses were collected through the data collection process and not names or other identifying information. The email addresses were only accessible to the researcher and were removed from any materials provided to the research team during data analysis (ACA, 2014; G.4.d.). Informed consent was obtained from all participants, who were given an accurate explanation of the research purpose and all procedures that were applied, including the Zoom medium and the research target sample. Potential risks and benefits as well as limitations to confidentiality and target audience for dissemination of the study were considered throughout the study design process. Participants were also informed that they may withdraw at any time if they so choose (ACA, 2014; G.2.a).

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mental health? What is your opinion about why mental health services might be underutilized in The Gambia?

CHAPTER IV: RESULTS

Data were collected from 17 participants who were, at the time of the study, living in The Gambia. For the results, demographic information is presented in addition to the factual reporting of the results which includes direct quotes from the participants.

Demographic Information

When asked a control question to ensure each participant met the criteria, 100% of the participants indicated that they live in The Gambia. Participant age ranges included one person who was 18–19 years old, three participants who were 20–29, 10 participants who were 30–39, one participant who was 40–49, one participant who was 50–59, and one participant who was 60–69. The gender of participants was split 70% male and 30% female. The marital status of the participants was 65% married and 35% single. Regarding level of education, five participants had a high school degree or equivalent, seven attended college but did not have a degree, two had an associate degree, and three had a graduate degree. When asked how many people live in their household, three participants indicated 3–4 people, four indicated 5–6 people, four indicated 7–8 people, four indicated 9–10 people, and two participants indicated 11 or more people living in their household. When asked about religious or spiritual beliefs, 88% of participants indicated that they were Muslim, and 12% indicated that they were Protestant Christian.

Factual Reporting of the Project Results

A team approach with three analysts was utilized for the data analysis. All three researchers identified as female, with ages ranging from 33 to 52. Two researchers identified as Black and African, while another identified as White and of European descent. As part of the bracketing process, it was identified that two researchers had related lived experience, while one

had methodological experience. Potential biases and positionality included all three researchers having an interest in the mental health of the population of focus, being concerned about stigma, and having an awareness of the impact of colonization. Five themes were identified as part of the data analysis, as shown in Table 1.

Table 1

Themes

Themes	Subthemes
Theme 1: Social and cultural conceptualizations of mental health/mental illness	Cultural constructions/attributions about mental health/illness Labels attached to mental health/illness
Theme 2: Sociocultural determinants of mental health/mental illness	Poverty Substance use Migration/failed migration
Theme 3: Mental health care interventions/bio-psycho-social interventions	Biomedical Multicultural counseling Local and traditional/spiritual/faith-based
Theme 4: Barriers to mental health care	Mental health/stigma labels/social exclusion Mental health literacy/lack of awareness Lack of access to services/inadequate services/affordability Lack of training/counselor education
Theme 5: Legal framework to support mental health change	Mental health policy Mental health laws Need for facilities/de-centralization Increase standards of facilities

Theme 1: Social and Cultural Conceptualizations of Mental Health/Mental Illness

Constructions of mental health and mental illness differ across cultures and communities. For example, one participant stated,

> Mental health is very much linked to our cultural beliefs and understanding of mental health, because we have certain norms, certain beliefs, certain ways of doing things that

> very much align with the ways mental health is treated and even the people's own understanding and conceptualization of mental health.

Another participant shared,

> I want to clarify something, and I can see that the question itself has made a distinction between mental health and mental illness. Here in The Gambia, there is not a distinction between the two. I mean, as long as it's anything to do with the mind and there is not complete wellbeing there, it's really considered as one thing, mental illness.

Another participant stated,

> I think in The Gambia, most of the people they still associate mental health issues with either witchcraft or with something of a supernatural power. Or being charmed by [an] evil spell or somebody who hates you retaliating. These are some of the local concepts. A punishment from God also. So that's why the first treatment that they resort to is the marabouts who are traditional healers.

Another participant said, "those ones are the ones that are mentally imbalanced. Like one of their senses is lacking." In describing their understanding of the phenomenon, another participant added, "What I know about mental health in The Gambia is like, someone that has lost their common sense, five common sense." One participant gave a description of people with mental health/mental illness, stating, "Those are the people that are in the streets that are mad, throwing their clothes or walking under the sun." Another participant stated, "my understanding of the whole thing from people's perspective is mental illness is not God's doing. It's not God's doing."

Another area of emphasis included social and cultural conceptualizations of mental health/mental illness as attributions and shared beliefs about some of the causes of the research phenomenon. For example, one participant shared that "Others tend to say that they steal from people; that is why they are taken to the marabout and the marabout put a charm on them." Another participant said, "Some people feel like they are possessed by demon[s] or things like

that, you know. The public will run away from them because it's believed that these people are cursed or evil spell from the Devil or wicked spirit." Another participant also noted,

> Some people even go to the extent of chasing them away because they think, when people are near the mentally affected, that they themselves might also contract the mental illness. Those are traditional beliefs and myth[s] that people have which are also stigmatizing mental health people.

A participant shared that mental health was also seen as something that could be inflicted, hence, "Many of them think that the person [was] taken to the marabout to be mad." Another participant said,

> To some people, it's just a problem that is prompted by a jinn. It's more common here that people see it as something that is being inflicted from the spiritual world. When I say the spiritual world, it's the jinn or Satan that the people believe to possess people.

One participant said,

> Mysticism, yeah. Because actually, on a large scale, many people believe mental problem[s are] caused by something that is unseen. So, because they don't understand it, they have a concept, a prevalent belief system in the society, a belief that when you touch them the thing that is affecting him or her will fight you.

The participant further shared,

> I've seen that. It's like when you start helping the person, for example, even mere escorting the person to a healer, like for example to the hospital or even the traditional healer, you will start seeing strange things happening to you. For example, you might have an accident where you can't even understand how the accident [came] about. Recently, I heard from somebody who said he took his brother to a healer, and he was coming from around a village maybe some 35 or 47 kilometers away from the capital, and he just fell off the motorcycle like that. He was explaining this to me personally. Naturally, he is attributing it to just mere escorting the patient just to treatment.

Participants also claimed that disease is a cause of mental health/mental illness. For instance, one participant said, "Epilepsy is also believed to be part of the problem. Yeah, a

gradual process that can send somebody crazy." Another participant stated, "Some believe, for example, that cerebral malaria causes [mental illness]."

One participant explained, in reference to people with mental health issues, "People fear them thinking that they might attack them." Another participant stated, "The moment you see a mentally ill person you start running away from them because you don't feel safe being with them." One participant stated, "Well, I think it's the way they look and the way they talk to people. It's like they are violent. So, people are scared of them."

Participants also associated mental health with suffering. For example, one participant explained that "In The Gambia mental health is something that is not easily curable. It's not easy for people that have mental health to recover from the mental illness in [The] Gambia." Another participant also spoke of the suffering related to mental illness, stating, "Since I was a child to now over 40 years old, people that I know that had mental illness are still suffering from it." Another participant said, "Traditionally, you cannot be healed when you have mental health [issues]. You cannot be healed by traditional means. Something is lacking in your brain, or your system is lacking something, so a marabout cannot heal you."

Theme 2: Sociocultural Determinants of Mental Health/Mental Illness

One participant shared,

> To me mental health issues are directly from society. It is like society is the first enabler of mental health, or mental ill health I will call it. Because society plays a crucial role in helping a person, to prevent him or her from falling into that condition."

Another participant stated that

> the social dimension is so much. Personally, from my own point of view, I think mental illness, if it's not caused by society, then society will exacerbate it. It will make you

> worse because once they start labeling you, calling you names like Duff, Nyamatour, like, he is mad, this guy is mad.

In relation to poverty, a participant said,

> Actually, nowadays, when you don't have money, people call you as an outcast. Somebody who is being afflicted with jinn. Society now believes that you have to have money in order to be a human being. Once you don't have money, which means you have mental problem.

A participant stated,

> I think personal experience [has] shown that mental ill health, like, any other ill health owes its cause or infliction and cures and solutions to society. And because of society's attachment to money, you don't have money, that is, if you are poor or if poverty is your luck, then society never consider[s] you as somebody who is mentally healthy. And what will come after is stigma. They also see mental health from poverty causes. It's a social cause, and people risk their life to get [a] better future [rather] than die in the poverty.

Another participant said,

> In fact, 79 of the patients at Tanka Tanka, when I asked them, they said their condition is directly related to poverty. They traveled to look for money in Europe or America. And, when deported, it's like they have no purpose living any longer. They said that their parents sold all compound or cattle; they had to send them through back way to Europe. If they don't reach or they are deported, they have nothing left.

One of the participants shared that "Poverty, I think is, well, I don't want to say it's the number one reason, because we don't know. But it adds to frustration that also adds to people having anxiety disorders and stuff like that." Another participant stated,

> Most of our parents, only when they wake up early in the morning, they go to work; they won't come back. So, they will not have time to sit with their children to counsel them and tell them these are the good ones, and these are the bad ones. That affects the society very well.

Another participant said, "The stigma from poverty is creating a lot of mental health issues, you know, among members of the society. Yeah. I think poverty is, nowadays, I call poverty as the main enabler." One participant stated, "the majority of members of the society feels that once you are poor, then there's something happening to you. Some may call it bewitching, like the

guy in bewitched, that is why he is poor. The person cannot have opportunity." Another participant shared, "In fact to be possessed doesn't always mean you have to be mad. But even lack of access to opportunity here, many would believe the person is possessed." One participant also stated, "So poverty, nowadays, is the driving force of mental problems, especially the trend of going through backway, you know, reinforced this view." Another participant shared,

> Oftentimes, you see people looking for work when you are keeping two wives, three wives just because they cannot afford, for example, fish money for their basic needs of livelihood. So, poverty is a big player in mental health or mental ill health.

Another subtheme is stigma, discrimination, social isolation, and labeling. For example, one participant stated, "It's like when people feel that one is mad, they will not eat with the person. They will not sit with the person in one place. So, total isolation and discrimination." Another participant stated, "Once people feel that you are not in right sense, they avoid you totally. They just cease interacting with you. I see this day in, day out." One participant also shared, "whenever there is talk of somebody being mentally disturbed, the first thing people do is try to stigmatize the person. Yeah, that's stigma, that will start even from the immediate family members, most of the time." Another participant described the experience associated with mental health/illness stigma as,

> In general, in The Gambia, here, people tend to marginalize them. They tend to isolate them. They don't allow them to decide anything for themselves. They are not included, because even if you include them, what they say is not making any sense.

One participant shared,

> We are all equal. So, whether you lose one of your senses or not, people should treat you as a normal human being. So, when you call that individual a name, he tend[s] to see

> himself as stigmatized in society. So, he tends to be not included or is not part of the society.

Another participant stated,

> They feel bad because they are not treated well. Some of them are bullied because they are not feeling okay, or they don't reason like how people reason in The Gambia. They are isolated from people and many of them are bullied. They make them feel like they are not people, they are not the same as people or the same level with people.

The participant further shared, "the next thing is they will just disassociate themselves with the person even if it's a family member." One participant explained that "The stigma around mental health is very high. This is one of the reasons why even with the awareness creation that we are doing at the moment, many people are still reluctant to come out to local services." This participant also shared, "There's this common statement that we say, (Duff due musa wayrl) a crazy person can never be well again" or "if you have any mental problem, you will never recover from it." This statement alone is very powerful to stigmatize an individual. Another participant also stated,

> When you look at it, many families, or individuals, may not want to associate themselves with somebody who is going to a mental health facility. Instead of taking you for services, they might even lock you in the house because of stigma that can follow the family. So, all those things can be associated to stigma.

A participant noted,

> Of course. It is affecting a lot of people going for services, even the ones that already know that these services are available. But because of this whole condition associated to mental illness even when someone has it, they will rather hide it until things get worse.

One participant further shared,

> The people that have attempted to commit suicide, or the people that have committed suicide, what are some of the things associated with that? Because with suicide, no individual would just end their life just like that and commit suicide. If you look at it, most individuals fail to get support. It could be indirectly, but the people around him or her might not be aware that this individual is suffering, and that the person need[s] help.

> And when they start ridiculing or stigmatizing the individual, the only thing that they think of is to commit suicide.

Another subtheme relates to labels and names that are used to describe and refer to people with mental health/illness. The meaning of mental health/illness in some of the participants' language and cultural groups were shared by participants. For example, one participant shared, "Yes we call them Nymatou in Mandinka. In Wolof, they call them duff; in Jola, also, they call them Ahnymatou. These mean crazy or mad person." Another participant said, "If you call somebody who is not mad, you call them kangardo, they will not like that. You are abusing them." One participant stated, "they are lacking some of the five common senses." Another participant added, "They lack self-esteem. That's what they lack. Self-esteem and common sense." Another participant said, "In our language, people with mental health, we call them duff. Duff means the person is crazy. So just let them be as they are." One participant shared, "The word duff, come to think about it, it's negative. It's negative because it's not [the] kind of word that is encouraging, you know, or sympathizing with someone with mental illness." Another participant shared the same view, "In my traditional language, which is Fula, we call them kangador, like crazy people, people that are not in [the] right senses or mind." Another participant also said, "In my own culture, when somebody is called kangngado, it is like it's really negative. It doesn't tell well about you, you know."

Another subtheme is substance use. One participant explained that "mental health or illnesses have some interesting classifications, ranging from drug abuse related, absent mindedness either by drug addiction or affliction by black magic." Another participant said,

> People feel drugs, especially marijuana, is one of those things that's part and parcel of mental disorders or issues relating to the mental disorder, because there is some disorder

> in the brain due to taking drugs or taking something that you should not take that affects the brain.

Another subtheme is migration/failed migration. Participants spoke of the issues around this topic. One participant stated, “I call it the great migration. The great human migration.” The participant went on to explain,

> Many young people here today who look at what’s going on in other nations, who feel like they’re not getting what they deserve in their nations, sometimes want to leave this nation and go abroad, perhaps for studying and to greener pastures, or perhaps hopefully, go on abroad so they can be able to work and send money back home to their family.

Another participant shared,

> Sometimes people see their friends, who are perhaps lucky enough to have that opportunity, leave them behind. And to some people, this can bring about some stress, major stress. They see their friends are finally sending money back home, taking care of their families. And here they sit and can’t do the same. Some people actually do go insane just because of this. This is mentally straining to some people. They can’t handle it.

One participant also shared that “We have a saying over here. We say, ‘Nerves.’ We say, ‘This boy is nerves.’ What that means is that this person wants to go abroad so bad that they’re starting to go crazy.” Another participant shared,

> They try to smuggle themselves to different nations, maybe traveling to the Sahara Desert, to Mauritania, just trying to find their way to Spain. And from Spain, perhaps they will find their way to another country in Europe or something like that.

One participant also stated,

> It’s a dangerous journey because some people get killed trying to make this journey. And some people who make it will find that once they make it across those borders illegally, they are locked up [in] a jail or detention camp for many years and are sent back as deportees.

Another participant associated deportation with mental health/mental illness, saying,

> The trauma due to the deportations of people varies. Yeah, for some people, they cannot cope with the feeling when they are deported. It is like to them they’re just deprived of

> their life or livelihood. And it's like, when they come down here, they'll be feeling lonely and feeling sad, feeling, you know, feeling not a part of the society.

One participant shared, "What aggravates the problem of these people is mostly when they are deported back to their native land. There is this stigma that goes with it when they come back." One participant called it "psychological effects as a result of deportations." Another participant noted, "These are conditions that come from frustrations as a result of bitter feelings from deportations, for example, from Europe and America." One participant also stated,

> People see them as failures. They went to search for money and opportunity but ended up being sent back with nothing. And here society tends to look at them very negatively because they [missed] the chance to develop in life and now have to stay in this poverty life.

Theme 3: Mental Health Care Interventions/Bio-Psycho-Social Interventions

A major theme addressed mental health care pathways in The Gambia. Participants were asked, *How might people seek mental health treatment in The Gambia?* The following subthemes captured how participants responded.

One of the subthemes focuses on biomedical services. One participant described this treatment pathway when he said, "Mental health in The Gambia is more chemotropic. When I say chemotropic, I mean the use of drugs (medication). They look at every mental illness or issue to be treated only with the use of drugs." This participant further stated,

> When you look at it, it's beyond that, because some people might be having certain challenges and they don't need [drugs] medication. They may need someone to talk

> to…maybe they may go into some social issues, and they don't know how to resolve those things that [have] led to their depression or isolation.

Another participant explained that "the biomedical service is being rendered in three components. There is the outpatient basis, the inpatient, and then the community mental health team." Another participant explained,

> Of recent, what we have started developing is to incorporate mental health services into the primary health service, that is the existing health services to train non-mental health specialists to be able to diagnose and make simple interventions for common mental health problems.

Another participant stated, "Normally, lots of family people here cannot afford to take their mental illness people to the medical sector for them to be treated, so they lack support." One participant also shared, "the medical side, they only give them medication to tame them, if the person is violent, but not actually to treat the person." Another participant stated, "As you can see, there is only one center in The Gambia where they normally take these mad people. They shove them in one place, that is Tanka Tanka." Another participant added, "Even in that one sometimes, they are not given the proper treatment, because sometimes they normally inject them just to make them sleep the whole day."

In terms of multicultural counseling, one participant shared,

> Well, there are counseling and other services for other illnesses, but for mental health, I see very minimum. Because as far as I know, there's only a few psychiatrists that are working in the hospital and who do consultations on this. But giving proper counseling and psycho-social support to mental health issues is really lacking.

One participant also shared, "Just recently, people are becoming aware of counseling and the psychosocial support. And I think that one is more related to people who are mentally distressed." One participant provided a background of their activities, stating,

> I think we are the only organization in The Gambia focused on that. We are promoting these services by delivering these services. We have psychologists and psychotherapists on call. We are also trying to raise the awareness of people and also offering training to

> other service providers; like, currently, we are training the social workers and then the nurses on the mental health and psychosocial support in the mental health services. Yeah, so this is what we are doing right now. But in our office, we do see every individual that need[s] the services. So, you can have psychotherapy, sometimes, if need be, psychoeducation.

This participant added,

> We are not encouraging the admission of patients in Tanka Tanka, so we encourage the patients to be staying in their own family while we go there time to time to visit them. Our volunteers, who are students of psychology, they will see them all the time. They educate the family and check on the patient, how the patient is doing. And then the psychologist will do the psychotherapy for this patient every week or every other week, based on the need.

One participant shared,

> Many of the deportees may know about Western treatment because they are coming from detention camps. I understand that they give them counseling when they are at those camps. When they come here against their will, they are angry and some of them they reject the culture. So, they can accept the counseling psychotherapy.

Another participant shared,

> "As for counseling and psychotherapy, they are new innovative treatment[s] but are not known. Some Europeans are starting it here. They need to sensitize the public. Like I said before, maybe they are not really advertising them for people to know about them."

One participant also said,

> When you look at the psychiatric hospital, there is no psychologist there to help in the assessment or map or to provide the counseling or the psychotherapy for some of those who are patients. So, you only have the psychiatrist nurses or the psychiatrist doctors and one social worker in that hospital.

Another subtheme is local and traditional healing. One participant shared, "It is very normal when somebody is perceived to be mentally ill because the belief is affliction from the jinn or a devil." Another participant stated,

> In most cases, many people tend to go to [a] traditional healer or a marabout rather than medical. Yeah, because since there is a deep-rooted belief this is spiritual thing, many people here in The Gambia believe it is spiritual rather than medical. So, the first protocol for treatment is mostly marabouts or traditional healers. I'm using both names because

> the traditional healers are different from marabouts considering the religious nature of the society which is mostly Muslims.

Another participant added,

> I've experienced the Muslim way of treating the problem aside from [the] medical way of treating. There is this religious formula that they use called Ruqya. Ruqya I think is exorcism in English. Yeah, he will be calling out names, for example, names of Allah as in the Quran or in prophet's tradition.

Another participant shared,

> People believe when you successfully cure a mentally ill person, that disease or that mental problem will transfer to you. If it cannot do anything to you as the healer or as the traditional doctor, it will transfer to the family. A form of like reciting Quran when healing them.

One participant shared,

> Traditional healers but mostly religious, like they normally cure with the Quran, such as Ruqya. Yeah, I've personally seen that, using methods from the Quran and some, you know, Arabic textbooks, Islamic textbooks to cure them. When you are watching them they'll be, like, talking, and it's like they are instructing or commanding something inside the person to come out.

Another participant shared,

> That is the most used method. As I said, people see it, associated mental issues, with customary belief. And for that being the case, it's normally the practice. Most of the people that I see who develop psychological issues always get to traditional or alternative medicine instead of the conventional medicine first.

This participant added, "So, the customary way, customary or traditional therapeutics is most of the things people use first, before anything else." One participant shared,

> But, sometime last year we decided also to visit one traditional healer in around Lamin, Kerewan in the Kombos (a village). And when we arrived there, we found about more than 30 patients who are there receiving medication. So, he has a lot of houses there, and then he keep[s] them there and then treat[s] them. So, he's the one we engage trying to ask. So, he told us, for him, he's using a combination of all the drugs, the herbs, and the

> recitation of the Quran. According to him, there are instances where he also referred to Tanka Tanka.

One participant stated, “when I engaged a colleague of mine who is residing around that end, and according to him, he [has] seen many people that went there, and they have improved and went home successfully.” Another participant stated, “They will give them miracle water for them to drink on a daily basis.”

Theme 4: Barriers to Mental Health Care

Some of the barriers to access are stated here in relation to the subtheme of mental health literacy, awareness, and affordability. One participant, for example, expressed the need to “sensitize people on the use of the drugs and order stuff and taking care of our children in our own place.” Another participant added,

> We need to create more health awareness, educate people about health, make them know about mental health issues, especially people that don’t know about mental health, the illiterates will be taught [about] mental health and what to do with a person with mental health.

Another stated, “They should build more health places to have those that are mentally ill.” One participant also commented on the lack of awareness and need for psychoeducation saying,

> I don’t think people are understanding it, how it should be. That is to understand the other signs of it, recognizing it in the early stage, getting advice, psychological advice … the real feeling of society in terms of mental health is not at a good stage to be precise.

One participant stated, “I don’t think they see as a sickness that people develop from one stage to another. They just see it as something that just come, and that is only when it has reached the climax.” Another participant also emphasized,

> People may not realize the kind of behavior that the person is indicating, or the kind of signs that will warn them that this person is developing certain things. So, people will not

> be aware, and they term it as the person is being rude, the person is being mean, and so on. And that has to do with the awareness.

On the issue of counseling awareness, one participant stated,

> Many people go to traditional healing first and spend thousands and thousands of dalasis. And, to me, the issue of going for counseling, the idea is still not widely spread. There needs to be awareness and people to accept it. It's new, and people don't trust it yet. Yes, people are still not aware of such services.

Increasing access to mental health services was discussed in the interviews, and participants shared their experiences. A participant narrated,

> We have succeeded in decentralizing the outpatient services in every region … there is one in Basse, one in Bansang, Soma, Farafeni, and Esau. But for the in-service mental health facility, we have not succeeded in the same capacity yet, because we only have one, that is Tanka Tanka Psychiatric Hospital.

This participant further enumerated,

> For the community mental health team, previously, they used to go around the country quarterly, every three months, they will take around all their equipment, and then they will announce their outreach dates. But recently, also due to gross lack of finance or lack of a sponsor in [the] mental health sector, such services [have] been truncated in such a way that it is only available within [the] greater Banjul area. And even the greater Banjul area, it's only few communities that are benefiting from that community mental health services. Mobility is a problem … they used to visit prison, every month. But that also has not been possible as we are speaking.

Theme 5: Legal Framework to Support Mental Health Change

Participants discussed the need for comprehensive mental health policy and legal frameworks for mental health. One participant noted:

> We have a mental health bill that has been validated in 2019. But unfortunately, still now, it has not been enacted. We are pushing very hard, but yeah, it has not been enacted yet. Since 2019, the bill was drafted, validated, but still [has] not been enacted. The law that

> we are going by is the Lunatic Act. It's the law of the land, which does not provide any right to a person with [a] mental disorder. And it's very vague.

Another participant described human rights violations against people with mental illness in seeking traditional treatment:

> When they reach that place, if the craziness has deeply entered inside the person's system, they might chain the person. They might put a chain on the legs to avoid misbehaving, and the marabout there will have a lot of men, big men, strong men that would help him when he is reciting and doing the healing. There are some healers that will chain some of the patient[s] that then are quite aggressive to make sure that they are in one place. And some will even include beating them. So, yes. In providing these services they are also abusing the people, which is also against their human rights. Human right violations. That's [the] downside of the traditional healing.

One participant stated,

> We are trying to … train non-mental health specialists to be able to assess, diagnose, and make simple interventions for common mental health problems. … to train the general health care personnel, to make sure that mental health services can be accessed at every facility, irrespective of where you are.

It was also expressed that,

> Because the stigma that is attached to mental health in The Gambia, I can say, it makes so many people not to be willing to readily seek for mental health services. So, of recent, what we have started developing is to incorporate mental health services into the primary health service, that is the existing health services.

CHAPTER V: CONCLUSIONS

Interpretation of Data

The purpose of this phenomenological investigation was to understand the phenomena of mental health and mental health stigma amongst adults living in The Gambia. Phenomenology has its roots in constructivist ideals. A constructivist lens posits that multiple realities exist, and people make their own meaning or realities. The essence of participants' experiences in this study was captured through phenomenological interviews, which were predicated on the participants' shared understanding of a culture that is impacted by the shared social values and social norms of the communities (Babalola et al., 2017). The findings from the study show the role of culture in how many people currently understand mental health. These understandings significantly impact the social identity of people with mental health issues, the limited treatment pathways and modalities for mental health care and identify public stigmatization of mental health/illness. From the collective contextual understandings of participants' lived experience of the phenomena under study, five main themes were captured.

According to the results, the first theme emphasized social and cultural conceptualizations of mental health/illness in The Gambia. The second focused on sociocultural determinants of mental health/illness. The third theme attended to mental health care interventions. The fourth theme identified barriers to mental health care. Finally, the fifth theme focused on the legal framework to support mental health change.

Theory and Research

In utilizing the ecological systems theory by Bronfenbrenner, we attended to individuals' relationships within the communities and wider society in the context of the study findings. In this case, the individuals are those in need of mental health care. First, we examine the

perspective of the microsystem, which refers to systems that most immediately impact development, such as family, school, religion, and peers. According to participants, many people with mental health issues rely on the family system for care and access to mental health care. Families, it was noted, utilize pathways that align with their own worldview and cultural nuances, since they are the decision makers in affairs concerning individuals in need of mental health care. This reflects the important role the family has in a collectivist system. For instance, family members must be involved in decision making. The mesosystem examines interconnections between peers and family. Sometimes families fear sharing that a member of the family is struggling because of the prevailing beliefs about being possessed or cursed. This can cause isolation and stress for the family system. In addition, it is important to recognize that with some psychoeducation, communities might be able to come together for early intervention. The exosystem involves links between social systems that do not necessary directly involve a person, for instance, a family member's job that requires travel. In this instance, it makes it more difficult for the family to care for the person in need and can lead to isolation. The macrosystem describes the overarching culture, for instance, socioeconomic status and poverty that are challenges in The Gambia. Finally, the chronosystem investigates which beliefs are embedded in the culture and can be passed from generation to generation, such as the beliefs about all people being mentally ill are assumed dangerous, cursed and often incurable. As is seen in the results, there is also a widely held belief that little can be done to support the health of the mentally ill

beyond attempts a traditional methods or institutionalization. However, some participants with more education recognize opportunities for revisions to policy, systems and care.

Theme 1: Social and Cultural Conceptualizations of Mental Health/Mental Illness

The findings from this study indicate that mental health/illness in The Gambia is closely tied to social and cultural beliefs. For a population that is 90% Muslim, it was surprising that cultural norms featured more prominently than religious beliefs in the way mental health was conceptualized. Causes of mental health/illness were seen as spiritual and outside the human realm and attributed to many explanatory forms, for example mysticism, possession by jinns or demons, and even revenge from causative agents on healers or family members for healing or helping the person with mental health/illness. Transgressions from norms by a person or their family member was also identified as a cause of mental health/illness. It was seen as a retaliation either through spiritual unseen forces or from the person that was wronged, who took revenge in the form of inflicting the condition through spiritual means. As one participant shared,

> People believe, when you successfully cure a mentally ill person, that disease or that mental problem will transfer to you. If it cannot do anything to you as the healer or as the traditional doctor, it will transfer to the family.

These core beliefs about mental health go to the very root of understanding how mental illness is perceived, lived, and treated. They further explain why some mental health problems may persist. A participant shared,

> The social dimension is so much. Personally, from my own point of view, I think that mental illness if it's not caused by society, then society will exacerbate it. It will make you worse because once they start labeling you, calling you names like duff, Nyamato (like, he is mad, this guy is mad).

These beliefs have been in existence for so long that it has formed part of the contextual understanding of how people experience mental illness, are labeled, stereotyped, and discriminated against (Galvin, 2021). For there to be improvements in mental health, it is very

important that the population is educated on the etiology of mental health, treatments, and possibilities for care that have been identified elsewhere. Unless this education is given, the treatment gap and mental health stigma will remain.

A community-based study focusing on beliefs regarding mental illness in different populations in Al-Ahsa was conducted by Firdos et al. (2021). The sample consisted of a Muslim population who had similar held beliefs about the causes of mental illness as the participants of this study. This study plays a key role in understanding how similar Muslim countries also conceptualize and experience the research phenomena.

Cultural beliefs are at the heart of how to address mental illness in The Gambia. To address this gap in treatment, psychoeducation for both the awareness and treatment of mental health concerns must considered within the context of the beliefs that have made treatment both individually and systemically difficult. Counselor cultural humility would necessitate the continual learning and openness toward clients' diverse cultural experiences and beliefs (Zhu et al., 2021).

Theme 2: Sociocultural Determinants of Mental Health/Mental Illness

The Gambia is a low- and middle-income country, and like many countries of the same status, there is inherent economic inequality. This affects the self-concept of people in terms of lifestyle choices. Social issues such as poverty impact the majority of the population. The study participants spoke about poverty as both a cause of mental illness and a factor that deters people from accessing treatment. Family support in the form of financial assistance to get treatment and also to purchase medication was noted in the study as very important for participants. The findings of this study align with those of a recent foundational study on mental health in The Gambia (Barrow & Faerden, 2022). That study provided significant discussion on poverty as a

factor that impedes positive outcomes in mental health and cited the costs of treatment and purchase of prescription injections and medications as very high and often as a barrier to accessing care. Barrow and Faerden (2022) also cited the cost of traditional healers as around US $187 and the cost of bio-medical interventions for injections and medications as around US $9–12. This high cost and disparity in costs is a notable barrier to accessing services (Barrow & Faerden, 2022). Barrow and Faerden's (2022) study also noted that reducing the factors contributing to mental illness would greatly reduce mental health prevalence and help close the treatment gap, which is consistent with the dissertation findings.

Although substance use was not a focus of this study, it was often mentioned by participants. Participants discussed the experience of substance use as a cause of mental illness. This links the phenomena of mental illness to poverty, a lack of resources, and a lack of opportunity, which was described as pushing people, especially youth, toward substance use. There are initiatives to reduce substance use through seven-step treatment programs and psychiatric hospitalizations. Furthermore, the research participants for this study suggested that the majority of patients in psychiatric inpatient admissions are related to drug use. The participants called for separate facilities for the treatment of drugs and the exploration of halfway houses as a means for treatment to transition from inpatient to daily life.

Participants also referenced migration and failed migration as social issues that caused the displacement and death of thousands of Gambian youth. It was noted that globalization has opened the eyes of many Gambians who want to have better lives and improve the living conditions of their families. Without opportunity available within their own country, they look to distant shores for more opportunity. One way of seeking more opportunity is through the "back way," by illegally migrating through the Sahara Desert and the Atlantic Ocean and entering

Europe. This illegal migration has proved fruitful for some. However, the study noted that widespread illegal migration has led to more control and repatriation agreements, which have made it somewhat easier for migrants to be held in detention centers and eventually returned home. Participants also shared that when people plan to leave, their families incur debt or sell land and resources in the hope that their children will make it through and have the opportunity to support them and create change by augmenting the family status. Therefore, when people do not make it and are detained for many years and eventually deported or returned, the whole family suffers. Stigma is also attached to these deportations. As described, they are seen as having lost an opportunity and are mitigated to a life of poverty. The findings of this dissertation illustrate that this can result in stress, depression and traumatic conditions, which can be compounded by stigma and limited access to professional counseling services.

The understandings, descriptions, and labels attached to mental illness reflect the public stigma at the highest level. Stigma is socially constructed, and it permeates all aspects of Gambian society. Mental health stigma research posits that language shapes perceptions and can have a significant influence on psychological or cognitive processes (Granello & Gibbs, 2016). The terms describing mental health by study participants do not reflect linguistic relativity (Wolf & Holmes, 2011) or align with “people first” language (Granello & Gibbs, 2016). They are stereotyping and portray mental health as a permanent, incurable condition that affects the self-esteem and social identity of people with mental health/illness. A prevailing sentiment amongst the participants was that people do not associate with the people with mental illness. Globally, evidence exists that public stigma is a deterrent for seeking treatment for mental illness. This present study also identified such findings. Participants shared that many people would rather lock up a family member with mental illness than face public stigmatization. Women from

families with mental illness are especially adversely affected, and their chances of marriage are limited due to the negative connotations attached to the family history of mental health (Amuyunzu-Nyamongo, 2013). It is imperative that the government, which is well placed to make changes to policy, continue to step into the role of reducing mental health stigma.

Theme 3: Mental Health Care Interventions/Bio-Psycho-Social Interventions

The findings from this study indicate that The Gambia has a pluralistic system for the treatment of mental health. This includes the biomedical system, which is the conventional system of mental health care, multicultural counseling, which is an emerging system, and local/traditional counseling, which includes spiritual and faith-based treatments. The prevailing belief is that local and traditional or faith-based healing are most popular and most accessible. In a seminal study on mental illness in The Gambia, Coleman et al. (2002) found that approximately 80% of people resort to local and traditional pathways. These are more aligned to people's understandings of mental health as they are rooted in local and cultural beliefs.

The biomedical services in The Gambia are the mainstream conventional system of treating mental health in terms of formal services. In The Gambia, people have limited access to outpatient services. There is currently only one inpatient facility within the country, which is difficult for people to access. The participants shared that the implication for this is that people must find the finances to travel to the region or not come at all. The findings of this study also suggest that The Gambia had a community mental health team that would go around the country every three months to provide greater access, but that program has been difficult to maintain. A lack of funds has greatly impacted community services that could enhance access.

From a multicultural standpoint (Ratts et al., 2016; Bharti et al., 2021; Sue, 1994), it is important to recognize that counseling is an emerging field in The Gambia. Some

nongovernmental organizations are working on growing services; however, a lack of awareness of mental health issues in the community is a risk factor in its sustainability. Given the importance of the globalization and internationalization of mental health counseling in African countries, there have been significant intersectional challenges regarding contextual factors, such as stigma, lack of awareness, and lack of infrastructure (Amuyunzu-Nyamongo, 2013). Multicultural counseling can also involve certain ideals, such as decolonizing concepts. Given people's beliefs about mental health, it is difficult to show the potential healing capacity of Western counseling. It is a balance to recognize current beliefs while also showing the possibilities related to mental health care, which a multicultural counseling approach might be able to help.

Traditional healing system of treatment includes the local, traditional, spiritual, and faith-based pathways. Participants shared that these are the most available and accessible forms of treatment, grounded in local belief systems, and accepted by many people as a first choice of treatment. Other studies in the region have also pointed to this alignment with local cultural beliefs and the treatment's accessibility. Further, the WHO Alma-Ata (1978) declaration recognized the role of traditional medicine in the primary health care sector. The participants in this study empathized with this treatment modality. Study findings from the subregion also show that 80% of people seeking mental health treatment in Ghana rely on the above-mentioned system of care (Krah et al., 2018). Findings show that, although on a small scale, The Gambian government health sector is moving toward full integration of mental health care. This move is an opportunity that could also spur the integration of traditional healing with delivery. There may also be an opportunity to integrate multicultural counseling into mainstream biomedical services

or to collaborate with local and traditional healers. The government could also help with an integration of multicultural counseling and psychoeducation.

Theme 4: Barriers to Mental Health Care

Participants across the board shared their experience of poverty being a social factor that has immense impact on mental wellbeing. They described poverty as a barrier to mental health treatment and as a cause of mental health. Therefore, reducing the circumstances that cause economic inequality could be a prime policy matter for the government. Since about 60% of the population is youth, the government could support the training and skills development of projects to alleviate poverty for young people. The research did not examine the mental health of youth and women, which are groups that are significantly affected by poverty; however, this is an area of needed attention. Further, a lack of funds to pay for medication or money to provide for daily meals could impact mental health and wellbeing.

There is a need for mental health literacy in The Gambia, while also paying respect to long held traditions and values. Local people could be trained to be aware of mental health practices that promote wellness. There are some efforts in this area already, which could also promote access to services. As participants shared, the community mental health services could help with access. Programs have been put in place in the past. However, those programs were cut due to a lack of funding. This sentiment was posited in a study by Kutcher et al. (2016), which aligns to the findings of the present study. If communities are to benefit from counseling, there needs to be adequate training from qualified professionals. These professionals could work within the guidelines of multicultural counseling practice and ethical standards. So far, there are no known counselor training programs or institutions in the country. The training of paraprofessionals could be useful but cannot fully replace professionals. Professional

associations could also help grow counseling in underdeveloped nations. Furthermore, the field must be regulated to ensure that professionals who treat people have the appropriate clinical background to do so.

Theme 5: Legal Framework to Support Mental Health Change

Greater attention should be placed on mental health policy, laws, facilities, and access to services. The Gambia has stated its stance on mental health: to promote mental health. In addition, there is a call to meet United Nation conventions. For instance, addressing the rights of people with disabilities. The Gambia has an opportunity to identify well trained, experienced, mental health professionals and collaborate with these professionals to grow services and policy. It is important to have mental health policy to guide mental health regulations and access. In this research, participants described the concerted efforts by government and stakeholders in developing mental health policy and draft legislation. However, the research has shown that the legislation is yet to be enacted into law. In the research literature, other studies have mentioned the need of protections for people that are mentally ill. For example, Lund et al. (2011) posited that to optimize mental health services in low- and middle-income countries', legislation and policies are required. The Gambia alludes to this in the mental health policy 2021-2030.

Policies could start by revising the practices within the existing facility and increasing the standards of care. For instance, only one facility has both substance abuse treatment and conventional mental health care. A lack of a half-way house has also been noted in this study. Furthermore, it is important to address the financial burden of family caregivers, if possible. Currently, a risk factor is that traditional healing practices are not regulated by the government and can include physical beatings and other human rights violations, which could further exacerbate the mental illness. There is a call to ensure access to food, housing, employment, safe

living/working conditions and gender equity along with mental health (Cosgrove et al., 2021). Collaboration between traditional healers and counseling professionals could help find common ground that also uphold human rights.

Limitations and Recommendations

While a qualitative data analysis yields descriptive data, it is not generalizable and does not show the exact prevalence of issues and needs in The Gambia. Additionally, this study was conducted in English, which does not necessarily accommodate local dialects. It also excluded many people that do not speak English. Furthermore, data were collected via Zoom, which required an internet connection. Another limitation was that this study did not focus on women and children, who are perhaps the most widely affected.

Future research could utilize a quantitative approach that could better identify the prevalence of mental illness and the need for services. Additionally, a quantitative approach might further identify specific needs of the people with statistical data. The last population-based study was conducted in 2012. Future research could also investigate opportunities for those trained in multicultural counseling to collaborate with traditional healers and biomedical services. Furthermore, researchers could collaborate with the government to identify legislature and policy that promotes mental health and wellbeing in the country. Many opportunities exist for further research to implement services in The Gambia, while also keeping in mind the challenges of a low to middle income country.

Importance of the Findings and Implications

There are many opportunities for mental health care and advocacy in The Gambia. However, it is also important to recognize the traditional healing practices and beliefs about mental health as these areas can impact mental health stigma. In working with populations that

are just beginning to explore mental health services, it is important to recognize the community-based resilience in The Gambia. For instance, people are not used to seeking care on their own. Rather, family members are typically tasked with care. Further, by recognizing the inherent worth of people, acknowledging and accentuating personal strengths can assist with buffering the impact of mental illness. This also pushes back on the idea that people are solely defined by their deficits, illness, or life circumstances, and that when connected with caring communities and systems, they are capable and resilient (Ward & Reuter, 2011). This also brings us back to the importance of the ecological systems theory and how different systems interact and have great importance. In working with lower-income countries, mental health cannot be one dimensional and financial among other needs must be addressed. Further cultural humility is important in advocating for people in The Gambia. It is essential to help clients identify the issues as they see them and to focus on the specific needs of the population to promote mental health and wellbeing.

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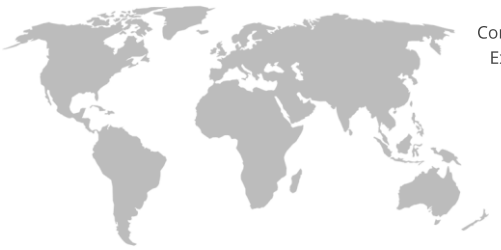
APPENDIX

APPENDIX A: ETHICS TRAINING

CITI PROGRAM



Completion Date 31-Oct-2021
Expiration Date 30-Oct-2024
Record ID 40147394

This is to certify that:

safiya njai

Has completed the following CITI Program course:

Not valid for renewal of certification through CME.

Human Participants in Research
(Curriculum Group)
AU Seattle - Human Participants in Research
(Course Learner Group)
1 - Basic Course
(Stage)

Under requirements set by:

Antioch University

CITI
Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?w60b4281f-56e6-4c50-b789-9b2171007b84-40147394

APPENDIX B: PARTICIPANT RECRUITMENT

Social Media Post:
Please consider participating in research study on mental health in The Gambia. In order to participate you must be an adult, over the age of 18, currently living in The Gambia. You may follow this link for more information about the study and a 30-minute zoom interview: https://www.surveymonkey.com/r/DissertationGambia

Participant Recruitment Email:
You are invited to participate in a research study for Safiya Njai. This project is part of the PhD in Counselor Education and Supervision at Antioch University. The purpose of this project is to examine mental health in Gambia. You were selected as a possible participant because of your experience.
These are the questions that each participant will be asked:
1. What do you know about mental health or mental illness in Gambia?
2. How do you think people feel about mental health/illness in Gambia?
3. What is your understanding of how people see mental health?
4. What is the meaning of mental health in your language/cultural group?
5. How might people get help for their mental health in Gambia?
6. What is your experience in seeking local and traditional healing for mental health?
7. What is your opinion about why mental health services might be underutilized in Gambia?

If you are interested in participating:

- Follow this link for the informed consent form, questions about your background and to schedule a 30-minute Zoom interview: https://www.surveymonkey.com/r/DissertationGambia

Thank you for your time and consideration!
Scheduling the Interview
Thank you for your willingness to participate in a 30-minute Zoom interview. We are scheduled to meet on: ADD DATE AND TIME.
This is my zoom link: ADD LINK
These are the questions that you will be asked:
8. What do you know about mental health or mental illness in Gambia?
9. How do you think people feel about mental health/illness in Gambia?
10. What is your understanding of how people see mental health?
11. What is the meaning of mental health in your language/cultural group?
12. How might people get help for their mental health in Gambia?
13. What is your experience in seeking local and traditional healing for mental health?
14. What is your opinion about why mental health services might be underutilized in Gambia?

I look forward to meeting with you.

APPENDIX C: INFORMED CONSENT

RESEARCH STUDY CONSENT FORM:
You are invited to participate in a research study conducted by Safiya Njai, a Doctoral student at Antioch University. This form describes the study to help you determine if you are comfortable participating.

CRITERIA FOR PARTICIPATION:
You are invited to participate if you meet the following criteria:

- Adult, over the age of 18, currently living in Gambia.

If you do not meet this criteria, thank you for your interest. You do not have to proceed further. You may simply close your browser window.

If you do meet this criteria, please continue reading the informed consent form for more information and to participate.

STUDY OVERVIEW AND PROCEDURE:
The purpose of this study is to explore mental health in Gambia. You will be asked to complete a demographic questionnaire, schedule a time for a 30-minute interview, participate in an interview via Zoom and review transcripts following the interview. This includes an approximate time commitment of 30-60 minutes.

RISKS AND BENEFITS OF PARTICIPATION:

No study is completely risk-free. However, we do not anticipate that you will be harmed or distressed during this study. You may stop being in the study at any time if you become uncomfortable. Occasionally, people who participate in psychology research find that they would like to seek out mental health care and/or support. [Inserted local number for support.]

You should also be aware that there is a small possibility that unauthorized parties could view responses because it is an online survey (e.g., computer hackers because your responses are being entered and stored on a web server).

In terms of benefits, there are no immediate benefits to you from your participation. However, we may learn more about the topic of focus.

DATA PRIVACY:
No identifying information will be asked at any time. IP address collection is turned off and your name or contact information will not be requested. Aggregate data will be shared upon conclusion of the study.

YOUR RIGHTS AS A PARTICIPANT:
Your participation in this study is voluntary. You can decide not to be in the study at any time and can simply close the browser window. Only completed surveys will be utilized for data analysis. In addition, it is important for you to know that your decision to participate or not to

participate will not affect your relations with Antioch University in any way.

CONTACT INFORMATION:

This study has been approved by the Antioch University Institutional Review Board (IRB). If you have ethical concerns about this study or your treatment as a participant, you may contact the chair of the IRB the faculty advisor or the researcher.

Faculty Advisor: Dr. Colin Ward
Email: Cward@antioch.edu

Researcher: Safiya Njai
Email: Snjai@antioch.edu

If you have any questions about or do not understand something in this form, please contact the primary researcher for additional information. Do not click "next" unless the researcher has answered your questions and you decide that you want to be part of this study.

CONSENT TO PARTICIPATION:
By clicking "next" you agree to the following statements:

- I have read this form, and I have been able to ask questions about this study.
- I have not given up any of my legal rights as a research participant.
- I fit the criteria to participate in this study.
- I voluntarily agree to be in this study.
- I will save a copy of this consent information for records.

APPENDIX D: DEMOGRAPHIC TABLES

Frequencies for Do you live in The Gambia?

Do you live in The Gambia?	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	17	100.000	100.000	100.000
Missing	0	0.000		
Total	17	100.000		

Frequencies for What is your age range?

What is your age range?	Frequency	Percent	Valid Percent	Cumulative Percent
18-19	1	6	5.882	5.882
20-29	3	18	17.647	23.529
30-39	10	58.824	58.824	82.353
40-49	1	5.882	5.882	88.235
50-59	1	5.882	5.882	94.118
60-69	1	5.882	5.882	100.000
Missing	0	0.000		
Total	17	100.000		

Frequencies for What is your gender?

What is your gender?	Frequency	Percent	Valid Percent	Cumulative Percent
Female	5	29.412	29.412	29.412
Male	12	70.588	70.588	100.000
Missing	0	0.000		
Total	17	100.000		

Frequencies for What is your marital status?

What is your marital status?	Frequency	Percent	Valid Percent	Cumulative Percent
Married	11	64.706	64.706	64.706
Single	6	35.294	35.294	100.000
Missing	0	0.000		
Total	17	100.000		

Frequencies for What is your highest level of education?

What is your highest level of education?	Frequency	Percent	Valid Percent	Cumulative Percent
Associate degree	2	11.765	11.765	11.765
Graduate degree	3	17.647	17.647	29.412
High school degree or equivalent (e.g., GED)	5	29.412	29.412	58.824
Some college but no degree	7	41.176	41.176	100.000
Missing	0	0.000		

Frequencies for What is your highest level of education?

What is your highest level of education?	Frequency	Percent	Valid Percent	Cumulative Percent
Total	17	100.000		

Frequencies for How many people live in your household (including yourself)?

How many people live in your household (including yourself)?	Frequency	Percent	Valid Percent	Cumulative Percent
11+	2	11.765	11.765	11.765
3 to 4	3	17.647	17.647	29.412
5 to 6	4	23.529	23.529	52.941
7 to 8	4	23.529	23.529	76.471
9 to 10	4	23.529	23.529	100.000
Missing	0	0.000		
Total	17	100.000		

Frequencies for What best describes your religious or spiritual beliefs?

What best describes your religious or spiritual beliefs?	Frequency	Percent	Valid Percent	Cumulative Percent
Islam	15	88.235	88.235	88.235
Protestant Christian	2	11.765	11.765	100.000
Missing	0	0.000		
Total	17	100.000		

**Additional options were provided. Only those selected are represented in the tables above.*