Assessing the Effects of People's Misconception about Mental Retardation on Patients and Caregivers at Upper Denkyira West District of Ghana

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Abstract

Misconception about mental retardation seems to be widely endorsed by the general public. The aim of this research study was to assess assessing the effects of people's misconception about mental retardation on patients and caregivers at Upper Denkyira West District of Ghana. A descriptive cross-sectional study was used integrating both quantitative and qualitative research methods. The study engaged purposive and Snowball sampling techniques to select the study population. The sample size for the study was 40 respondents consisting of heads of households in Diaso with a person who is mentally retarded within any age category and structured interview and observation were the research instrument. From the study findings, regarding respondents' view in terms of what people think are the causes of their wards' mental retardation, almost all the respondents consisting of 32 (80%) indicated spiritual cause, 6 (15%) respondents indicated medical cause whereas 2 (5%) respondents said physical cause. All the respondents 40 (100%) strongly agreed that they faced social stigma and discrimination and all the respondents 40 (100%) strongly agreed that they felt tired most of the time. Dealing with their expenditure on quarterly medical bills, 22(55%) respondents indicated that they spent GH 200-GH 400, 8 (20%) respondents said they spent GH 401-GH 601, 6 (15%) respondents said they spent above GH 601 whereas 4 (10%) respondents said they spent below GH 200. In terms of the mean expenditure on quarterly medical bill the mean is 2.40 with the standard deviation of .871. It therefore showed that caring for mentally retarded persons are time consuming. The study concluded that ignorance, cultural and religious beliefs of the people caused the misconception about mental retardation and this negatively affect the parents, caregivers and the victims themselves and recommended that Ministry of health and Ghana Health Service must implement health education on mental retardation to educate the general populace, mental nurses must be integrated to the various health centers, clinic and health post in order to provide health care services to persons and parents should be referred to clinical psychologist to manage stress of care giving in such parents/caregivers.

Keywords: Mental health, misconception, mental retardation, health policy

1.1 BACKGROUND OF THE STUDY

In Bruce (1993), the World Health Organization (WHO) launched a global initiative aimed at increasing public and professional awareness of the importance of mental retardation which together affect hundreds of millions of people. The challenge is to draw attention to neurological illness including mental retardation to have them acknowledged as public health problems and to emphasize the huge possibilities that exist for prevention.

According to the World Health Organization, (1996) Mental retardation is a condition of arrested or incomplete development of the mind, which is especially characterized by impairment of skills manifested during the developmental period, which contribute to the overall level of intelligence, including cognitive, language, motor, and social abilities. Retardation can occur with or without any other mental or physical disorder. However, mentally retarded individuals can experience the full range of mental disorders, and the prevalence of other mental disorders is at least three to four times greater in this population than in the general population. In addition, mentally retarded individuals are at greater risk of exploitation and physical/sexual abuse. Adaptive behaviour is always impaired, but in protected social environments where support is available this impairment may not be at all obvious in subjects with mild mental retardation (WHO, 1996).

Mental retardation is manifested in different forms with different causes such as, hydrocephalus, asphyxia, genetic defects (e.g. Down syndrome) and exposure to toxoplasmosis and drugs (including alcohol) during the neonatal period. Mental retardation is characterized by low intelligence and deficits in adaptive skills that are observed before the age of 18. The majority of people with mental retardation are mentally healthy and free of serious behavior problems, although the prevalence of psychiatric disorders is higher than in the general population (Payne & Isaacs, 2002).

In another WHO document, Saraceno (2003) indicated that throughout the history of the WHO mental retardation or mental health program, the attention dedicated to children and adolescents has not been commensurate with that dedicated to adults. Yet from demographic and epidemiological perspective as well as from the burden of mental retardation of children represents a key area of concern. The exact prevalence of many of them is unknown, as their real impact on society – their effects on families and their communities, the cost of care and treatment, are sheer waste of human potential.

Misconception about mental retardation seems to be widely endorsed by the general public. People with mental retardation in Ghana, are given derogatory names in the local dialects among the various ethnic groups in the Ghanaian society (Agbenyega, 2005). Agbenyega stated that names given to these people by different ethnic groups in the Ghanaian society connote insults such as feeble mindedness, fools or idiots. For instance, the Ewes refer to them as "asotowo" meaning a fool or an idiot and the Gas call them "buulu"; which means reduced psychological well-being of siblings of children with mental abilities. These names are often given because of the belief systems of the Ghanaian society, and this negatively affects the individual with the disability.

Unfortunately, the effect of a disability does not end with the individual alone but extend to significant others who have some form of relationship with the disabled individual, for instance the family members and people who relate to him or her on a daily basis (Anum, 2011). Studies done in Ghana on disability and family relations have concluded that family members experience stigma from the general public, even though the family members do not necessarily have the disability. The effect of mental retardation on the child and the family's everyday life depends on several factors including the severity of the disease; the complexity of the clinical management; the meaning of the illness to the child, family, and society as a whole; restrictions in the child's and family's activities; the level of social support and extent of resources available to deal with the illness and the innate coping abilities of the child and family (Anum, 2011; Slikker, 2009).

On the other, societal misconception and reaction to severe mental retardation results in stigma and discrimination that unjustly impede the person with psychiatric disability from attaining work, affiliation, and other independent living opportunities. Clinical psychology and other disciplines have developed and evaluated psychopharmacological and rehabilitation strategies that successfully address mental retardation (Corrigan &Penn, 1997). However, addressing the mental retardation is not sufficient to improve the course of severe mental retardation; societal misconception, stigma and discrimination must also be remediated. Therefore, it is very imperative for this study to assess the effects of people's misconception about mental retardation on patients and caregivers at Upper Denkyira West District of Ghana

1.2 STATEMENT OF THE PROBLEM

Parents often fear divulging their child's mental retardation problem to friends and relatives because they have experienced misconception, sense of shame, self-blame and rejection about mental retardation. They may consequently withdraw from their relatives and social circle. Parents may fear that the child's mental retardation is due to neglect during pregnancy, labour and delivery. Feeling of guilt and inadequacy develop leading to further loss of self-esteem.

Parents of these children with special needs and or chronic illness are intimately involved with the children's health care on day to day basis because the majority of these children are normally cared for at home. The families of children with special needs are under greater strain and are more vulnerable than other families. The substantial effects of mental retardation are perceptible on individual, family and social planes. Personal observation in rural societies indicated that neurological conditions are thought and believed to be due to wrong behaviors such as breaking a taboo, witchcraft, or due to evil people or spirits. It is also generally believed that for these chronic neurological conditions, orthodox or western medicine has no cure or management.

There is a large body of literature on the impact of the different types of mental retardation on the society. There is less literature found on the causes and effects of misconception about mental retardation in Ghana. Nevertheless, there is recognition of the crucial need to promote the awareness of mental retardation for better management which may reduce the burden on the parents and the family. Therefore, this study assessed the effects of people's misconception about mental retardation on patients and caregivers at Upper Denkyira West District of Ghana.

1.3 RESEARCH QUESTIONS

To accomplish the stated objectives, the study answers the following questions:

1. What factors contribute to people's misconception on mental retardation?
2. What are people's attitude towards mental retardation in their community?
3. What are the effects of people's misconception on mental retardation on patients and caregivers?

2.0 LITERATURE REVIEW

2.1 Meaning and Causes of Mental Retardation

Mental retardation (MR) is a genetic disorder that manifested significantly in below average overall intellectual functioning and deficits in adaptive behaviour. Mental retardation is a particular state of functioning that begins in childhood and is characterized by decreased intelligence and adaptive skills and also is the most common developmental disorder (Bregman, 1991). Mental retardation in young children is often missed by clinicians. The condition is present in 2 to 3 percent of the population, either as an isolated finding or as part of a syndrome or broader disorder (Daily, Ardinger & Holmes, 2000).

An accurate and consistent definition of mental retardation is critical because of its impact on the prevalence, or count, of those with MR. However, despite the importance of consistency, MR is not always defined in the same way across research studies or service agencies, even within the same state (Koller et al., 1984; Borthwick-Duffy, 1994). The American Association on Intellectual and Developmental Disabilities (AAIDD, 2002) has defined mental retardation as significant limitations both in intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills. This disability originates before the age of 18. Intellectual limitations refer to an Intelligence Quotient (IQ) which falls two standard deviations below the population mean of 100 (<70), and adaptive functioning limitations refer to impairments in at least two out of ten skill areas (AAMR, 2000).

Mental retardation is also defined in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV) by the American Psychiatric Association (APA). Similar to the AAMR definition, the DSMIV has three diagnostic criteria for MR, including sub-average intellectual functioning (IQ < 70), impairments in adaptive functioning and onset before age 18 (APA, 1994).

Zigler and colleagues (1986; 1987; 1991) argued that an appropriate classification of Mental retardation employs both IQ score and etiology of the retardation. Consequently, they suggest categorizing MR into cultural/familial and organic groups, based on the presence or absence of a known organic etiology. This two-group approach is one of the most well documented distinctions in the mental retardation literature over the last century. WHO guidelines on "Assessment of People with Mental Retardation" (WHO, 1992), has classified mental retardation in to types. These are mild mental retardation, moderate mental retardation, severe mental retardation, profound mental retardation and unspecified mental retardation.

Approximately 3% of the population has an intelligence quotient (IQ) of less than 70, among whom a cause for the mental retardation can be established in less than half of all cases (Flint et al., 1995).The prevalence of severe mental retardation is about 3 per 1.000 population and 30 per 1.000 for mild mental retardation (Harper, 1993).

A number of environmental, genetic or multiple factors can cause mental retardation. It is also believed that behavioural or societal factors such as poverty, malnutrition, maternal drug and alcohol use, as well as severe stimulus deprivation can contribute to mental retardation (McLaren & Bryson, 1987). Unfortunately, in approximately 30 to 50 percent of cases, the etiology is not identified even after thorough diagnostic evaluation (Cury et al., 1997; Schaefer & Bodensteiner, 1992).

Some persons have a congenital malformation of the brain; others had damage to the brain at a critical period in pre- or postnatal development. Acquired causes of retardation include near drowning, traumatic brain injury and central nervous system malignancy. The most common cause of mental retardation in industrialized nations is fetal alcohol syndrome with an incidence rate of 1 in 100 births. The second leading known cause of mental retardation is Down syndrome, or trisomy 21, with an incidence rate of 1 in 800-1.000 births (Campbell, Morgan & Jackson, 2004).

2.2 Factors Contributing to People's Misconception on Mental Retardation

Misconceptions of people with mental retardation, grounded in the cultural and religious beliefs and misconceptions have also negatively affected the relationship other people may have with intellectually disabled persons (Quinn, 2007). Children are seen as assets in the Ghanaian family and so a lot of measures are put in place to protect a child from being born disabled. Pregnant mothers are subjected to the adherence of various kinds of rituals and taboos, especially in rural society, in order to "curb the menace" of giving birth to a child who is disabled (Agbenyega. 2005).

When children are born, the expectation is that they develop and behave normally. A child is expected to sit, crawl, walk, talk and perform many actions as any normal child at the expected time. But a deviation from this norm is seen as a breach of such traditional belief systems (Avoke, 2010). The birth of a disabled child could lead to negative or ambivalent reactions from the society towards the family of persons with disability.

Various ethnic groups in the Ghanaian culture have the belief that children born with any form of disability especially mental retardation are outcasts who cannot be integrated into society. Furthermore, persons with mental retardation are seen as dangerous, unable to achieve anything profitable or "imperfect human beings" (Slikker, 2009). Large part of the morbidity and mortality from neurological problem seen in children are preventable.

The reasons why these preventable diseases result in permanent disability in children are rooted in poverty, ignorance and tradition. In rural societies, neurological conditions are thought and believed to be as a result of wrong behaviors, breaking a taboo, witchcraft, or due to evil spirits. It is also generally believed that for these chronic neurological conditions orthodox or western medicine has no cure or management.

According to Ocloo (2005), some communities in the Ghanaian society believe that people with mental retardation are cursed because of some evil deeds done by the children themselves or a member of their family.

It is also believed by the people from the Brong Ahafo Region that Down's syndrome is caused by the expectant mother eating fish caught from a particular river in the region; hence they are called "nsuoba" meaning "water children" (Agbenyega, 2005).

In the Northern parts of Ghana, their belief is also similar. It is believed that such children are spirit beings or are possessed by evil spirits who come to harm members of their family and society (Ocloo, 2005). Another belief about the cause of intellectual disability in a family especially if that family is known to be rich in the society is that the family exchanged the child's intellect for money and riches (Slikker, 2009).

These beliefs, based on the cultural and religious views and also lack of understanding of the causes of mental retardation, have negatively affected families in which a person with mental retardation is found (Agbenyega, 2007; Ocloo, 2005; Anthony, 2009). Such families are ostracized, labelled negatively, isolated from the rest of the society and stigmatized. Such families may not be allowed to participate in certain traditional and cultural practices; for instance, persons with any form of disability are not allowed to visit the chief's palace because; it is believed that they will make the palace and the chief impure. They are also not able to hold a leadership role.

Some of the children are locked up so that members of the society will not know of their existent. In some communities, children with mental retardation are also used as clowns and jesters in the chiefs‟ palace during durbars (Ocloo, 2005). It is recognised that negative labels applied to social groups can lead to negative attitudes and beliefs about individuals associated with the group label (Agbenyega, 2005).

2.3 People's Attitude towards Mental Retardation

Attribution theory has been used to explain the stigmatization of disabilities, especially mental disabilities. According to Weiner (1993), attribution explains people reactions to disabilities; in that both negative and positive reactions towards disability are based on the causative factors. Persons, who are seen as not having control over their disabilities because of the biological or physical cause, are shown positive and more helpful behaviours as opposed to persons whose disabilities are recognised as caused by themselves and who have control over what happens to them (Boysen & Vogel, 2008).

A study was conducted on ignorance and misconceptions about mental health in the rural tribal area of jargant state, Ranchi. The sample consisted of 800 people 15-54 years of age. From rural areas of jargant. The results indicate majority 81%of tribal's believed that insanity caused by evil spirit the recommends a need for intervention. Study to remove ignorance and misconceptions to promote a mental health (Journal of social psychiatry, 2005).

Studies of attitudes towards intellectual disability, have considered societal influences such as stigma as a major factor to negative attitudes towards intellectual disability. Stigma is an important consideration, however, because of its deleterious effect on families of children with disabilities (Fong, 2005; Skinner & Weisner, 2007). Assertions have been made that exposure to social discrimination and stigma affects the well-being and attitude of a person. Stigma is defined as "any attribute that discredits or disqualifies a person from full social acceptance" (Dale, Smith, Norlin & Chess, 2006).

General attitudes from the society towards persons with intellectual disability and their inclusiveness in the community have been negative, with differing beliefs and perception from different communities (Anthony, 2009). One reason for this negative attitude, according to Agbenyega (2005), is because of the labels placed on individuals with intellectual disability. These labels are consistent with religious or cultural models. However, parental attitudes on the other hand, seem to be positive, especially in making decisions concerning their wards (ElZein, 2009). It has been explained that parents, because of their relations to the children with intellectual disability, are able to show positive attitudes. However, sometimes, in order to protect and shield them from societal prejudice, they keep them away from public view (Slikker, 2009).

Slikker posited that family members and individuals with disability felt stigmatized in the society because most people have the belief that the causative factors were more likely to be of the traditional view. Explaining the relationship between stigma and attribution theory, Corrigan (2000) also assented to the fact that people's reaction to disability depends on the interpretation of the symptoms of the disability. This is also true for those perceived as having control over their symptoms. The general attitudes in many communities towards children with disabilities are negative because disability is generally considered an offence against gods, atonement for sins of family and ancestors. Thus, some persons with disabilities are ostracised, and excluded from the mainstream community (Avoke, 2010).

Stigma sometimes extends to other individuals or things because they have a relation with the stigmatized. This type of stigma is known as stigma by association (Mehta & Farina, 1988) or courtesy stigma (Goffman, 1963). Stigma by association or courtesy stigma is when other people are regarded "as having spoilt their identity because they share a web of affiliation with the stigmatized". Stigma by association results from the affiliation that one has with a person already being stigmatized; and this happens through physical, biographical or relational role (Birenbaum, 2010).

Courtesy stigma or stigma by association includes the emotions and beliefs of those surrounding the stigmatized person, including family members and professionals (Larson & Corrigan, 2008; Rusch, Angermeyer, & Corrigan, 2005). Stuart (2005) argue that family members who feel or experience courtesy stigma, may experience it as fear, loss, lowered family esteem, shame, secrecy, distrust, anger, hopelessness and inability to cope. Family members of people with intellectual disability feel stigmatized for the reason that, they are associated with the intellectually disabled person and secondly being associated with the cause if the cause is perceived as a curse or a punishment of evil- doing.

The effects of stigma-by association are especially powerful because they are likely to persist after even a single exposure. Risen & Gilovich (2007) found that the mere association of a rare group member with a rare behaviour is sufficient to produce a link with the stigmatized and set the stage for more elaborate stereotyping. Siblings' positions place them in a unique position; in that they are associated with the disability but are not the stigmatised themselves. Whereas siblings themselves do not have any disability and are not likely to feel stigmatized against, they may suffer from the courtesy stigma. Despite this attitude from persons from outside the family, acceptance and learning to live with a disabled sibling, affects siblings attitudes towards their intellectually disabled brother or sister which in turn may have an impact on their well-being. Aksoy & Yildirim (2008) emphasized that acceptance of a brother or sister with intellectual disability in the family depended on the level of handicap and the diagnosis of the mental retardation.

2.4 Effect of Mental Retardation on Patients and Caregivers

A philosophy of family-centered care based on the belief that all families are deeply caring and want to nurture their children, is considered central to the nursing care of a hospitalized child (Ford & Turner, 2000). Integral to the child's care there are many barriers to providing family centered care to hospitalized children in general and to children with special needs. This was also proposed by Ford & Turner, (2000).Several studies have demonstrated a noticeably elevated incidence of behavioral disturbances among families of children with neurological problems.

Mental retardation poses a different kind of problem to families in which the retarded individual does not deviate significantly from the family norms and standards. In these families the problems do not stem from the psychological trauma and ego threat characteristic of the intellectually adequate family. The social pathology in these families arises from many causes. Retardation is only one of the factors contributing to the worries with which these parents are beset. To these parents the problems of retardation are often buried under more acute and pressing concerns. Nevertheless, the mental handicap of this child is another link that ties this family to its present state of inadequacy (Ford & Turner 2000).

An evaluation of a mentally retarded child encompasses the emotional strengths, attitudes, general parental performance and physical resources of the family. The quality of these familial components, along with the severity of the child's defect, determine the direction of help, and the achievable goals for the child. The adequacy of the familial role in behalf of the child is the key to his potential usefulness within and outside of the home. It is therefore important, in our approach to the problem of mental retardation, that our understanding of the child's unique problem be a segment of our understanding of the family (Risen & Gilovich, 2007).

Denial is operative in the parents' failure to hear the diagnosis. Some parents dwell upon the child's physical problems and ignore the mental limitations. Where parents find that denial is impossible they often call upon projection for their defense. Where self-blame is too painful they shift the blame wherever it can fit into their system of rationalization. The blame is sometimes shifted back and forth between the parents, particularly where the marital relationship was not very stable prior to the child's birth. On the fear of negative consequences for the parent themselves, both groups have a lower level of fear as compared to fear for negative consequences for the child. Some parents expressed the fear of losing their patience with their child, fear of not being taken seriously when talking to others about their child, fear of needing to depend on other people because of their child's disability and fear of visiting other people with their child Gostautas & colleagues (2006).

The family worries about the retarded child in the home do not diminish as the child successfully adjusts in the home and achieves some reasonable degree of usefulness. There is the constant uncertainty about the protection of the child's interest in the future. Psychosocial adjustment of adolescents with mental retardation has been studied extensively. However, it is unclear whether different health disorders have specific impact on adjustment, or disorder in general relates to the development of adjustment difficulties as a factor limiting adolescent's physical and social activity.

The well-adjusted parents are usually capable of coping with the hurt related to their retarded child. Help to them may be largely educational in nature - guidance toward providing the child with experiences appropriate to his potential. Working with parents who have not achieved a stable adjustment may be aimed at the parents' personal and marital conflicts, rather than on their feelings about the child. Recognition of the roots of the maladjustment will prevent the error of supporting pathological neurotic patterns. Work with the culturally deprived parent frequently involves another approach.

Gostautas & colleagues (2006) have reported that psychosocial adjustment, difficulties and low self-esteem are more prevalent in clinical groups as compared to healthy controls. Parents of children who have mental retardation face multiple psychological and economic problems that are often neglected. The balance of affective and instrumental communication employed by nurses appears to be essential, especially during admission interview with clients particularly those who have long-term illness. Kruijver, Kerkstra, Bensing & Van de Wiel (2001) studied communication skills employed by nurses during interactions with recently diagnosed cancer patients.

In conclusion, mental retardation is a genetic disorder manifested in significantly below average overall intellectual functioning and deficits in adaptive behaviour. A number of environmental, genetic or multiple factors can cause mental retardation. In at least 30 to 50 percent of cases, physicians are unable to determine etiology despite thorough evaluation. The systems review of the child should be complete, with special attention to growth problems, history of seizures, lethargy and episodic vomiting. The systems review of the child should be complete, with special attention to growth problems, history of seizures, lethargy and episodic vomiting.

Methodology

3.1 Background of the Study Area

The Upper Denkyira West District is one of the twenty (20) Metropolitan, Municipalities and Districts in the Central Region of Ghana. The Administrative Capital of the District is Diaso. The District Shares Boundaries with Upper Denkyira East Municipal to the South, to the North with Bibiani-Anhwiaso-Bekwai, to the East with Amansie West and to the West with Wassa-Amenfi West.

3.2 Study Design/Type

A descriptive cross-sectional study was used to assess the effects of people's misconception about mental retardation on patients and caregivers at Upper Denkyira West District of Ghana. This cross-sectional survey strategy would support to generalize for the population, and permit inferences to be done about the entire population at one point in period. The study type was mixed method research approach. Mixed methods research approach is a methodology for conducting research that encompasses collecting, analysing and integrating both quantitative and qualitative research method**.** This approach to research is employed to provide an enhanced understanding of the research problem than either of each only.

3.3 Study Population

The study population comprised all heads of households in Upper Denkyira West District with a person who is mentally retarded within any age category and who has agreed to participate in the study. The inclusion criteria were that the person must be a head of a household and had stayed in Upper Denkyira West District for not less than one year. The exclusion criteria consisted of family members who are not heads of household and heads of households out Upper Denkyira West District with mentally retarded person.

3.4 Sampling Technique

This study engaged purposive and snowball sampling techniques. Purposive sampling was used to select all heads of households in selected towns in the Upper Denkyira West District with a person who is mentally retarded within any age category and who has agreed to participate in the study. Snowball sampling was a useful choice to select all heads of households with a person mentally retarded for the study. Snowball sampling strategy was used because the population we were interested in studying was hidden or hard-to-reach owing to the social stigma and marginalization of mental retardation as well as there was no obvious list of the population that researchers were interested in. The sensitivity of coming forward to take part in research was more acute in research dealing with abortion context.

3.6 Sampling Size

The sample size for the study was 40 respondents consisting of heads of households in selected towns in the Upper Denkyira West District with a person who is mentally retarded within any age category and who has agreed to participate in the study. Forty respondents were used as other respondents were not willing to identify themselves and take part in the research because the study involved individuals recruiting other individuals to take part in the research.

3.7 Data Collection Tool / Research Instrument

Two principal data collection techniques were used in this study. These were structured interview and observation. Structured interview offers a richer, more comprehensive view of an issue and can be easily repeated to check the reliability of the data. Due to the educational background of the respondents, structured interview was used to get the required from the respondents. The use of observation will help the researcher to get deeper understanding of assessing the causes and effects of misconception about mental retardation and cross check from the responses from the structured interview. Participant observation is the process enabling researchers to learn about the activities of the people under study in the natural setting through observing and participating in those activities.

4.0 PRESENTATION OF RESULTS AND DISCUSSION

4.1 Presentation and Discussion of Results

4.1.1 Demographic Characteristics of Respondents

Forty households' heads were chosen for the study and according to table 4.1 below, females were 34 (85%) out of the respondents and males were 6 (15%). In terms of respondents' age, 19 (47.5%) of the respondents ages fell above 50 years, those within the ages of 41-59 years were 12 (30%), those within the ages of 31-40 years were 5 (12.5%), those within 21-30 years were 3 (7.5%) and below 20 years was 1 respondent. Concerning respondents' marital status, 30 (75.5%) respondents were married, 8 (20%) were divorced whereas 2 (5%) were single. In relation to respondents religious affiliation, majority of the respondents who were 32 (77.5%) were Christians, 6 (15.5%) were Moslems and 3 (2.5%) were traditionalist. The religious background of the respondents influenced people's misconception on mental retardation.

Regarding the educational level of the respondents, 24 (60%) had basic education, 9 (22.5) had secondary education, 6 (15%) had no formal education while 1 respondent had tertiary education.

Table 4.1: Demographic characteristics of households' heads

Variable	N=40 Frequency	Percentage
Gender		
Male	6	15
Female	34	85
Respondents' Age		
Below 20 years	1	2.5
21-30 years	3	7.5
31-40 years	5	12.5
41-50 years	12	30
Above 50 years	19	47.5
Marital Status		
Single	2	5
Married	30	75.5
Divorced	8	20
Religious Attachment		
Moslem	6	15.5
Christian	31	77.5
Traditionalist	3	2.5
Education		
Tertiary	1	2.5
Secondary	9	22.5
Basic	24	60
No formal education	6	15

Source: Field Survey, 2015

With regards to respondents employment status, more than half of the respondents who were 27 (67.5) were self-employed, 6 (15%) were apprentice/artisan, 4 (10) were unemployed whereas 3 (7.5%) respondents were working at formal/private sector.

Table 4.2: Respondents' Employment Status

Responses	Frequency	Percentage
Unemployed	4	10
Self-employed	27	67.5
Formal/private sector	3	7.5
Apprentice/artisan	6	15
Total	40	100

Source: Field Survey, 2015

4.1.2 Factors contributing to People's Misconception on Mental Retardation

Table 4.3: People's misconception on mental retardation

Variable	N=40 Frequency	Percentage
Name of child sickness		
Yes	15	37.5
No	25	62.5
Health facility first point		
Yes	14	35
No	26	65
Type of management for child		
Healing by pastors	15	37.5
Rehabilitation	4	10
Herbal and traditional medicine	10	25
Orthodox medicine	5	12.5
Pacification of gods	6	15
People's perception on causes		
Spiritual cause	32	80
Medical cause	6	15
Physical cause	2	5

Source: Field Survey, 2015

Respondents were asked if they knew the name of their ward's illness/sickness and from Table 4.3 above, 25 (62.5%) respondents said no and 15 (37.5%) yes they knew the name of their wards. Sickness. To find out whether first call for medication was a health facility, 26 (65%) stated no they did seek treatment at any registered health post whereas 14 (35%) stated yes indicating at they sought their wards treatment first at a health facility.

Respondents were asked question on the possible type of management of their wards condition to be treated effectively, 15 (37.5%) respondents mentioned healing by their pastors, 10 (25%) of the respondents mentioned herbal and traditional medicine, 6 (15%) respondents mentioned pacification of gods, 5 (12.5%) mentioned orthodox medicine and 4 (10%) mentioned rehabilitation centre. This result findings confirms Quinn (2007) assertion that misconceptions of people with mental retardation is grounded in the cultural and religious beliefs of the people

Regarding respondents' view in terms of what people think are the causes of their wards' mental retardation, almost all the respondents consisting of 32 (80%) indicated spiritual cause including curse, punishment for wrong doing and witchcraft, 6 (15%) indicated medical cause comprising disease or illness, birth defect and genetic disorder whereas 2 (5%) respondents said physical cause. This result finding agrees with Ocloo (2005) posited that some communities in the Ghanaian society believe that people with mental retardation are cursed because of some evil deeds done by the children themselves or a member of their family. In rural societies, neurological conditions are thought and believed to be as a result of wrong behaviors, breaking a taboo, witchcraft, or due to evil spirits

4.1.3 People's Attitude towards Mental Retardation in their Community

In trying to find people's attitude towards mental retardation, respondents were asked if they were reserved or faced withdrawal from social activities as a result of their wards mental retardation, 11 (27%) respondents agreed that they faced withdrawal from social activities and 29 (72.5%) strongly agreed to the claim. All the respondents 40 (100%) strongly agreed that they faced social stigma and discrimination. The above results confirms Anthony (2009) conclusion that general attitudes from the society towards persons with intellectual disability and their inclusiveness in the community have been negative, with differing beliefs and perception from different communities.

About loss of friends, 22 (55%) agreed that they have lost friends as a result of their wards mental retardation and 18 (45%) of the respondents strongly agreed. In terms of caregivers having difficulty in taking their wards to social gathering, 36 (90%) strongly agree with this assertion and 4 (10%) agreed with that. The above results confirms Anthony (2009) conclusion that general attitudes from the society towards persons with intellectual disability and their inclusiveness in the community have been negative, with differing beliefs and perception from different communities.

All the respondents 40 (100%) strongly agreed that they faced false accusations for their contribution in their wards condition and thus supporting Avoke (2010) declaration that some persons with disabilities are ostracised, and excluded from the mainstream community (Avoke, 2010). Respondents facing poor relations with their family members, 9 (22.5%) strongly disagreed with this assertion, 13 (32.5%) disagreed with that, 12 (30%) agreed that they faced poor relations with their family members and 6 (16.5%) strongly agreed with and this supports Agbenyega (2005) study report that such families are ostracized, labelled negatively, isolated from the rest of the society and stigmatized.

Table 4.4: People misconception on mental retardation

Variable	Strongly disagree	Disagree	Undecided	Agree	Strongly Agree	Total
Withdrawal from social activities	0 (0)	0(0)	0 (0)	11(27)	29 (72.5)	40 (100)
Social stigma and discrimination	0 (0)	0 (0)	0 (0)	0 (0)	40 (100)	40 (100)
Loss of friends	0 (0)	0 (0)	0 (0)	22 (55)	18 (45)	40 (100)
Difficulty taking child to social gathering	0 (0)	0 (0)	0 (0)	4 (10)	36 (90)	40 (100)
False accusations	0 (0)	0 (0)	0 (0)	0 (0)	40 (100)	40 (100)
Poor relations with other family members	9 (22.5)	13(32.5)	0 (0)	12 (30)	6 (16.5)	40 (100)

The figures in parentheses are the percentages

Source: Field Survey, 2015

4.1.4 Effect of Mental Retardation on Patients and caregivers

Respondents were asked the question how much time they do spend with your sick ward in order to ascertain the effect of mental retardation of parents and caregivers. From table 4.5, below, 34 (85%) respondents said they spent their time daily with their sick wards and 6 (15%) said week. In terms of the mean for time spent with the sick person, the mean is 1.15 with the standard deviation of .362. It therefore showed that caring for mentally retarded persons are time consuming. This result support Ford & Turner, (2000) study concluding that integral to the child's care, there are many barriers to providing family centered care to hospitalized children in general and to children with special needs.

Table 4.5: Time spent with the sick

	N=40	
Responses	Frequency	Percentage
Daily	34	85
Weekly	6	15
	Mean	Standard deviation
	1.15	.362

Source: Field Survey, 2015

Concerning the financial burden that taking care of mental retarded person has on the parents and caregivers, respondents were asked the amount of money they spent on their wards' medical bill quarterly, 22(55%) respondents indicated that they spent GH 200-GH 400, 8 (20%) respondents said they spent GH 401-GH 601, 6 (15%) respondents said they spent above GH 601 whereas 4 (10%) respondents said they spent below GH 200. In terms of the mean expenditure on quarterly medical bill the mean is 2.40 with the standard deviation of .871. It therefore showed that caring for mentally retarded persons are time consuming.

Table 4.6: Expenditure on quarterly medical bill

	N=40	
Responses	Frequency	Percentage
Below GH200	4	10
GH200-400	22	55
401-600	8	20
Above 601	6	15
	Mean	Standard deviation
	2.40	.871

Source: Field Survey, 2015

Regarding the question if family members involve themselves in the care of the mentally retarded persons, 30 (75%) said yes and 10 (25%) respondents said no.

Table 4.7: Other family members' involvement in the sick care

Responses	Frequency	Percentage
Yes	30	75
No	10	25
Total	40	100

Source: Field Survey, 2015

Table 4.8: Consequences on Patients and Caregivers

Variable	Strongly disagree	Disagree	Undecided	Agree	Strongly Agree	Total
Resource constrain on necessities	0 (0)	0(0)	0 (0)	4(10)	36 (90)	40 (100)
Feels tired most of the time	0 (0)	0 (0)	0 (0)	0 (0)	40 (100)	40 (100)
Self-blame/guilt	12(30)	0 (0)	0 (0)	8 (20)	20 (50)	40 (100)
Family breakdown	0 (0)	0 (0)	0 (0)	18(45)	22 (55)	40 (100)
Frequent conflicts in the home	14 (35)	6 (15)	0 (0)	10 (25)	10 (25)	40 (100)
Problems at work	7 (17.5)	5(12.5)	0 (0)	21 (52.5)	7(17.5)	40 (100)

The figures in parentheses are the percentages
Source: Field Survey, 2015

Responding were asked statements in order describe the effect of mental retardation on them and the entire family's life. From Table 4.8 above, in terms of resources constraint on basic, 36 (90%) respondents strongly agree with the assertion necessities and 4 (10%) respondents agreed. All the respondents 40 (100%) strongly agreed that they felt tired most of the time. With reference to self-blame/guilt, 12 (30%) respondents strongly disagreed with the assertion, 8 (20%) respondents agreed with the claim. Having experiencing family breakdown as a result of having mentally retarded person in the family, 22 (55%) respondents strongly agreed with that and 18 (45%) also agreed.

Experiencing frequent conflicts in the home owing to mental retardation issues, 14 (35%) of the respondents strongly disagreed with that, 6 (155%) of the respondents disagreed, 10 (25%) of the respondents strongly agreed while 10 (25%) also strongly agree. In relation to respondents having problems at their work place due to mental retardation issue at home, 7 (17.5%) respondents strongly disagreed, 5 (12.5%) disagreed, 21 (52.5%) respondents agree with that whereas 7 (17.5%) strongly agreed with that.

Table 4.9: Respondents' Suggestion on care

Responses	Frequency	Percentage
Good parental care	6	15
Information on medical condition	2	5
Free medical care	8	20
Public education	24	60
Total	40	100

Source: Field Survey, 2015

Respondents suggested how to care for a child with mental retardation, 24(60%) of the respondents public education to the general public, 8 (20%) suggested free medical care for mentally retarded persons, 6 (15%) of the respondents suggested good parental care for mentally retarded person and 2 (5%) respondents suggested that there should be the need for information on medical condition of mentally retarded person. This result findings further support Risen & Gilovich (2007) study concluding that in our approach to the problem of mental retardation, that our understanding of the child's unique problem be a segment of our understanding of the family

5.0 CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

The study findings on assessing the effects of people's misconception about mental retardation on patients and caregivers at Upper Denkyira West District of Ghana could be concluded that ignorance, cultural and religious beliefs of the people caused the misconception about mental retardation and this negatively affect the parents, caregivers and the victims themselves. The study finding showed that almost all the respondents consisting of 32 (80%) indicated spiritual cause including curse, punishment for wrong doing and witchcraft for mental retardation 6 (15%) indicated medical cause comprising disease or illness, birth defect and genetic disorder whereas 2 (5%) respondents said physical cause leading mental retardation and all the respondents 100% agreed that they faced stigma. Above all, some people do not know the causes of mental retardation, society attitude towards mental retardation is very negative and mental retardation has negative socio-economic and cultural effects on the parents and caregivers. Therefore, there is the need for much education on mental retardation across the entire Ghanaian society.

5.2 Recommendation

Based on the finding of the study, the following recommendations are provided to do away with causes and effects of misconception about mental retardation and promote health education on mental retardation to reduce the stigma attached to it:

- Parents/caregivers should not see the care giving function as a problem, but rather as a challenge this would help them cope better with the day to day care giving thus reducing frequent conflicts in the home, prevent family breakdown, and problems at work.
- Ministry of health and Ghana Health Service must implement health education on mental retardation to educate the general populace to understand and have sufficient knowledge on mental retardation to reduce the misconception on mental retardation. Also, the possibility out there for the prevention of these disorders or where it they have occurred, emphasize on prevention of complications.
- Mental nurses must be integrated to the various health centers, clinic and health post in order to provide health care services to persons who are mentally retarded and organize home visit to monitor the health conditions of their clients.
- It is also recommended that in order to reach out to the rural population, Neuro-developmental clinics (NDC) should be set up in all regional hospitals. These units should be well resourced to reduce work overload on the staff and the existing facilities.
- There is the need for a multidisciplinary set up to improve quality of life to deal with the sense of hopelessness; training of specialists, psychological support and schools for children with special needs.
- Parents should be referred to clinical psychologist to manage stress of care giving in such parents/caregivers.
- Parents should balance the provision of care to the sick children with other sibling to avoid or minimize sibling rivalry.

Suggestion for Future Study

Future study must examine the effects of stigma on the psychological well-being of siblings of persons with intellectual disability

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