For a long time, mental health has received very little attention in Sierra Leone. It is only in the last five years that significant efforts have been made to actually talk about it and create not only the awareness needed but put in place proper systems for mental health care.

The understanding of mental health in Sierra Leone is usually quite myopic and one-sided, if one can put it that way. Mental health is believed to comprise only ‘severe’ disorders (i.e. the psychoses), and ‘lunatics’ are considered untreatable. Therefore, once any mention is made of mental ill health, the individual concerned is a ‘case’ and a hopeless one at that.

In my experience as a family physician, I have come to understand that one has to have a way of explaining mental ill health without using the word ‘mental’ or even alluding that management of a particular condition may involve psychotherapy or a visit to a psychologist or therapist. However, I am yet to have that way.

In order to substantiate what I already know, within my community I held small focus group discussions with people of varying ethnicity (four ethnic groups), socio-economic status and age.

I asked a variety of questions, and the answers I received are detailed below.

**Q: What do you think mental health is?**

Mental health concerns the care of lunatics or the mad man. In Sierra Leone, this will comprise mainly those who are loose on the streets and those who are admitted to mental hospitals. It was interesting to note that even university students and graduates did not think, even on probing them, that neurotic disorders, panic anxiety disorders and even depression are mental health disorders.

**Q: What do you think causes mental ill health?**

All the different ethnic groups believed that mental ill health was a curse that had been put on the person for something that he/she had done wrong. It was interesting to note that all groups believed that the person suffering from mental ill health was guilty of something and was therefore receiving the punishment. Two persons from different ethnic groups—one a student and one a recent graduate—added that abuse of narcotics, demon possession and involvement in religious cult activities were also causes of mental ill health. The general consensus was that some wrong must have been done by the individual in order for him/her to be suffering from mental ill health.

**Q: In your ethnic group, how do you respond to persons with mental ill health?**

All ethnic groups viewed it as embarrassing to the family, and that the normal practice would be to keep the person locked up in order to prevent other members of the community from knowing. The only time the person might be allowed out was if the mental disorder was perceived to be a curse for breaking a taboo. In this case, the family would not want to have any contact with the person so as ensure the curse was not transmitted to the family.

Having a relative suffering with a mental health condition is one of the reasons why some families will not allow members to marry from that family, as it is believed the curse will affect all the descendants.

**Q: Do you believe that a person suffering from mental ill health can be successfully treated by doctors?**

The general consensus was that mental disorders were not a medical condition and hence could not be treated with orthodox medicine. It is as a result of this belief that any signs of disorientation or delirium in a patient suffering from any illness causes relatives to conclude that the illness cannot be treated by orthodox medicine and thus the patient is withdrawn from hospital to seek help from a native (traditional) doctor.

In light of this belief, several individuals develop complications and even die from common illnesses because the minute there is any sign of disorientation or confusion the illness is perceived as being a curse or demonic intervention, and so medical treatment is stopped immediately and the patient isolated or taken to a traditional medicine practitioner.

It is therefore not surprising when an individual is diagnosed as suffering from post-traumatic stress and is referred for psychotherapy, treatment often ends there, as the sufferer believes their illness to be ‘only’ something somatic, physical. There may be flat refusal to see the therapist, with medication refused as long as it has been prescribed for altered behaviour or what the person thinks is ‘madness’.

Taking all these views into account, it is no wonder that little, if any, sympathy or care is available for the person who may have a neurosis, let alone psychosis.

Cultural perception obviously plays a large part in the planning of care for mental ill health, and if the general perception is uninformed, one-sided or myopic, then planning for care will not be effective as the scope of services will be limited.

Although these results are from informal, small-scale research only, I believe these kinds of perceptions are not unique to my country but are prevalent also in neighbouring West African countries. From the focus group discussions, it is evident that even having tertiary education does not necessarily change the ‘commonsensical’ perception of what mental ill health is and what may cause it.

I believe that advocacy for changing this perception must start from the cultural and religious heads in the community if there is to be a breakthrough in mental health care.