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Prayer Camps and Mental Health

A Study of the Religious, Human Rights, and Media Dimensions of the Healing of Persons with Mental Illness in Ghana

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Francis Ethelbert Kwabena Benyah, Turku, Finland

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Abstract

This is an article-based thesis that explores the religious, human rights, and media dimensions of healing of mental illness at prayer camps in Ghana. Prayer camps are healing centres established across various parts of Ghana (and other African countries, e.g., Nigeria, Togo, etc). The main activities of prayer camps include prayers, fasting, Bible studies and counselling. In Ghana, prayer camps attract people from diverse social backgrounds who go to the camps to seek solution or answers to their problems. These problems may be social, economic, health, or spiritual such as infertility, barrenness, HIV/AIDS, witchcraft accusations, mental illness, education, unemployment, visa, marriage, etc. Among these, the healing of mental illnesses has become one of the dominant activities known to take place at prayer camps in Ghana. This study thus focuses on healing practices for persons suffering from mental illnesses at prayer camps in Ghana. The study has been conducted with an extensive interview with patients, prayer camp staff, and health professionals working in collaboration with prayer camps in Ghana. Theoretically, the study was guided by the concept of health and healing among the Akan of Ghana and how the understanding of healing in Akan traditional framework is recast in Pentecostal interpretation of healing especially at prayer camps in Ghana. Through an Interpretative Phenomenological Analysis of in-depth interviews with patients, staff of prayer camps and mental healthcare practitioners, this study points out the varied ways in which prayer camps have assumed an important role in the healing and care for persons with mental illnesses in Ghana. The study argues that the perceived causes of mental illness and the healing practices found at prayer camps appeal much to the Ghanaian because they resonate with indigenous worldviews. It highlights the challenges associated with the healing of the mentally ill at prayer camps. Some of the challenges highlighted are chaining, infrastructural and logical constraints, and inadequate financial resources. The study further highlights the network of relationships between prayer camps and healthcare professionals as new ground that may contribute to the training and building of cultural competence for clinicians working in the field of psychiatry in Ghana. The findings made suggest that the concept of health and healing and the general understanding of the concept of the person have implications for the way mental illness is understood and treated. These concepts also influence the interpretation given to the cause of mental illness and the therapeutic interventions that are sought by patients and their relatives. The prayer camps provided social support and avenues that helped patients to deal with their illness by managing their fears, anxieties and recurrent behaviours. The camps also provided hope in dealing with chronic mental illnesses. The findings also suggest that the abuse of patients at prayer camps is influenced by ineluctable belief systems and practices as well as logical and infrastructural constraints. Another finding made in the study is that media reportages about mental illness and the prayer camps in Ghana are presented differently based on the targeted audience.

Abstrakt

Detta är en artikelbaserad avhandling som utforskar religiösa, till mänskliga rättigheter kopplade och mediebaserade dimensioner av helande i böneläger i Ghana. Bönelägren är center för helande på olika ställen i Ghana (och andra afrikanska länder som Nigeria, Togo osv.). De viktigaste aktiviteterna i dessa läger är bön, fasta, bibelstudier och själavård. Bönelägren i Ghana attraherar människor från olika sociala bakgrunder som uppsöker lägren för att få hjälp med sina svårigheter, som kan vara allt från sociala, finansiella, andliga eller hälsorelaterade problem, såsom infertilitet, HIV/ AIDS, anklagelser om häxeri, till sinnesjukdomar osv. En av de viktigaste av dessa aktiviteter har blivit just helandet av psykiska sjukdomar. Denna studie fokuserar på de praktiker som bönelägren i Ghana utvecklat för att hela människor med psykiska sjukdomar. Den har genomförts genom utförliga intervjuer med patienter och vårdare – både lägrens egen personal och utbildade hälsovårdare som arbetar i samarbete med dem. Teoretiskt grundar sig studien på Akanfolkets i Ghana egna förståelse av hälsa och helande och hur denna traditionella syn på helande i bönelägren omskapats genom pingströrelsens teologi. Genom en tolkande, fenomenologisk analys av djupintervjuer med patienter, personal och professionella vårdare visar denna studie på de olika sätt på vilka bönelägren tagit på sig en viktig roll i helandet och vården av människor med psykiska problem i Ghana. Studien argumenterar för att bönelägrens förklaringar av psykiska sjukdomar och deras vård av dem blivit så populära i Ghana för att de resonerar med lokalbefolkningens världsbild. Studien lyfter fram de utmaningar som vården av de psykiskt sjuka vid bönelägren står inför, såsom frihetsberövande, till och med fastkedjande, strukturella och logistiska begränsningar och finansiella svårigheter. Studien lyfter också fram nätverket mellan böneläger och professionell vårdpersonal som en ny möjlighet för skapandet av kulturell kompetens för dem som arbetar inom psykiatrisk vård i Ghana. Studiens slutsatser visar att förståelsen av hälsa och helande och den allmänna förståelsen av vad en person egentligen är påverkar hur man ser på och behandlar psykisk ohälsa. Denna förståelse påverkar också hur man tolkar psykisk ohälsa och vilka terapeutiska ingrepp som patienter och närstående väntar sig. Bönelägren erbjuder socialt stöd och vägar för patienter för att arbeta med sin sjukdom genom att behärska sina rädslor och återkommande beteendemönster. Lägren erbjuder också hopp för dem som kämpar med kroniska psykiska sjukdomar. Slutsatserna antyder också att de missförhållanden som finns på bönelägren påverkas av lokala trossystem och handlingsmönster, liksom logistiska och strukturella hinder. Studien visar också att de beskrivningar media ger av psykisk ohälsa och bönelägren i Ghana påverkas av den målgrupp som det ifrågavarande mediet primärt riktar sig till.

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1 Introduction

Prayer centres or prayer camps, as they are popularly referred to in Ghana, are Pentecostal healing centres that emerged in Ghana in the 1940s and became more prominent in the 1980s (Larbi 2018; Onyinah 2012).[1] These healing centres organise revival programmes and regular prayer meetings where people with various needs go to with the aim of seeking supernatural solutions to their problems. Emmanuel Kingsley Larbi, a Ghanaian Pentecostal theologian, has observed that people visit prayer camps for varied reasons, including sickness and the need for healing, financial and economic problems, lawsuits, drunkenness, educational issues, accommodation, witchcraft accusation and demonic attacks, etc., (Larbi 2018).

Prayer camps may be categorised into two kinds: the residential and non-residential. The residential ones are those with hostel facilities to house visitors. The non-residential camps do not have hostel facilities. Some of these camps are established, owned, and operated by individuals commonly referred to as prophets, prophetesses, or evangelists. Others are also owned and managed by well-established churches with centralised administrative structures such as the Church of Pentecost (Ghana's largest Pentecostal denomination), the Methodist Church-Ghana and the Presbyterian Church of Ghana (Mohr 2013). As of 2020, the Mental Health Authority of Ghana, the state agency that oversees the administration of mental health service delivery, had estimated that there were about 1,016 prayer camps spread across the 16 administrative regions of Ghana.[2] These camps are located in rural, peri-urban, and urban centres.

The activities of prayer camps mostly centre around the personality of their leaders or founders. The leaders, who are either prophets, prophetesses, or an evangelist, are individuals who are believed to have a special gift from God that allows them to see beyond the physical realm and, through the help of the Holy Spirit, diagnose people's problems and pray for them for solutions (Larbi 2018; Onyinah 2012). Thus, the leaders of the camps promote belief in miracles, consultation with angels, and spiritual healing. Pneumatic ingredients such as prophecies, visions, dreams and speaking in tongues are also very much evident in their practice of worship.

Symbolically, prayer camps share striking affinities and cultural resonance with the old anti-witchcraft shrines and indigenous healing cults that emerged in Ghana in the first half of the twentieth century (Debrunner 1961; Parker 2004; Geschiere 1997). Indeed, the prayer camps have largely been described as a reinvention of the anti-witchcraft shrines and healing cults that were solely occupied with traditional healing methods in addressing both the social and psychological effects of mental disorders (Read 2018; Meyer 1999; Field 1960). They have also been described as Africa's version of psychotherapy (Michael et al. 2019; Ayim-Aboagye 2006; Forster 1962). These prayer camps have sanatoriums where the mentally ill are kept in order to undergo treatment. Treatment options at the camps combine both religious rituals and biomedicine although some camps rely on religious rituals such as prayer and fasting as the sole means for curing psychiatric ailments.

The motivation for this study was born out of the desire to explore the perceived causes of mental illness in Ghana and the usefulness or value of religion in mental health care as found in the healing practices of prayer camps in Ghana. Although religion/spirituality is frequently

[1] The terms 'prayer camp/prayer centre/healing centre' are used interchangeably to refer to the same thing.
[2] See report available at: https://www.graphic.com.gh/daily-graphic-editorials/prayer-camps-not-hospitals.html

considered when looking at African medical and healing systems (Roberts 2021; Ayinde et al. 2021; Azevedo 2017; Twumasi 2005), the prayer camp scene in Ghana is unique.

The growth of traditional healers across Africa complimented the World Health Organisation's effort to expand primary health care in areas that faced scarcity of healthcare facilities and human resources (Bannerman 1983). Following the effects of Structural Adjustment Programmes on Africa's already ailing health system, the campaign for the promotion of traditional healers as complementary medical providers gained momentum (Senah et al. 2001). One of the ensuing effects is the exponential rise of various Christian healing centres that have, quite frankly, exceeded the popularity of traditional or indigenous healing practitioners[3] (Read 2019).

Marleen de Witte (2018), an anthropologist, writing from the context of Ghana has argued that it was during the period of the Structural Adjustment Programme in the 1970s and its attendant economic difficulties that the Pentecostal and charismatic churches emerged with the message of hope and restoration, and this got them a large following.[4] The period also saw the establishment of Pentecostal healing centres (or prayer camps). De Witte, therefore, argues that "the rise of African charismatic Pentecostal churches since the 1980s alerts us to the close link between political-economic shifts and religious renewal..." (de Witte 2018, 66). Reportedly, the economic quagmire that engulfed Ghana's economy between the 1960s and 2000 plunged the country into severe economic hardships, a situation that drove a number of people to turn to religious institutions in search of spiritual help, including health (Mohr 2013). During this period, the government of Ghana, as part of its Structural Adjustment Programme from the International Monetary Fund (IMF), had to introduce what became popularly known as the "cash-and-carry"[5] system in 1992, where patients who went to the hospital were not attended to, even in an emergency medical situation, until service fees had been paid (Mohr 2013; Gifford 2004). Many families were reported to have lost loved ones including those who could not afford their medical bills.[6]

Emmanuel Akyeampong (2015), a Ghanaian historian, has emphasised that the growth of Islamism and Pentecostal and Charismatic Christianity, with a little resurgence of African Indigenous Religions, means that faith healing will continue to remain central to the landscape of healing in Africa. What is worth mentioning in the observation by Akyeampong (2015) is that one of the ongoing challenges in mental health care in Africa is the attempt to clarify the relation between Pentecostal and indigenous healing (which is mainly spiritual/faith-based)

[3] Traditional or indigenous healing practitioners are people who have been trained and specialised in the use of traditional healing methods to cure illness. Some of the methods or approaches may include the use of herbs, spirit of divination depending on the type of healer or the sicknesses been cured.

[4] In Ghana, religion is believed to be a powerful resource that provides pragmatic solutions to people's basic problems. In fact, any religion that is not able to offer its adherents the solution to existential challenges is seen as ineffective (see Larbi 2018; Atiemo 2016). During the country's economic downturn, the churches that emerged preached messages that sought to offer hope and solution to people's problems. This resonated with the beliefs of the people and thus attracted a large following (Gifford 1998).

[5] Before the introduction and implementation of the "cash and carry scheme", the government of Ghana, through its Ministry of Finance and Economic Planning, provided initial seed funds or capital in terms of free drugs through the Central Medical Store to government health facilities. The individual facilities were expected to sell the drugs to patients and use the proceeds to procure more drugs under a revolving fund scheme. However, the cash and carry scheme was introduced and the government stopped providing funds for drug purchases except for special cases. The costs were directly shifted to the consumer or the patients (See Asenso-Okyere et al. 1999; Biritwum 1994).

[6] These challenges were the reasons behind the introduction of Ghana's National Health Insurance Scheme (NHIS) in 2003 by President John Agyekum Kufour to abolish the "cash and carry" system at the time. Despite the relief brought by the NHIS, the scheme is reportedly saddled with various challenges including the late payment of fees by the government, forcing some health centres and providers to demand cash before treating or administering medication to clients.

and Western psychiatry.[7] Indeed, the different healing modalities present a plurality of medical healing systems with their own myriad of challenges.

What is, however, common is the notable semblance and similarities in the patterns and approach to healing in both Christian and/or Pentecostal healing centres and the traditional healing centres or shrines. Despite the fluidity and interconnectedness of these two (indigenous healing practices and healing at prayer camps in Ghana), scholars seldom discuss the nexus between the two. Indeed, a significant gap exists in our knowledge of the transition and transformation that recalibrated contemporary practices and experiences of healing, particularly in Ghana. The reinvention of prayer camps as indigenous healing cults and what they hold for modern healing practices and health care in Ghana have seldom been examined by the growing literature in Ghanaian Pentecostal studies and, broadly, in the intersection between religion and health care. By taking a tour of the cultural and religious landscape of Ghana, particularly the Akan, this study maps healing practices for mental health patients[8] in Ghana's prayer camps within traditional Akan indigenous frameworks. The study argues for substantial attention to be given to the religious institution, such as the prayer camps, which seeks to provide health relief, a community and social support for people in low-income countries with limited resources in the area of healthcare.

1.1 Background to the Study

1.1.1 What is Mental illness?

It is important to emphasise here that there is no clear-cut definition of mental illness. Indeed, "mental illness does not refer to a homogenous group of problems, but rather to a number of different types of disorder" (Patel et al. 1995, 217). Despite the fact that every society has people it categorises as mentally ill, mental illness shifts in meaning from one society to another. There are a plethora of reasons given in relation to causation, symptoms, treatments, and outcomes. Studies conducted in Ghana so far reveal that there is a lack of unified understanding of the concept of mental illness (Yendork et al. 2016; 2018; Kpobi and Swartz 2018). According to the Mental Health Authority of Ghana (2018, 24), studies conducted so far on mental health cannot be generalised because "they are not epidemiologically robust".

In Ghana, the group of disorders mostly associated with mental illness are psychotic and affective disorders such as mania, bi-polar, schizophrenia, etc. These disorders are commonly labelled *abodam,* translated "madness", and they are the most common disorders one could find among people seeking treatment at prayer camps or healing centres (Yendork et al 2018; Arias et al. 2016). There are also cases of mental disorders resulting from substance abuse and alcoholism. Mention can also be made of cases of anxiety disorders and depression. When I use mental illness in this discussion, most often, I am mainly referring to psychotic and affective disorders such as mania, schizophrenia, bi-polar and other forms of mental disorders induced by the abuse of substances such as narcotic drugs, marijuana, and alcoholism.

[7] I use the term "western psychiatry" to refer to forms of psychiatric practices as developed and practised in America or Europe.

[8] I use the term "patient" to refer to those receiving treatment for mental illness at prayer camps from the Prophet. The Akan word for patient is *yarefo,* which translates as "sick person". At prayer camps, some of the caregivers and health professionals use the same term in referring to the mentally ill seeking treatment.

Despite the biological, physiological, social and environmental factors that may influence the cause of the above-mentioned mental illnesses, there is a strong belief that some of these illnesses may, at times, be caused or influenced by personal or impersonal evil forces such as witchcraft and *juju.*

1.1.2 Religion and Mental Health: A Challenge or Resource?

For some practitioners and scholars, religion and spirituality in mental health care are only a figment of people's imagination; there is no scientific truth in religion in mental health care (Dein 2018; Crossley 1995). The role of religion in the general health care of mental health patients is less regarded and even in places where there is some recognition, it is not held without disdain. For instance, the division between "health care and religion has been deepest and widest for mental health specialties" (Koenig 2007, 162). In fact, "religion has long been considered neurotic and often inimical to good mental health by MH [mental health] professionals…" (Koenig 2007, 162; see also Walach 2021; Sommer 2021). In the treatment of mental illness, religious beliefs are often ignored by psychiatrists and other mental health professionals. In practice, mental health professionals are often ill-trained in the assessment of factors such as religious beliefs in clinical settings (Rosmarin et al. 2011).

The attempt to jettison religious beliefs in clinical settings "creates a reticence to broach" the topic of religious beliefs "in psychiatric research and practice, which in turn perpetuates assumptions throughout the field that these facets are tangential to human functioning and a side issue in treatment" (Rosmarin et al. 2011, 254). Rosmarin et al. (2011, 254) argue that "protocols for assessment seem to ignore religious beliefs and there seem to be a few interventions that take control of religious and spiritual beliefs". Simon Dein (2018, 127), an anthropologist and psychiatrist, has observed that "religious beliefs and practices are widely seen to be 'primitive', dependency forming, guilt inducing, non-empirical and necessarily bad for mental health". Indeed, in some societies, religious practices for health and healing "are considered to be irrational (even superstitious or magical) and ineffective ways of thinking and acting" (McGuire 2008, 119).

Such an attitude towards the role of religion in mental health has often led to misgivings about the promise of religion in aiding recovery for mental health patients.[9] This sometimes results in tensions that provide grounds for conflict and competition. Conflicts arise out of the dichotomy of worldviews that guides the practices of both religious healing and biomedicine and, consequently, produces a disruptive effect on the wellbeing of the people in search for a relief. In Ghana, for example, healing spaces have often become a ground for cultural negotiations, contestations and tensions that are animated by conservations and interactions between ethnomedical diagnosis of traditional or indigenous healers, faith healers (more particularly those from the Pentecostal or charismatic spectrum, and Islam) and the modern hospitals (Michael et al. 2021). Thus, "around the sickbed swarm conflicting interpretations of disease and competing prescriptions for cure. The medical arena turns

[9] This is not to assume that there are no harmful or negative effects of religion and/or spirituality in health care. Evidently, not all the effects of religious beliefs and practices are positive, and it is important that healthcare professionals be aware of times when religious beliefs become injurious or conflict with appropriate medical care. Indeed, religion has been used to justify all kinds of negative practices in human history, not forgetting the rigid and inflexible nature of religion that sometimes becomes excessively restrictive and limit progress (see, Koenig 2007). See also Exline's (2002) article, "stumbling blocks on the religious road: Fractured relationships, nagging vices, and the inner struggle to believe" for further reading.

adversarial forum. Curers [or healers] not only battle disease there. They confront one another's opposing views of sickness or health-beliefs molded in personal development, social events, and cultural history" (Sullivan 1989, 3).

Despite the negative and sometimes corrosive view of the role of religion in general health care and mental health in particular, several studies have highlighted the potential of religion and/or faith-based resources in the management or prevention of severe mental disorders (Janus 2019; Koenig 2018). These positive expressions of the role of religion are not just descriptive imaginative events but are tangible experiences of people about the role of religion in improving, aiding, or healing their medical conditions (Walker et al. 2020; Cabo and Mattson 2019; van Dijk et al. 2014). The question that needs an answer is: why do people around the globe continue to rely on religious and/or faith-based resources to cope with illness and health conditions despite the massive development and advancement in science and technology, resources and facilities and the manufacturing of scientifically tested and approved medicines and vaccines to address public health issues such as pandemics? Indeed, the recent Covid-19 pandemic appears to have dazed the world because it defied "the fawning hope invested in technology" (Prempeh 2021, 2).[10] The Covid-19 pandemic has shown the world the limited nature of science and technology and biomedicine and rather, to an extent, provided a sustained trust in religion as a source of hope in times of crisis.[11]

One factor that has led to definitional boundaries, contestation, and disillusion of the role of religion in health care is the rationalistic spirit of the enlightenment that birthed the development of science and technology and, subsequently, biomedicine, and relegated traditional and even religious healing to the periphery (Taylor 2007; McGuire 2008; Brown 11).

However, it will be sufficient to acknowledge that, ironically, while the clergy and nonclergy alike had, before the period of the reformation and enlightenment, relied on religious resources to cope with or address ill-health conditions, they later denounced such practices during the long reformation as "magic", "superstitious" or "witchcraft".[12] In fact, many religious organisations or established Christian denominations criticised "religious groups that preached religious answers to believers' material concerns such as illness…" (McGuire 2008, 135). The definitional boundary between religion and medicine that was socially constructed in Europe in the period of enlightenment became a colonial relic and fostered the binary differentiation between medicine and religion (or the secular and profane) in mission field in West Africa in the 19th and latter part of the twentieth century (Heaton 2020; Mohr 2009; Ranger 1982).

[10] Indeed, a rapidly interconnected world through technology, for example air travels, was a major vehicle for the transmission of the virus to other parts of the world.

[11] During the Covid-19 era, reports were rife of some nations, including the United States of America, declaring a National Day of Prayer and Fasting to seek God's face for deliverance from the pandemic. See the Pew Research Centre report "more Americans than people in other advanced economies say covid-19 has strengthened religious faith", https://www.pewforum.org/2021/01/27/more-americans-than-people-in-other-advanced-economies-say-covid-19-has-strengthened-religious-faith/. Other arguments could also be made that it has weakened religious faith to an extent.

[12] Indeed, "the first hospitals in the West for the care of the sick in the general population were built by religious organisations and staffed by religious orders. Throughout the Middle Ages and up through the French Revolution, physicians were often clergy. For hundreds of years, in fact, religious institutions were responsible for licensing physicians to practice medicine. In the American colonies, in particular, many of the clergy were also physicians—often as a second job that helped to supplement their meagre income from church work" (Koenig 2012, 1).

This conundrum was later to be seen in the stark opposition to Akan[13] indigenous therapeutics by Western European missionaries (and even colonial authorities) who worked in Ghana. These Europeans sought to rationalise traditional medicine as "backward", "primitive", "fetish" or "demonic"[14], even after some of them had evaded the missionary graveyards as a result of treatment they received from local native doctors (Mohr 2009).[15] Andreas Riis, a Basel missionary who worked in the Gold Coast (now Ghana) from 1832 to 1839 and 1843 to 1845, recounted his experience as follows:

> Under the treatment of Dr. Tietz, my condition deteriorated each day for the next eight days. Some old Europeans, who visited me and recognised from experience my ailment, now gave me hope and pleaded that I refrain from taking the medicine from Tietz, but rather I should contact a negro-doctor […]. He [the negro-doctor] washed me with soap and lemon and then repeatedly with plain cold water all over my body and that was mainly the cure: the cold baths were not only pleasant and invigorating, but also worked upon the illness extremely quickly (Quartey 2005, 34).

Riis' encounter with the native doctor was after a recommendation by some old Europeans who found the medical practices of a Danish doctor at the Christiansborg Castle in Accra ineffective, resulting in the death of many who employed his services.[16] Riis' experience, indeed, shows an "implicit opposition to the nineteenth century Euro-centric belief that Africa culturally had nothing of significance" (Quartey 2005, 34). The development of biomedicine became more of an empirical and rationalist science and "shut itself off from non-Western forms of knowledge, thereby derogating their value" (Mohr 2009, 451). In contemporary Ghanaian society, the dominance of faith healing practices as found in the prayer camps continues to attract significant attention both locally and globally due, in part, to its assumed potential healing efficacy as claimed by users of the prayer camps, especially those with mental illnesses.

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[13] The Akan constitute more than half of Ghana's population and are the largest ethnic group in Ghana, comprising the Ashantis, Fantes, Nzema, Ahanta, Akuapem, Sefwi, Bono, etc. (Buah 1998). The results of the 2020 census conducted in Ghana show that the Akan ethnic group is made up of 45.7% of the current population in Ghana (see Ghana Statistical Service 2021).

[14] Some Western Christian missionaries and colonial authorities demonised and denounced traditional medicine because of the relationship between traditional medicine and local divinities (see Asamoah-Gyadu 2014).

[15] In the nineteenth century, West Africa was referred to as the graveyard of the Whiteman due to unfavourable weather conditions and the perennial deaths of Christian missionaries to tropical diseases such as malaria. These native doctors might have included the herbalist (*odunsini*), traditional priest (*ɔkomfo*), medicine makers (*aduruyefo*) and the amulet or charm maker (*asumanfo*). These practitioners were and are still noted for their role in traditional healing or alternative medicine in Ghana (Michael et al. 2021). Mohr (2013) reports that the Basel Mission in the Gold Coast did not introduce any spiritual healing alternative nor Christian ritual protection against harmful evil forces. Despite the fact that Akan healers saved the lives of missionaries and were also frequently consulted by Akan Christians, the Basel Mission later demonised these systems as fetish and witchcraft, and they excommunicated anyone from the church who consulted such mediums. However, the Presbyterian Church of Ghana, a scion of the Basel Missionary Enterprise, reconstructed this notion about Akan healing systems and religion and later established healing centres (prayer camps) to address the growing concerns of its members who were drifting to other churches due to the inability of the church to respond to the spiritual needs of the people, especially religious healing (See Mohr 2013, chapter 3 for further reading).

[16] After treatment from another serious illness by a native doctor, Riis is reported to have claimed that Dr. Tietz' treatment approach was "useless" (Mohr 2009, 445). Dr. Tietz was a European physician in Christiansborg, the administrative seat of the colonial government in Accra at the time. Available reports indicate that Riis was not the only missionary to be treated successfully by a native doctor. Johannes Zimmerman, who first wrote the *Ga* dictionary and translated the first *Ga* Bible, also employed the services of a traditional or native doctor (see Mohr 2009).

1.2 The Religious and Socio-Cultural Contexts of the Study

While there is no doubt that Christian missionary activities in the late nineteenth century introduced the Ghanaian (or more particularly the Akan in the context of this study) to Christianity, the traditional Akan architecture and systems of beliefs and practices suggest that the Akan had a prior knowledge of God (*Nyame*) or the Supreme Being before the coming of the missionaries.[17] Contrary to the long-held erroneous belief that Christianity arrived with the first Basel Missionaries in the nineteenth century, the Christian religion had been present in the Gold Coast (now Ghana) for almost three and a half centuries but only with exceptions notwithstanding, it remained exclusive to European merchants and their workers (Grant 2020). Indeed, before European expeditions by the Portuguese in the late fifteenth century, the geo-political space of what is now known as Northern Ghana had been Islamised; and some states of the present day Akanland had also had encounters with some Muslim emissaries, particularly through trade (Silverman and Owusu-Ansah 1989; Ellis 1966).

Prior to the evangelisation by Western Christian missionary groups, the practice of the traditional religion, which manifested through the chieftaincy system, included systems of governance, belief systems and their associated practices. The contents of the belief systems and practices included notions about health and healing (Mohr 2013). Thus, the Akan had their therapeutic traditions long before Christian evangelisation began in Ghana (Mohr 2009). The Ghanaian philosopher, Kwame Gyekye (2013), has argued that a deeper reflection on the characteristics of African thought would ultimately reveal the empirical orientation that underpins their sources of knowledge and culture which has immediate practical influence in areas such as herbal medicine. Gyekye (2013, 145) notes that "long before the introduction of Western medicine, they [the Africans] knew, through trying and testing, about the medicinal potencies of herbs and plants – their main natural sources of healing".[18] And "even today, there are countless testimonies of people who have received cures from 'traditional' healers where the application of Western therapeutics could not cope" (Gyekye 2013, 145).

The practice of medicine, health and healing was the preserve of herbalists, midwives and traditional priests or priestesses referred to in the local parlance as *odunsinni* (herbalist), *awogyefo* (traditional birth attendant) and *ɔkomfo* (traditional priest).[19] These practitioners were and are still known to have the curative powers in curing illnesses (both natural and supernatural) in present day Ghana. I will show later in subsequent sections how such belief systems have remained relatively unaltered, and influenced the systems of medical practice in Ghana today. The herbalist makes medicine from plant roots (and herbs) although there is a spiritual component associated with his or her work. Traditional priests are known for employing divine methods (for example spirit possession) to diagnose illness.[20] They also

[17] The Akan affirm knowledge in the Supreme Being through Akan maxims such as *Obi nkyerɛ abofra Onyame,* which may be interpreted either ways as No one shows a child the Supreme Being (he knows by instinct) or No one shows a child the sky (which is the abode of the Supreme Being). The Akan affirmed in the Supreme Being but only through the pantheon of smaller gods or the deities who were believed to be children of God (Busua 1954; Meyerowitz 1958; Danquah 1968).

[18] The expression "Western medicine" is used to refer to medicines or drugs produced in Western countries such as North America or Europe which are mainly administered at hospital settings. Western medicine could also be broadly defined to include application of or healthcare seeking at a clinic or hospital.

[19] For a detailed description of the roles of these practitioners, please read Appiah-Kubi (1981) and Ayim-Aboagye (2006).

[20] This practice is similar to what pertains in shamanistic forms of healing. Indeed, the *ɔkomfo* has also been referred to as the "Asante shamans". See, for example, "Twin Cult of the Akan & Asanti Shamanism", http://africanshamanism-anth375.blogspot.com/p/twin-cult-of-akan-and-asanti-shamanism.html. See also,

engage in the practice of driving out demons or evil spirits from people that are believed to be influencing the cause of their illness. Traditional birth attendants are generally women who specialise in all maternity needs.[21] In indigenous Ghanaian societies, these distinctions might not necessarily apply because of the homogeneity and the mutual imbrication of their work. Again, there is also an ambivalent power relationship; though the medicines they provide are used to protect people against sickness, they could also be manipulated to inflict harm against a fellow human being (Mohr 2013; 2009; Rattray 1927). Thus, "medicine was not always a consumable or applied object but was often spiritual in nature (immaterial)" (Mohr 2009, 441).[22]

Christian missionary activities began in the coastal regions of Ghana (then the Gold Coast) in the middle of the nineteenth century, and later spread to the Akan states in the hinterlands (Debrunner 1967). Despite some resistance from traditional authorities, the missionaries made inroads and gained converts. Later, tensions erupted when the converts were made to discard their traditional customs and adopt the lifestyle of the Western missionary (Grant 2020; Mohr 2013). What is significant, as part of these tensions and conflicts, was the attitude of converts who, despite their newfound faith, were still found to synchronise their old beliefs and practices (usually seen as "backward") anytime a misfortune such as illness struck (Mohr 2013). Indeed, the Akan religion and healing institutions had become so reified as part of the natural order of things for the indigenes that their therapeutic effects could not be conceivably challenged. Adam Mohr (2009, 442), a medical anthropologist, has observed that "Akan healing institutions did not disappear with the establishment of Christianity through the nineteenth century, but coexisted, sometimes symbiotically and sometimes competitively, with churches". In short, Akan converts to Christianity did not abandon their traditional worldview (Omenyo 2002). An eminent Ghanaian sociologist, Kofi Abrefa Busua (1954, 208), has described the impact of Christianity on Akan worldview as a "thin veneer" denoting the acceptance of Christianity by the Akan, albeit superficially, if one considers the continuous attachment of the Akan to his or her culture which had religion as its base.

Despite these conflicts and tensions, the indigenous people appropriated the gospel message, reformulated and incorporated it into their world of ritual power and communal relationships. They recalibrated the Christian faith, which subsequently became the precursor of contemporary Christian revival (Grant 2020). Commenting on the ways Africans appropriated the gospel message, Abraham Akrong (2008, 63-64), an astute Ghanaian theologian, was right when he emphasised that:

> the result is a different understanding of Christianity that has made it possible for African Christians to appropriate Christianity as a liberating, life-transforming religion of salvation which can help many desperate people in Africa to deal with the existential raptures and structural violence that continue to define their lives. At the centre of this liberated Christianity is a radical paradigm shift nurtured by African traditional spirituality, which has given a place for the questions and concerns shaped by African culture and worldviews.

Ephirim-Donkor (2008), "Akom: The Ultimate Mediumship Experience among the Akan", http://www.jstor.org/stable/40006025.

[21] Read Twumasi (2005, 25) for a detailed description of the role of traditional birth attendants in Akan communities.

[22] E. Bolaji Idowu (1973), the Nigerian theologian, has attempted to describe as well as deal with the contested categorisation between magic and medicine in African traditional societies. See pages 189-202.

In Ghana today, Christianity has become a dominant religion with 71.3% of the citizens claiming affiliation to it as shown in the 2021 census results.[23] The 1992 Constitution of the Republic of Ghana makes the country a secular state, but it is undoubtedly not an atheistic one, especially when one considers the numbers of those who identify with one form of religion or the other. The claim to religiosity is not only seen in the percentages but the sheer number of churches spread across the country as well as the popularity of religious activities in Ghana's public space attests to this fact. Mention can also be made of the enthusiasm and vitality that most Ghanaians attach to religious services and rituals. Abamfo Ofori Atiemo (2013, 95), a Ghanaian scholar of religious studies and history of religion, has argued that Ghana's population "presents a kaleidoscope of several different religious manifestation, all of which, to different degrees, have affected the way people attempt to understand and relate to the world around them". This characteristic nature of religion among the Ghanaian necessitates the frameworks that provide explanations, norms, hope and essence of values for the people.[24]

Religion has an essential influence on and pervades the life of the average Ghanaian in all areas of life and this makes religion an important social, cultural and spiritual capital. Undeniably, "religious activities are among the deepest and the most manifest passions of Ghanaian people. Both in the city and in the village, Ghanaians demonstrate a religious consciousness that suffuses with their entire life" (Atiemo 2013, 95). In Ghana, several religious traditions are harnessed as resources to enhance not only one's spiritual life but also to achieve material ends such as health and healing, good marriage, guidance in life's pursuit, success, and social protection.

Common to Ghanaian religiosities is the belief that "the world is full of divinities, spirits, [as well as] demons and their human allies in the forms of witches and wizards" (Imasogie 1983, 75). These can be harnessed for either good or evil and as a result, there is a need for religious functionaries such as prophets, pastors, *malams,* priests or diviners who neutralise and ward off supernatural evil realities. These religious functionaries hold a central cultural and societal role.

Religious institutions and traditions also continue to "serve as powerful agents of social control and make for the integration, maintenance, and reinforcement of social values" (Assimeng 1989, 9). More so, contemporary events have shown that the metaphysical forces (deities, witchcraft and other traditional religious practices) which were largely held as ignorant superstitions to be left behind as society embraces monotheistic religions and other modes of modern life, continue to be appropriated by members of all levels of society and religions (Tweneboah, 2020; Atiemo 2006; 2014). This expression of religiosity is rearticulated when searching for solution to matters relating to health and healing. It is this feature of religious outlook that explains the Ghanaian attitude towards health, social and economic matters. A sociologist of religion, Meredith McGuire (2008, 121), has emphasised that "to understand the relationship between people's health and religion, we must consider broad areas of social life: all the beliefs, practices, and relationships that address people's

[23] Ghana Statistical Service, 2021. Islam 19.9%, and traditional and/or indigenous religion 3.2%, other religions 4.5 including Christianity 71.3 making a total of 98.9% claim to different forms of religiosity. Available at https://census2021.statsghana.gov.gh/getthefacts.php?readpage=MzE2Njk3MDQ0LjUxOA==&Overview-of-the-2021-PHC (accessed on 21st October 2022).

[24] In the project "Young Adults and Religion in a Global Perspective (YARG)", the Ghanaian sample scored the highest level of religiosity in all values among all the thirteen national samples that were included in the project. See for example, Golo et al. (2019; 2020).

physical and emotional health and well-being and their religious/spiritual needs and aspirations".

Apart from the religious fervour of the Ghanaian society, another salient aspect of Ghana's social structure is the kinship relationship, which acts as a source value in Akan social life. Individuals are socially knit together and what affects one affects others. Akan maxims such as "I am therefore we are and since we are therefore I am" evince the dependence of one another in the social web of relationship. For instance, "misfortune as well as good fortune [is] considered not only individual problems or joys but as societal concerns. Any individual act has societal repercussions either for good or evil. This becomes highly significant when an individual is ill" (Appiah-Kubi 1981, 15). In times of sickness such as mental illness, the kin group, or the family shares in the illness experience by contributing their time and resources to ensure the recovery and wellbeing of the person.[25] In the context of healing, social relationships have often been cited as a distinctive marker between hospital "medicine" and religious or traditional healing, where the former focuses on the individual and the latter on the social group. A classic example where illness is treated as a group and not an individual issue can be found in Turner's work on *The Drums of Affliction* on the *Ndembu* of Zambia. For Turner (1968), it is the kinship relationship, when invoked during the process of divination and rituals, that enhances the healing process and helps to restore the afflicted person.[26]

1.3 Problem Statement

The work and activities of prayer camps have often come under severe criticisms, especially from different stakeholders who seem to construct or interpret the operations of the camps from secularist orientations with little or no attention to the religious and socio-cultural context within which they operate. Whereas such studies and criticisms may not be far from right, a closer and more emic interaction with users and staff of the camps reveals a narrative on the meanings participants ascribe to the camp or the healing centres.

The medical system in Ghana is pluralistic, denoting a parallel or co-existence of indigenous/traditional, faith healers (including Christianity and Islam) and biomedicine (Roberts 2021; Ayim-Aboagye 2006; Owoahene-Acheampong 1998; Twumasi 2005).[27] The plurality of belief systems in general, and of medical systems in particular, often present a myriad of healing practices and models that results in differential boundaries and, sometimes, suspicion, mistrust and unhealthy competition that obfuscate or trivialise intended integration and collaboration between practitioners aimed at addressing the wellbeing of people or to resolve shortfalls of each medical category. Mistrust and lack of openness between different healing modalities thus creates a problem of "theoretical closure"[28] and bifurcates any attempt

[25] See summary chapter 3 for further discussion on the kin group relation during times of sickness.
[26] Alternatively, Read and Nyame (2019) have also examined how poor households in Ghana find it difficult in ensuring social solidarity during situations of mental illness of a family member due to the increasing economic costs incurred in the treatment and management of chronic illness such as mental illness.
[27] Some scholars such as Twumasi (2005) lump both indigenous and faith healers all under the umbrella term of *traditional healers*. Appiah-Kubi uses the umbrella term *priest-healer* in reference to various types of healers in the Akan community (See Appiah-Kubi 1989). In Ghana, however, traditional healers are often used in reference to indigenous medical practitioners whose services chime with traditional belief systems. They have long been advocated as important resources for mental health care in sub-Saharan Africa (Patel 2011; Ayim-Aboagye 2006).
[28] The term "theoretical closure" is a borrowed term from Jean Comaroff (1981, 367) to refer to the supposition that "medical systems" form a natural and discrete domain, and the view that such "medical systems" would be "parts of

at finding a solution that illuminates an understanding to general problems, such as the articulation of thought and action, of individual experience and cultural (and religious) form, and symbols that are fundamental to addressing the health needs of a society that is religiously and culturally diffused and more diverse (Michael et al. 2021; Comaroff 1981).

Again, despite the many direct and indirect problems associated with mental health in Ghana, mental health patients and mental health care in general, remain one of the most under-researched groups in the country (Yaro et al. 2020). Previous studies have shown that "mental health research in Ghana remains limited in both quantity and quality. In the absence of a comprehensive research record, much is assumed based on scant evidence, and services are heavily influenced by the results of research conducted elsewhere, most often in high-income settings" (Read and Doku 2013, 101). Read and Doku (2013) were of the view that epidemiological studies in mental health in Ghana should be done by local researchers and mental health workers, including social scientists, since research work done by foreigners is sometimes crusted with or influenced by their own cultural biases. They recommended further studies in qualitative research, especially ones that employed anthropology/ethnographic approaches.

However, what they left out in their recommendation is studies that draw on religious sensibilities, though they acknowledged in their studies the role of religion in matters relating to mental health care and its influence on help-seeking behaviours. Indeed, such failures of the recognition of the role of religion in the practice of mental health care account largely for the gaps in most recent studies. Only a handful of studies have attempted to systematically analyse the religious components and their place in mental health care in Ghana (Read 2019; Kpobi and Swartz 2018; Yendork et al. 2018). Thus, there is a dearth of research examining the effect of ritual, prayer, and other aspects of religious experience on mental health care in Ghana.

Early works give little or no value to the role of religion (Opare-Henaku 2013; Tooth 1950). Previously conducted studies have examined the phenomena mainly from anthropological, psychological, and clinical perspectives whereas very little attention has been given to socio-cultural factors including religion, i.e., factors that contribute to the lack of wellbeing that follows from forms of mental illness (Ofori-Atta et al. 2018; Kpobi and Swartz 2018; Read 2017; Arias et al. 2016). This lack of interest of the role of religion is perhaps due to the malaise or the irrational approach to the role of religion in mental health care.

1.4 Research Question(s)

To comprehend the role of religion in health and healing and how it is expressed and articulated in mental health care, the study asks the following question(s):

a. Why do people go to the prayer camps and what do they seek to find? In other words, what meanings do participants ascribe to camps in general and healing rituals and how do participants recall their overall experience from the camps?

ahistorical and closed systems". In simple terms, Comaroff uses the term to describe a situation where the etiological explanation and therapy of a particular medical system is held as important against the other. She is of the view that such etiological hegemony of medical systems prevents an opportunity of sharing of knowledge among different medical domains which in effect has consequences on the patients who seek the services of these medical practices in solving their problems.

b. In what ways do Ghanaian Akan traditional and Pentecostal beliefs, practices and actors serve as a vehicle in managing and dealing with mental illness?

c. What role do healing rituals at prayer camps offer to people with mental illness and the human rights concerns that are expressed with the performance of such rituals?

d. How do media narratives construct mental illness, religion and Ghanaian society, and to what extent do they provide understanding or risk causing further exclusion for people with mental illness?

Prayer camps hold a central public religious position, and this study discusses how they can better deal with the deep-rooted societal stigma and prejudice associated with persons with mental disabilities, and consequently how a potentially vicious cycle can be altered.

1.5 Aims of the Study/ How Research Questions are Answered in the Articles

The main objective of this study is to explore the role of religion and/or faith-based resources in mental health care in Ghana. The aim here is to explore how people deploy religious resources in the management of mental illness and the importance of these resources to general health care in Ghana. In Ghana, religion is very important as it is the means through which people identify themselves and cope with life realities (Assimeng 1989). Healing is thus connected to religious practices and is one aspect through which faith in God is demonstrated. By describing and mapping belief frameworks within the Akan traditional context, this study aims to contribute to an understanding of lived religious and healing practices in Ghana.

Each of the four articles aimed at answering one of the above research questions. The first article, "Healing and mental illness in Ghana: Why prayer camps in Ghana are sometimes alternatives to psychiatric hospitals", aimed at answering the first research question. In this article, the reasons behind the continuous reliance or why people continue to seek treatment at prayer camps as institutions of health care for the mentally ill in Ghana were explored. The article provides answers to the meanings participants ascribe to the healing rituals at the prayer camps. It also provides insights into participants experience at the camps and the reasons why the prayer camps continue to enjoy patronage against the backdrop of criticism from some health professionals, human rights observers, and NGOs. In addition, the article also discusses and provide reasons to why the prayer camps, sometimes, becomes an alternative to psychiatric hospitals in the choice of therapeutic interventions by patients and their families.

The second article, "Prayer camps, healing, and the management of chronic mental illness in Ghana: a qualitative phenomenological inquiry", focused on answering the second research question. The article investigated the perceived causes of mental illness among participants and their caregivers at prayer camps. Thus, the article provides an answer to the perceived causes of mental illness among patients and analyses how these perceptions influence help-seeking behaviour as well as the ways in which mental illness is managed by both patients and their caregivers. In answering the perceived causes of mental illness, the article presents how Akan traditional and Pentecostal beliefs about the perceived causes of

mental illness influenced participants' choice of therapy or treatment intervention as well as the ways in which such beliefs help in the management of their illnesses.

The third article, "Prayer camps, mental health, and human rights concerns in Ghana" examined the role healing rituals at prayer camps offer to people with mental illness and the challenges associated with the performance of the healing rituals. The article aimed at dealing with one of the contentious issues associated with healing practices at prayer camps in Ghana. The prayer camps in Ghana have been heavily criticised for engaging in abusive practices as part of their healing rituals, practices which, some have argued, take away any eventual promise of restoration of people who go to seek treatment at the camps. This article investigates these concerns and provides an alternative lens in examining the situation of mentally ill persons at prayer camps in Ghana and recommends ways that such abusive practices could be addressed at prayer camps in Ghana.

The fourth article, "media portrayals of religion, prayer camps and persons with mental illness in Ghana: a discursive and narrative analysis", answers the fourth research question by focusing on the media reportages about the prayer camps and people with mental illness and the ways this construction of the mentally ill and the institutions where the mentally ill are catered for (i.e., prayer camps and psychiatric hospitals) have implications on social attitudes towards the mentally ill in the Ghanaian society. In answering this question, the article provides insights into what extent these media portrayals challenge or contribute to the stigmatisation of persons with mental illness in Ghana.

1.6 Observations on the Research Process and Compilation of the Articles

The articles are logically arranged in the thesis based on the order of the research questions. So, the first article answers the first research question, the second article, the second research question, the third article, the third research question and the fourth article, the fourth research question.

The compilation of this article-based thesis involved several processes, some of which bordered on which article to include in the compilation. This issue became a concern as the data that was collected during fieldwork generated a number of interesting findings and conversations about the activities of the prayer camps. That said, the articles that ended up in the compilation were carefully thought through on the basis of the key research questions and the motivation that guided the study. Therefore, the articles that form this thesis are mainly focused on the role of religion in addressing mental health problems in Ghana and some of the challenges that are associated with it. The issues discussed in the articles form part of the broad base conversation that surrounds the operations of the prayer camps by state and non-state actors such as NGOs, health professionals, academics, human rights activists, and religious leaders in Ghana.

Another difficult task in compiling this article-based thesis was how to weave all the four articles together as a coherent whole. This process involved back and forth examination and re-examination of the thesis research questions and objectives to ensure that everything that was discussed in the articles and the summary of the compilation were systematic and addressed the central goals of the study. As a result, let me take the opportunity to emphasise or inform the reader that there might be possible repetitions and over-emphasis of some of the

issues in the compilation. This should be accepted as one of the shortfalls in the compilation of the articles. I do admit these challenges, and, like all research process, these shortcomings should be taken as part of the research process which is ongoing and is subjected to several and continuous evaluation and re-evaluation processes.

In addition to the above observation, let me also state that this research took place in an environment that I was highly familiar with, although I had no connection with any of the prayer camps I studied. My ability to speak the local language (Twi) of the people I interviewed afforded me the opportunity to better understand and interpret the core meanings of some of the expressions and experiences shared by my participants. In the articles and the discussion of the main findings, I have made arguments and references that fuse a number of discourses from psychology and social and transcultural psychiatry. I make these discussions not as an expert in the field of psychology or psychiatry and I do not expect my readers to see me as such. I do agree that some of the findings and discussions in the study may be challenged and disputed by experts in the field of psychiatry. Nonetheless, let me also remind readers that studies in psychology and psychiatry are a social phenomenon that focuses on human behaviour and actions. The human beings at the centre of these disciplines are cultural beings with varied religious, spiritual, and cultural practices that make the examination of these aspects of psychiatry very pertinent. Therefore, though not an expert in psychiatry, I do expect that readers will find most of the issues discussed in the articles, including the findings and conclusion, crucial for consideration in the fields of psychiatry, religion, and culture.

With the exception of the article on media portrayals of religion, prayer camps and mental illness (IV), all the articles were written or authored solely by me. In the IV article, I co-wrote introduction. I wrote the section on mental illness and religion in Ghana, selected reportages of mental illness and religion in Ghana. Sofia Sjö wrote the section on theory and discussion and conclusion. I provided most of the data for the article as well.

1.7 Introduction of the research articles

This thesis is based on four peer-reviewed articles, three of which have already been published. The fourth article on portrayals of religion and mental illness has been accepted for publication. A detailed reflection on the findings of these articles is discussed in chapter 3.

Article I

"Healing and Mental Illness in Ghana: Why Prayer Camps in Ghana are Sometimes Alternatives to Psychiatric Hospitals." *Temenos: Nordic Journal for the Study of Religion* 59(1): 101-123. https://doi.org/10.33356/temenos.109270

This article presents the reasons behind the continuous reliance on prayer camps as institutions of health care for individuals suffering from mental illnesses in Ghana. The article contextualises health and healing from Akan perspective and draw implications on the importance of the Akan worldview on illness and help-seeking behaviour. The article argued that prayer camps would continue to exert public influence and play a dominant role in the treatment of mental health sicknesses due to the underlying religio-cultural beliefs and notions

associated with the illness, especially from traditional Ghanaian Akan perspective and the inadequate resources at the disposal of state-owned psychiatric hospitals.

Article II

"Prayer Camps, Healing, and the Management of Chronic Mental Illness in Ghana: A Qualitative Phenomenological Inquiry." In *Spiritual, Religious, and Faith-Based Practices in Chronicity: An Exploration of Mental Wellness in Global Context*, edited by Andrew R. Hatala and Kerstin Roger, 173-194. Abingdon and New York: Routledge. 2022

This study explored the experiences of individuals who have had chronic mental illness conditions. It examined the role of culture, religion, spirituality and faith in the daily experience and management of mental illness and wellness. The results in this study suggest that, despite the dilemma and uncertainty that surround the causal explanation of mental illness, the belief in the supernatural causes of mental illness is more pervasive and, as a result, religious and spiritual resources accessed at prayer camps in Ghana are believed to be effective in providing a powerful means of remediation. This makes the sufferers of mental illness, their family relations and sometimes health practitioners adopt not only a biomedical approach, but also spiritual approaches to remedy mental illness. Patients often rely on sacred spaces such as the prayer camps to cope with their ailments. The study also showed that the journey to remedy chronic mental health illness can be daunting and frustrating due to the complex narrative production of "diagnostic trial and error" in seeking both medical and spiritual resources.

Article III

"Prayer Camps, Mental Health, and Human Rights Concerns in Ghana." *Journal of Religion in Africa* 51 (3-4): 283-308. 2022. doi: https://doi.org/10.1163/15700666-12340207

This article discusses the role that Ghana's prayer camps provide in mental health care and the human rights concerns that are expressed. The article argues for the recognition of both state and non-state actors in dealing with the problem of mental illness and its related human rights concerns. The article maintains that the mere existence of mental health legislation to protect the rights of mental health patients is not enough if it fails to recognise the religious dimensions – the beliefs, faith, or transcendental orientation – of the people who are the target object of such legislation. The study recommends to policy makers, academics, clinicians, and international organisations whose work focuses on mental health and the ways in which religious views on mental illness can be harmonised to support modern projects such as human rights aimed at transforming the lives of people.

Article IV

"Media Portrayals of Religion, Prayer Camps and Persons with Mental illness in Ghana: A Discursive and Narrative Analysis." *Journal of Religion, Media and Digital Culture*. Accepted for publication.

In Ghana, the situation of persons with mental illness is precarious. This is due, in part, to the inadequate resources for mental health care. Individuals and families whose relatives suffer from mental illness rely largely on faith-based resources. The media has sought to highlight

aspects of the stigmatisation and rejection of the mentally ill. These reportages show the dilapidated conditions under which vulnerable persons are kept in religious institutions. They also highlight serious issues that need attention, but how exactly do they construct mental illness, religion, and Ghanaian society and do they challenge or uphold stigmatising notions about religion and the mentally ill? We use a discursive and narrative approach to unpack the depictions of three reportages and one official documentary about mental illness and religion in Ghana. We argue that stigmatisation prevails in the chosen videos, but the videos also do provide knowledge and understanding, however with varied focus on and insights into religious aspects of mental health care.

2 Theory, Methodology and Data

This chapter presents the theoretical and methodological approaches that were adopted for the study. It also provides insight into the various analytical tools or methods that were used in each of the articles and why. The aim is to present in a very detail manner the ways that this study was approached and the justification for the selection of methods, theory, and analytical frameworks for each of the articles.

The first section presents the theoretical and/or conceptual framework for the study. In this study, I conceptualise health and healing from a traditional Ghanaian Akan perspective and show how the understanding of health and healing from an indigenous perspective is expressed and articulated in the forms of healing at prayer camps. I further explore how this traditional worldview frames Pentecostal understanding of the causes of mental illness and the healing interventions that are invoked at the prayer camps to deal with mental illnesses. Section two provides a detailed account of the research design. This section gives an account of the methodology, background of research participants, the interviews and how they were conducted. It also provides an overview of participant observation and other sources of data collection for the study. Explanation as to how the data was analysed for each article and the choice of framework are also presented in this section under analysis. In the third section, I provide a reflection on my positionality. The final section discusses matters relating to ethical compliance and data management. This section is very necessary because the study focused on vulnerable groups of mentally ill persons.

2.1 Theoretical/Conceptual Framework

The concept of health and healing is theoretically relevant to this study. The choice of the concept of health and healing from Akan perspective is relevant for the analysis done in the study. In my view, we can only understand participants views, their attitudes towards health and healing practices only when we map such worldviews and behaviours within their frame of understanding of matters relating to health and healing. That is, the data presented in this study can only be understood within the lens of the definition and understanding of health and healing from the perspective of the Akan and in the context of the prayer camps. Thus, while the discussion presented here may be seen or characterized as folk-theories of some sort, they are the lens through which one can understand the practices of mental health and healing as presented in this study.

The concept of healing is in no way self-evident as many cultures and societies ascribe different meanings to it. It is, therefore, important to discuss how the concept should be understood within the framework of this study. In this study, I have attempted to map or contextualise health and healing as practised in prayer camps or healing centres within Akan indigenous or traditional worldviews.

I do this for three major reasons; first, I argue that the approach in dealing with illness (in this case mental illness) has long been influenced by historical trajectories and therapeutic approaches for the treatment of illness in cultural milieus. These approaches mainly consisted of the use of religious practices and herbs in the treatment of illness (Abel and Busua 2005). This has reified trust in the religious and cultural traditions in the treatment of illness. Thus, over the years, the nonmedical methods of dealing with ill-health conditions have shown the

tenacity of the personalistic aetiology and its operation as a cultural default in establishing or conceptualising the cause of illness and treatment interventions. This helps in providing a background to modern healing traditions and an understanding to the cultural and social variability of mental health problems in a particular context and, appropriately, develop preventive and resolution mechanisms.

Second, diagnostic measures and tools are largely influenced by surrounding cultural and religious worldviews. Thus, "culture provides explanation for affliction derived from local ontologies and ethno-physiological systems" (Kirmayer and Swartz 2013, 47). This helps in knowing or understanding the meanings people attach to their health conditions or problems.

Third, in the search for healing and recovery, affected individuals and families will only search for approaches that are culturally symbolic and therapeutically effective. I argue that the healing rituals that are found in the prayer camps are embedded in "local meaning systems that give them part of their social value and potential efficacy" (Kirmayer and Swartz 2013, 48). Since religion is very much part of culture, factors including worldviews and religious beliefs that form the broader spectrum of culture surface in matters relating to health and healing. In my view, this helps to better understand the phenomenon we are dealing with in its proper context and, at the same time, provides an analytical framework in analysing a very complex and more nuanced concept such as mental illness.

In what follows, I unpack the concept of health and healing from an Akan perspective. Before I attempt to look at the meaning of health and healing from an Akan perspective, I will first offer a background discussion to the Akan concept of disease causation and the human person. This is because the concept of health and healing and the attribution of different categories of disease find their concrete explanation in the concept of the person. I seek to do this to illuminate or provide a broader perspective within which one can view and understand the general discussion in this study as well as provide a framework to understanding matters relating to health and healing and the therapeutic approaches or remedies that are employed by the participants.

2.1.1 Akan Concept of Disease Causation

Literature on African systems of healing and medicine have established two main categories of causal narratives. These are 1) the natural, physical or biological causes of disease causation and 2) the spiritual and/or supernatural cause of disease. The most often cited one is George M. Foster's (1976) categorisations of "personalistic" and "naturalistic" in non-western disease etiologies. Personalistic is when an illness is believed to be caused by active, purposeful intervention of human agents through the machination of evil practices against a fellow human being usually through witchcraft, sorcery, or *juju*. Or, from a non-human agent such as an ancestor, evil spirit, ghost, and supernatural entities such as deities as a result of a punishment for wrongdoing. Naturalistic refers to diseases caused by natural factors which could be biological or caused by pathogenic agents (bacterial or a virus). The Akan disease categorisation can also be classified into two taxonomies of natural and supernatural.

2.1.1.1 Akan View on Supernatural Causes

The Akan believe that the world around them or the cosmos is full of spirits. Some of these are human and others non-human (Sarpong 2019). Kwasi Sarpong, an eminent Ghanaian

anthropologist, has explained that among the Akan, "human spirits are believed to be spirits of people, animals, or trees, rivers etc. that have appeared in the visible form before, but are no longer perceptible" (Sarpong 2019, 248). However, the non-human spirits do not take any visible or tangible form and they include both benevolent and malevolent categories. Sarpong further explains that "the unique *Onyankopon*, the Supreme Being, is naturally the best Spirit that one can think of. He is the creator of every being including humanity, the spirits, the world and the universe and all they contain or imply" (Sarpong 2019, 248). Apart from the Supreme Being, there are tutelary spirits and ancestors.

In contrast to these are the spirits that take pleasure in causing pain, misery, disaster and so on. Among these are the devil, witches, sorcerers, certain monsters in the sea and in the forest, etc. The Akan of Ghana attribute the cause of disease to these spirits for a number of reasons (Sarpong 2019). First, the Supreme Being (God) as the creator of life and death is believed to mete out punishment in the form of sickness to evil human beings or people who commit evil practices. The ancestors are also believed to cause disease and death when the living go contrary to certain moral codes or infringe on laws and traditions. The punishment from the ancestors, however, is only limited to the members of their clan or family. The *abosom*, tutelary spirits, also mete out unpleasant rewards to their adherents or the enemies of their adherents when they commit acts that are despicable to them (Sarpong 2019).

Another category of spirits are the witches and magicians. It is believed that both witches and magicians can inflict sicknesses or disease on their targets. The only difference between the witch and the magician (or a juju man) is that there can never be a good witch, the best witch being a selfish one. There are, however, good magicians (Sarpong 2019; see also, Obeng 2004).

Another cause of disease is one's destiny. The Akan believe that before one comes into the world, one tells God what one is going to do. This is one's *hyebre*. God also tells the person what he or she has to do. This is what the Akan call *nkrabea*. *Nkrabea* is inevitable, hence the proverb, *Onyame nkrabea nni kwatibea*. One's *hyebre*, for example a bad habit or lifestyle, can cause one to become sick or unhealthy (Sarpong 2019).

2.1.1.2 Akan View of Natural/Biological Causes

Apart from the belief in the supernatural cause of disease, the Akan society also believes that sickness could be caused by other external factors such as a bacteria or virus. For instance, the Akan knows if a person eats with a dirty hand, he or she could contract a bacterial infection that can cause someone to become ill. Or a mosquito bite could result in a malaria. What is, however, intriguing about the causes of natural events is the explanation behind it, sometimes.

Although the Akan believes that eating with a dirty hand could cause someone to become ill, the question the Akan would ask in such a situation is, who or what influenced the person to eat with a contaminated hand. In other words, the issue is not the dirty hand that caused the disease but what spiritual entity or force caused the person to eat with a contaminated hand (See, for example Asante 2017). Thus, although the Akan may be "aware of scientific or empirical causal explanation, he or she does not regard them as profound enough to offer complete satisfaction in terms of causality" (Asante 2017, 5). Consider this scenario, by Sarpong (2019): one's child is involved in a motor vehicle accident and dies. The parents of the child attributes this to a witch. You explain that this cannot be due to a witch. The accident was caused by a mechanical fault. The front tyre of the car burst. Sarpong explains that, for the ordinary Akan you have explained *how* the accident took place not *why*. 'Why did the tyre

burst?' 'Is that the first time the front tyre of a car has burst?' 'In all these cases, has there been an accident?' '*Why* was there an accident this time?' '*Why* did all the passengers not die?' why, why, why?' (Sarpong 2019, 255).

In Akan cosmology, the physical and metaphysical realm are not separated from each other. They are bound up in one whole unit because there is nothing that is purely matter (Atiemo 1998). Thus, the Akan idea of causality leans heavily on the spiritual, though it does not completely disregard the natural causes of events (Atiemo 1995; Gyekye 1987). Such beliefs are very pervasive and mapped onto the interpretation of illness and healing at Pentecostal prayer camps because they resonate with the traditional worldviews of the people.

It has been argued that "Pentecostals reinforce the causality pattern in primal worldview before providing a solution beyond the purview of indigenous cosmology" (Kalu 2008, 182). In other words, Pentecostals have "produced a culture of continuity by mining primal worldviews, reproducing an identifiable character, and regaining a pneumatic and charismatic religiosity that existed in traditional society" (Kalu 2008, 186). Through the divinatory and revelatory practices, the experience of illness is mapped onto a symbolic space created by the cosmological views on health and healing that are meaningful to both the patients and the healer (either a traditional priest or a prophet).

2.1.1.3. Akan Disease Classification: Some Divergences

Let me mention here that my aim in this study is not to provide Akan disease classification. Probably, we can leave that work for medical anthropologists. However, it is important to provide some basic or background information about Akan disease classification in order for readers to understand the context of the discussion or analysis provided in the study.

In the previous section, I mentioned that the Akan have two main forms of disease categorisations, which are the natural and supernatural. I also presented examples of different possible causes of illnesses. While this categorisation does not suggest or seek to provide a kind of disease classification, it provides a general view of the ways the Akan view illnesses regardless of whether they are spiritual or physical, biological or natural, and whether they are caused by external or internal factors within or outside of the person. The anthropologist, Dennis Warren (1975), has attempted to provide a neat categorisation of Akan disease classification or lexical inventory of various types of Akan diseases. While his classification is commendable, his work has been heavily criticized as not representative enough. This is because the work was based on an abstract generalized model of Akan medical knowledge out of information that was restricted to one particular Akan locality of Bono-Techiman in Ghana (See Konadu 2008). Some of the examples of disease classification provided by Warren are "mogya mu yadeɛ (diseases with a natural causation)", "sunsum mu yadeɛ (diseases with a spiritual causation)", "nsane yadeɛ (contagious diseases)", "bayifoɔ yadeɛ (diseases caused by witchcraft power used for evil purposes)", and so on.

It is important to emphasise that among the Akan, an illness is caused either spiritually or physically. So, irrespective of the classification, for example, as provided by Warren (1975), the Akan only know or are aware of two possible causes of diseases. This is often classified as *sunsum mu yadeɛ* (spiritually caused disease) or *honam mu yadeɛ* (physical or natural illness). Scholars such as Fosu (1981) and Obeng (2004), both Ghanaians, have maintained the binary distinction of physical and spiritual as the means by which the Akan classify diseases. Obeng (2004), for instance, maintains that contrary to the popular belief that Akan attribute illnesses

to spiritual causes only, he demonstrates that the Akan, through their practices, have a bipartite concept of disease denoting the spiritual and the physical.

Another important aspect worth mentioning is that the binary distinction between the natural and the supernatural disease causation among the Akan is not very strict but fluid. This is because a particular type of disease can be classified as both natural and supernatural depending on the medium through which the disease was contracted. In other words, the binary distinction can be context specific and does not always lend itself to easy identification or classification. Let me use Warren's own example which he claims was provided by one of his priest-healer informants to make my argument clearer.

> ...if a man slept with a married woman and later learned that the husband had visited a local medicine man, followed by the man contracting gonorrhoea (babaso), the babaso would be classified as a spiritually caused disease. The person would not have known that the married woman had contracted gonorrhoea, but would have realized that a cultural norm had been broken and that the spouse had visited a healer, probably to obtain means to punish the social deviance. The babaso would be considered to be that punishment. If the victim had, on the other hand, visited a prostitute, from whom it is common knowledge that babaso can be contracted, the disease would be classified as a naturally-caused disease (Warren 1975, 119).

From Warren's example, one can argue that the method of distinguishing between diseases as either natural or supernatural is made in terms of the medium or how the disease was contracted. In fact, Warren (1975) admits that a particular disease can fall under the two dimensions of natural and supernatural. In some cases, it is the treatment outcomes that determine or influence the kind of interpretation one gives to his or her illness as whether spiritual or natural. For example, it is normal for everyone to get a headache once in a while. Usually, a headache may be treated with a painkiller from a pharmacy shop. In a situation where the headache becomes persistent after several days and months of medication, the question of why the sickness continues to persist becomes pertinent. When this happens, several interpretations are given including possible causes of spiritual influence. This is the reason chronic illnesses are always assumed to have spiritual influence or dimension.

Furthermore, while the question of whether the natural or supernatural dualism existed in traditional Akan thought prior to contact with Westerners, and subsequently, the binaries of the disease classification would possibly be a recent introduction derived from Western discourses could be asked, I would admit that this is somewhat a difficult question to answer for some obvious reasons, one of them being the lack of documentation of these discourses in the pre-Western encounter period. It has been established that, prior to contact with Westerners or Europeans, the Akan already knew through testing and experimentation the use of herbs for the treatment of different kinds of diseases (Gyekye 2013). That is to say that the pre-encounter lifestyle of the Akan reveals that they had a knowledge of the kinds of diseases and their treatment methods. In fact, it will be safe to say that the Akan knew that some diseases only demanded treatment with herbs and not spiritual means of remediation. However, even regarding the use of herbs, the preparation of some of the herbs involved some spiritual methods of procedures such as pouring libation before plucking the back of a tree or some leaves for the treatment of particular diseases. Some leaves were even plucked or harvested only in the night. Since the documentation of some of these experiences only began during the post-Western encounter period, we may still have to resort to western sources in order to make such a determination about Akan disease classification. This will, therefore, make it difficult for one to make an emphatic claim on the matter.

2.1.2 Concept of the Person among the Akan

The attribution of disease or sickness to different categories of causes could be explained from the Akan concept of the person. Thus, to understand the causes of diseases or sickness among the Akan, we must understand who a person is in Akan worldview. This also provides a background to how health and healing is understood or conceptualised.

In Akan thought, a person or a human being is made up of three-dimensional beings of body, spirit, and soul, with composite kinship relationship explicated in physical and metaphysical terms (Atiemo 2013). In their physical dimension, a person is a matter which constitutes the body (*honam*). In their spiritual dimension, a person is believed to possess non-physical components which are made up of the *sunsum* (the spirit) and *okra or kra* (the soul) and the *mogya* (blood).[29] The Akan hold the view that "the soul is a life-force which animates the body; it is that which makes man a living person…though the *kra* is invisible, it is known through the activities of the living person" (Akesson 1965, 281). The essence of the *kra* is captured in the following statement by the anthropologist Meyerowitz (1951, 24):

> The *kra* is the great force that keeps man alive, the source of his energy, his great reservoir of strength, and his sustenance. It is also his instinct, which protects him [or her] and may save him [or her] from danger; and that is why the *kra* is believed to be a person's guardian spirit. It is also the source of good and bad luck, for it is has been observed that individual fate depends for the most part on man's uncontrollable impulses...the *kra* therefore appears to be what Freud called 'Id' and which Jung calls the 'unconscious' psyche, or the universal mind.[30]

In Akan cosmology, "the human being is also regarded not as a purely material or physical being but also as a psychosomatic unity in view of the soul with him or her" (Kudadjie and Osei 1998, 37). The Akan believe that the soul (*kra)* of a person is immortal and existed with *Nyame* (God) long before it became incarnated.[31] So, when a person dies, the soul returns to God. Kwame Gyekye (1995) notes that the *kra* is a spark of God and returns to God after the death of a person. As a result, a person is believed to possess something of a divine essence.

As a spark of God, the *kra* is also thought to endow humans with immortality, and this is what is expressed by the Akan *adinkra* symbol and proverb, *Nyame bewu ansa na mewu* (If God can die, then I would too) (Danquah 1968). Abamfo Atiemo (2013), a Ghanaian historian of religion, has explained that among the Akan, a person is considered a child of God because it is God who is believed to give the *kra*. This is, for instance, re-echoed in the Akan proverb *nipa nyina ye nyame mma obi nye asaase ba,* which translates as "all men are God's offspring; no one is the offspring of earth". Anthony Ephirim-Donkor, a scholar of religion and theology who is also a Christian priest and traditional ruler of Gomoa Mprumem, a town in the Central Region of Ghana, has argued that what this statement means is that "every human being has a divine origin, not corporeal in nature and therefore the notion that the human being is made of earth

[29] These categorisations have also been divided into two analytical categories of "normative" and "ontological" or descriptive categories with each having theoretical and empirical implications with the ways the human being is understood and expected to live within the society or community (Again, see Wiredu 1992; Gyekye 1995).

[30] See Ayim-Aboagye extensive discussion of the "psychological implication of the concept of the soul" and how it relates to Freud's theory on human personality. Ayim-Aboagye (1997, 34) postulates that the philosophical underpinnings of the Akan concept of personality makes it one that is both theologically and scientifically sound when viewed especially in the context of the scientific theory of Freud and Jung.

[31] In actual sense, the soul of an individual existed before he or she was born. Among the Akan the soul is believed to have come from *Asamando* (world of the ancestors).

is false" (Ephirim-Donkor 2015, 78).[32] Kwasi Konadu (2007), a scholar of African histories, cultures, medicine and healing in Africa, postulates that among the Akan, the human being is "spirit-encapsulated" rather than "matter animated", denoting the metaphysical nature of the person or human being. This threefold composition of the person (body, soul, and spirit) carries with it ontological links with various metaphysical entities and social units. Atiemo captures this succinctly in the following statement:

> Each person is thought to have been created by God with an independent soul that is said to carry something of God's essence. Each soul is viewed as unique in relation to other human beings and creatures and their unique destinies. But people are born into the world of humans, which is deemed to interact unceasingly with the world of the deities and the ancestors (Atiemo 2013, 130).

Among these three, only the *honam* (the body) is most distinguishable (Akesson 1965). The distinction between the *kra* and the *sunsum* is not easily discernible and scholars continue to offer various explanations to the two concepts (Gyekye 1995; Wiredu 1992). A distinguishable feature between the *kra* and the *sunsum* is that the *kra* (life-soul), which comes from God (*Nyame*), is identified, or associated with the blood of the maternal ancestors, referred to as the *abusua,* whereas the *sunsum* of a person exists in the material world and is linked with the spirit of the male ancestor called *ntoro*. Therefore, the *sunsum* becomes an operative component only when man (used in generic sense) becomes a living soul.

In Akan, the day on which a person is born also determines their soul. For example, there are seven different kinds of *kra*, which represent the seven days of the week (Ayim-Aboagye 2006; Meyerowitz 1951). Children who are born on the same day are considered to have the same *kra*. The day on which an individual is born is called *akrada* (the life soul). "Kra is not like the *sunsum,* the personality-soul which, though residing in the body may leave at will and have independent experience in free space as in dream-adventures. The life-soul does not seem to have influence over other souls as the *sunsum*. In its terrestrial life the main function of the KRA is to animate man to function and to enable him to accomplish his daily task" (Akesson 1965, 288).[33] Sometimes, the two concepts are used interchangeably and synonymously (Akesson 1965). What is, however, evident is the fact that the metaphysical or non-physical aspect associated with both are not denied by scholars.

Apart from the *sunsum* and *kra*, another important component of Akan personhood is the blood, which is called *moyga* (in Twi) or *bogya* (in Fante). *Mogya* is an invisible part of the body (*honam*) and is linked with the spirit of a person. Although *mogya* is a non-physical component of a person, it is matter in nature and thus differs a bit from other non-physical components or non-material substances such as the *sunsum* and the *kra*. Unlike, the *sunsum* and *kra*, *mogya* in its raw state or when it is out of the body can be seen. Despite these features, the Akan still consider *mogya* as having spiritual elements or dimension. The spiritual elements of *mogya* are determined through the *sunsum* (spirit), which is believed to be given to a child by the father during conception. Rattray (1923, 36) captures this in his explanation that, among the Asante, pregnancy or conception occurs through the "mingling" of a woman's *mogya* with a man's *ntoro* (which is his sunsum). Each *ntoro* is believed to be linked to a particular *obosom*

[32] See chapter three "the spirit incarnate" of Ephirim-Donkor's book titled: *African Personality and Spirituality: The Role of Abossom and Human Essence* for a detailed reflection on this.
[33] See Akesson (1965) for further reading on the distinguishing features between the *kra* and *sunsum.*

(deity). The Fante, for instance, call the *ntoro*, *egya bosom* (father's deity) (see Atiemo 2013; Chukwukere 1978).

Despite the dominant matrilineage, the Akan inclination towards the father's role of kin is rooted in the theory of *sunsum*, which the father transmits to all his children and sanctions behavior within the family or unit. Earlier, I mentioned that *sunsum*, which is the personality-soul, determines the behaviour or character and personality of a person. Indeed, the Asante believe that the separation of a father's *sunsum* from a child can result in several misfortunes including illness (Chukwukere 1978; see also Rattray 1929; Busua 1954). For instance, it is believed that "the anger of a child's father can result in the child's illness – a severe offense to the father can bring about the child's death. Respect, especially for the father and the paternal kin group, is expected of every individual if health, peace, and tranquillity are to endure" (Appiah-Kubi 1981, 13).

Among the Akan, *mogya* is considered the most paramount essence of the human person because the social unit or the clan (*abusua*) is formed or determined on the basis of one's blood relations which is traced through the mother, making the Akan society a matrilineal one. This makes the mother-child relationship within the *abusua* very important because they are the foundations upon which relational personhood of matrilineages among the Akan is founded and expressed. The Akan hold the view that blood is transmitted through the mother to the child; hence descent is traced through her and the mother-child bond confers rights or obligations. So, among the Akan, *mogya* determines one's lineage, kin relations as well as the succession to traditional offices such as kingship or chieftaincy positions, inheritance of property, one's status as a citizen (commoner or royal) and one's links with the spiritual world (Chukwukere 1978, 136; see also Schneider and Gough 1961).

This understanding of the mother-child relationship through *mogya* also has implications for or directly relate to matters concerning health and illness. Kin relations within the matrilineage play a significant role in the care of the sick (I will throw more light on this in the following section). Apart from that, some diseases are also noted to be inherited or caused through blood relations. In fact, the anthropologist, Warren (1975, 124), has alluded to the fact that some diseases are "inherited through the matriclan", which he categorises under the sub-category of "sunsum mu yadeɛ" (spiritually caused illnesses). Warren (1975, 124) uses the term "awosanne/abusua" yadeɛ (*awosanne* can be literally translated as inherited through birth, and abusua, is the family or clan) to refer to "diseases inherited through the matriclan." While this categorisation may be true, it also raises several contentions. For instance, among the Akan, diseases such as hypertension, diabetes, and glaucoma may be regarded as hereditary or genetically influenced and not spiritually caused diseases per se. So, to categorise diseases inherited through the matriclan as spiritually caused diseases may be an overstatement. Nonetheless, there are circumstances upon which such diseases may be looked upon by an individual as a spiritually caused illness depending on their own personal experiences, particularly pertaining to their individual narratives on how they contracted the disease and their treatment outcomes. Another way by which diseases inherited through the matriclan may be interpreted as spiritually caused is when such diseases are interpreted or looked upon as a generational curse within the family.

2.1.3 Akan Concept of the Person and its Nexus to Health and Wellbeing

The body (*homan*), spirit (*sunsum*), and soul (*kra*) which form the human person according to Akan thought, have a dialectical relationship with the environment and the cosmos. To ensure that one is healthy, an individual is expected to maintain harmony between him or herself and the environment and the cosmos, which is animated by different spirit beings that include the deities and ancestors.

The state of a person's health is dependent on the ways that individual relates to and maintains relationship in this ontological space (Larbi 2018; Obeng 2004). Thus, among the Akan, "a person is said to enjoy health only when none of these elements is in any way disturbed or impaired. Disease and, therefore, death occur when one or two or all the components are not in the appropriate condition in which they should be" (Sarpong 2019, 252). Sarpong continues to explain that "it is when these elements are in perfect harmony, when each and every one of the elements is intact that we can talk about the person's health. If anything goes wrong with any one of the elements the person is not in good health and therefore needs to be healed, depending upon which part of the person is wounded or hurt, causing disease and ill health" (Saprong 2019, 253). Thus, these components are supposed to be held in harmony without disturbance. Philomena Njeri Mwaura (2014, 326), a Kenyan theologian, has explained within the context of African aetiology that "when a person falls ill, it is assumed that the ontological balance between the human world and the spirit world has been affected." This is because "health depends on being in harmony with, or forming an integral part of, the 'life force'. Illness is regarded as a misfortune and a sign that one has fallen out of this delicate balance" (Mwaura 2014, 326).

Not only that, "it is also seen as a social sanction, so that living peacefully with one's neighbours, observing social norms and living in harmony with one's environment, with God, the spirits and the ancestors are essential for the protection of oneself and one's family from disease" (Mwaura 2014, 326). The ancestors are part of the community fabric and shape the morality, ethics, and group solidarity (Adjei 2019; Gyekye 1995; 1984). Kwesi Dickson (1984, 70), a Ghanaian theologian, has remarked that "The African sense of community requires the recognition of the presence of the ancestors as the rallying point of the group's solidarity and they, being the custodians of law and morality, may punish or reward in order to ensure the maintenance of the group's equilibrium". Individualism is eschewed in favour of communal support and togetherness. Dickson's observation is not a far cry from Fisher's (1998, 113) assertion that:

> …elaborate and advanced African traditional medical and mental health system have long existed…seeking the welfare of the community and lineage is the basis of the political social and political life. Moral obligations are rooted in social life. So a person's worth is measured in his or her personal and social relationships, which assure him or her as an individual of success in life, good health, and potency or fertility. Both wealth and health mean primarily well-being in mind, body, and spirit.

Thus, in most African communities, the language of health is associated with life and harmony rather than built around the germ theory. Health is achieved through reconciliation among human beings and restoring the integrity of creation (Kalu, 2008). Therefore, the notion of health and wellness is interpreted as a state of cosmological balance in the individual's physical, mental/emotional and social life (Onyinah, 2002; Asamoah-Gyadu, 2013).

Health is conceived as total wellbeing and it is concomitant to all that is valued in life including mental, physical, social, spiritual, and cosmic harmony. Health is a mark of a good relationship between people and their environment, with one another, and with God. This belief or attitude towards an understanding of health is manifested among the illiterates and the educated, whether Christian or not (Mwaura 2014).

Akesson (1965, 287) has, for instance, argued that "the awareness the Akan has of the purity of the *kra* makes him or [her] become sensitive to wrongdoing". A person's *kra* also reacts to sin and grief. "For instance, when shock or grief diminishes a person's life-force, it is said 'my kra has gone away' or 'my kra has flown away'; or when a person, dogged by his conscience, is getting thinner and more lifeless daily, people say of him 'he is losing his kra" (Meyerowitz 1951, 24). Hans Debrunner, who wrote on the history of Christianity and witchcraft in Ghana, put this succinctly when he concluded that "anger, bitterness, and resentment against others, especially if allowed to rankle without finding speech, are commonly recognised causes of illness. It is believed to be hopeless to expect health in the presence of rancorous thoughts. That some consciences are tenderer than others is expressed by saying that if a man has a good *kra* and he disgraces it, he often dies" (Debrunner 1961, 16-17).

The general understanding is that the concept of the person and its ontological links (sense of connectedness) among the Akan of Ghana have implications for health, healing, and wellbeing. Therefore, it is the responsibility of every individual to ensure his or her own welfare and that of the entire community by living in harmony with and ensuring proper relationship with other individuals as well as the cosmic order.

In regard to the concept of the blood (*mogya*) and its implications for health and wellbeing, the Akan believe that a person's physical wellbeing is derived from his or her mother and hence connected to his or her matrilineal family and ancestors. This is because blood relations also determine the role of the kin member in the care of a sick person. Perpetual Crentsil (2007) has highlighted the role and importance of kin relations in the care of sick persons among the Akan of Ghana. She argues that "caregiving expresses one of the most important periods when the encompassing nature of Akan matrilineage becomes visible" (Crentsil 2007, 171). Among the Akan, each individual is considered a property of the family or the *abusua*. When misfortunes such as illness strike, it is the family, particularly the uncles, aunts and relations from the maternal side of the sick person that mostly assume the responsibility of the care of the person. Caregiving mostly occurs in the form of contributions from family members in the areas of personal resources such as money and time in taking care of the person. The aim is to restore the sick person back to "normal" life and also convey the general understanding that the Akan have of illnesses in general (Crenstsil 2007).

2.1.4 Akan Notion of Witchcraft and its Implications on Health and Wellbeing

In the previous discussion, I have made mention of a number of spiritual agents that can be deemed responsible for illnesses. These include witches, ancestors, magicians, juju men, sorcerers, and devils. For the purposes of the discussion in this study, particularly in relation to the importance of matrilineal kin in the care of mentally ill persons, I will throw more light on the notion of witchcraft among the Akan. I will focus more on the negative dimensions of witchcraft within the context of relational personhood among the Akan.

Although the Akan believe that witchcraft can be used positively by those who possess it to achieve personal gains in areas of life such as education and business enterprises (Appiah-Kubi 1981), witchcraft practices are almost always viewed in negative terms. Some even hold the view that there can never be a good witchcraft because "witches are wicked people and it is their wicked feelings -their hatred or envy – that cause harm" (Appiah-Kubi 1981, 13). Witches are believed to be engaged "in mystical cannibalism" by spiritually sucking "the blood of victims, which results in the onset of diseases (Asamoah-Gyadu 2015, 23). The notion of witchcraft as an evil supernatural force behind the cause of illnesses "thus make[s] the cosmology of the Akan 'human centred'" (Crentsil 2007, 129). Witchcraft spirits are possessed by individual human beings who are believed to manipulate those powers to destroy others who are close to them. A popular proverb or saying *aboa bi beka wo a na ofiri wo ntoma mu* (literally translated an insect will bite you only from within your cloth; or your closest acquaintance is your worst enemy or adversary) among the Akan epitomizes this notion. The proverb conveys the idea that your destroyer is right next to you, or he or she is more knowledgeable about your vulnerability than anyone else. It is not surprising, therefore, that in Ghana, when a calamity or trouble befalls a person, he or she without any hesitation would say *wei diɛr efie foɔ nim ho bi* or *efie foɔ ka ho,* which literally means as for this problem my household or family has masterminded it or my household or my family is behind of the cause of the problem. This is to suggest that a witch from within one's family is responsible for the cause of the problem. In other words, "sickness and troubles are attributed to envy on the part of relatives and their spiritually powerful allies" (Asamoah-Gyadu 2015, 23), and this is mainly believed to come from the matrilineal group who are closely-knit by blood relations. Indeed, parts of the lyrics of a Ghanaian popular highlife song titled *fie nipa sei woa a* by J. A. Adofo captures this succinctly:

Fie nipa sei woa a saa
Fie nipa sei woa saa oh
Wo di wo yadeɛ bɛ Kyini amanso, amanso!
Nanso wonya ano aduro ara da ah ooh
Ɛba no saa wo brɛ oooh

Translated as
If someone from your household destroys you
If someone from your household destroys you
You will go to places with your sickness
But you will never find solution or cure for it
When that happens, you suffer a lot

The song literally conveys the idea and affirms the popular belief that it is only a witch within one's own household or from one's own family that can destroy them, and that when a person is attacked with illness from their own family, they can do whatever they can but will never find a solution to the cause of the illness. Thus, "witchcraft and destruction in situations such as illness" are commonly believed to come "from the matrilineal group" (Crentsil 2007, 131). This view or belief of the Akan that a witch can kill or destroy but only within their kin group resonates with the famous description of witchcraft as "the dark side of kinship" by anthropologist Peter Geschiere (1997, 11). Among the Akan, since a witch is thought to operate

within the matrilineage (*abusua*) and consume the blood (*mogya*) that it consists of, he or she is the epitome of antisociality.

Furthermore, Crentsil (2007, 132) has explained that the Akan theory of witchcraft within a kin group is "like an owner and the object owned. The analogy of an owner and the object owned is drawn in Akan conceptions about the jural right over the individual". Thus, "since by virtue of blood (and the womb), a person belongs to the matriline, lineage ideas determine the individual's place in the group – as the 'bona fide property' of the matrikin. This also gives the witch (or witches) in the kin group the right over the individual, and to 'kill' him or her as and when they want" (Crentsil 2007, 132). So, illness episode that is attributed to witchcraft is thus not external but immediate to the kin group and/or close relations. Thus, while the importance of the family (abusua) in the care of the sick cannot be overemphasised, there is also another dimension of the kin relations that is considered detrimental to the survival and wellbeing of the members within the kin group.

2.1.5 Akan Concept of Health

From the discussion so far, it can be said that according to the Akan, health is a holistic and integrated phenomenon. The Akan understand health as not just the absence of some biological pathogens or the proper functioning of bodily organs, but that health comprises mental, physical, spiritual, and emotional stability of oneself, family members and community. This view is underpinned in the understanding that the body is just a container of the *kra*, *sunsum* and *mogya*.

As a result, what happens to the body has a consequence on the *kra*. This explains why medicine in Akan traditional society encompasses the spiritual and physical wellbeing of the people. Ancestors also play an important role in Akan understanding of good health. Thus, it is generally believed that health depends largely on one's relationship with the ancestors. A proper relationship needs to be maintained between the living and the dead to ensure a healthy relationship. Good behaviour is expected from the living so they would be protected and blessed by the ancestors. Bad or corrupt behaviour and practices such as not taking good care of family properties and failing to observe certain sanctioned ethical behaviour could result in punishment which sometimes manifests in sicknesses including mental illnesses.

Since good health and wellbeing are predicated on maintaining the balance between the seen and unseen world or the visible and the invisible world, it is generally believed that there are several ways to explain the causes of diseases or afflictions as discussed above. As mentioned earlier, the invisible world is believed to be occupied by different spirits whose activities affect the living. These include different deities, ancestors, witches, and wizards, as well as individuals who are believed to possess supra human powers that can inflict sickness or illness against a targeted enemy, etc. Therefore, it no surprise that someone may interpret his or her mental illness as a result of punishment from a deity due to some wrongdoing, or as an affliction resulting from the activities of evil spirit or demons. This understanding guides the diagnosis of any ailment and the kind of treatment option that is harnessed to remedy an ill-health condition.

From this perspective, the Akan apply or combine various therapeutic approaches in dealing with sickness. Biomedicine, for all it is worth, is sometimes seen as incomplete without

the application of other local remedies. This leads to the consultation and deployment of many treatment options, including traditional healing shrines, herbalists, and prayer camps.

2.2 Research Design

2.2.2 Methodology

Since the study aimed at exploring the lived experiences of individuals in relation to mental health and the role of religion in aiding their recovery, an Interpretative Phenomenological Analysis (IPA) was employed. IPA is an approach that aims at exploring in detail how participants make sense of their personal and social world. At the core of this approach "is the meanings that particular experiences, events and states hold for participants" (Smith and Osborn 2015, 25). IPA was originally developed by the psychologist Jonathan A. Smith (1996), in his work "Beyond the Divide Between Cognition and Discourse" as a specifically psychological experiential research methodology and was largely influenced by the phenomenological philosophy or approach to research. Thus, "IPA is phenomenological in that it involves detailed examination of the participant's lived experience; it attempts to explore personal experience and is concerned with an individual's personal perception or account of an object or event, as opposed to an attempt to produce an objective statement of the object or event itself."

Interviews (semi-structured interviews most especially) are the main tools for collecting data when using IPA (Smith and Osborn 2015). In this study, the method was employed during interviews to elicit patients' views of their experiences with healing rituals at prayer camps, what they made of the healing rituals and practices such as Bible studies, counselling, fasting and prayers and how these contributed or aided in their recovery. This also included shared experiences at the camp as a community. This approach was necessary to make evident the patients' own shared experiences against an etic construction of the camps to avoid making unsubstantiated claims. Throughout the study, patients were allowed to share their experiences, what they made of those experiences, and how that had affected their general wellbeing. I explain in more detail in the next section about the interview process.

IPA was very useful in many ways during the research process. First, the IPA approach helped in dealing with prior scientific hypothesis or abstract conceptualisation about the camps. In other words, the approach helped me to forgo some of the preconceived notions I had formed about the camps before the start of my field work. The prayer camps in Ghana have come under severe criticisms and I had formed some notions about the camps through the readings of some of those reports. IPA was very useful as it opened the patient's world to me through the sharing of their own experiences. This helped me to do away with some of the preconceived notions about the camps.

Second, the dynamic nature of the methodology ensured my active participation in the process, and I was able to make sense of the patients' own experiences. For instance, while patients were sharing their experiences in relation to healing, the methodology also allowed for the opportunity to draw implications from patients' own experiences, a process Smith and Osborn (2015) have termed as an "interpretative activity and/or the hermeneutic development of phenomenology". IPA is "intellectually connected to hermeneutics and theories of interpretation" (Smith and Osborn 2015, 26). There are, however, different

approaches of doing interpretation and in this study, I employed "empathic hermeneutic with a questioning hermeneutic" (Smith and Osborn 2015, 26). This means that while there was an attempt to understand patients' healing experiences through personal narratives, there were also moments of personal reflections on the patients' own experiences. This enabled me to make meaning of some of the shared experiences of the patients. In other words, the IPA afforded me the opportunity to interpret and explain the patients' own accounts of their situation and the meaning they ascribed to it.

Third, the strength of IPA's attempt to make sense of the participants and researchers' own experience makes it one of the effective methodologies for research that focuses on mental processes because it has cognition as a central analytic concern, which Smith and Osborn (2015) see as sharing a theoretical alliance with the cognitive paradigm that is central in contemporary psychology. Thus, "IPA shares, with the cognitive psychology and social cognition approaches in social and clinical psychology", although "it differs from mainstream psychology when it comes to deciding the appropriate methodology for such questions. While mainstream psychology is still strongly committed to qualitative and experimental methodology, IPA employs in-depth qualitative analysis" (Smith and Osborn 2015, 26).

2.2.3 Strengths and Weaknesses of IPA as Phenomenological Approach in the Study of Religion

Every methodology has its own weaknesses and limitations, and this has implications on either the findings or outcomes of a study. In this section, I highlight both the critique and strengths of the phenomenological approach in the study of religions and what readers should be aware of in reading the analysis and findings made in this study.

Strictly speaking, although IPA was developed as a methodology in psychology and has been widely employed in that field, the application of the method in the study of religion raises several concerns. The phenomenological approach to the study of religion or religious experience has not escaped criticism, as some critics have averred that the concept is religionist, idealist, unscientific and lacks conceptual clarity and methodological rigour (Chitando 2005; Wiebe 1999, McCutcheon 2001; Segal 1994). A major issue is the claim to neutrality and the allegation that the phenomenological approach to the study of religion is theology in disguise. Indeed, the performance of "epoche and accepting a believer's point of view has been portrayed as potentially retrogressive although they have a liberating capacity" and that "epoche denies the need to assess institutions" critically (Chitando 2005; Wiebe 1999). Another critique is that "endorsing the believer's point of view avoids a critical approach to religious issues" (Chitando 2005). In fact, scholars who have critiqued the phenomenological approach to the study of religious experience have very often attacked the so-called inherent tendencies of the approach to approve or assent the existence of transcendent reality without critically questioning such beliefs (see, for example, Heinämaa 2022; Davis 2019).

The phenomenological approach to the study of religion seeks to interpret or understand religion as constructed, perceived, and experienced within "consciousness, or from the perspective of the religious subject" (Blum 2012, 1030). Thus, phenomenology does not necessarily seek to approve the existence of a supernatural reality, but the meaning as encapsulated and expressed in a religious discourse or experience under examination (Blum 2012). This is contrary to the notion that the phenomenological approach to the study of

religion seeks to assent the religious subject's claim about the existence of a transcendent or supernatural entity without questioning (McCutcheon 2001). In other words, phenomenology does not seek to approve the existence or nature of God (whether implicit or explicit), but rather explores how a particular religious individual or community regards these phenomena and the meaning this has for them.

In the context of this study, for instance, the question would be what religious individuals at prayer camps make of their relationship with God, how this is experienced, and in what forms. In this case, the interpretation of religious consciousness and experience would consist of exploring the implications of this experience with reference to rituals of prayer, fasting, and other activities such as worship services and the reading of the Bible. This does not suggest that the investigator must necessarily affirm the claims of the religious subject's attitudes, beliefs, and practices but to interpret, through empirical evidence, what meaning such practices hold for the religious subject. As argued by Blum (2012, 1030), "interpreting religion from the perspective of religious consciousness and experience means coming to understand how the religious subject (be that either a single individual or a community) regards such a phenomenon and specifically what the meaning and significance of such phenomena are for the subject". He further argues that "it is this interpretive function that should define phenomenology of religion, and which sets it apart from social scientific or naturalistic methods that seek to explain religion" (Blum 2012, 1029).

Indeed, this also raises an insider/outsider problem in the study of religion or religious experiences (McCutcheon 2005). To circumvent these possibilities, Donovan (2005) proposes the concept of "neutrality in religious studies" or what McCutcheon (2005) has termed as "methodological agnosticism" to help navigate the tensions between two fields without materially affecting both. McCutcheon (2005, 6) has argued that many a time, "the focus on only studying private experiences seems to validate the claims of the insider all too quickly, and where the emphasis on developing explanatory theories can all too easily dismiss insider's claim," there is the need to adopt a mediating position to circumvent such tensions and help undo unnecessary biases in analyses. According to McCutcheon (2005, 6), in "aiming to avoid both validating or dismissing, thus remaining neutral when it comes to questions of truth and value", the adoption of a neutral stance helps in emphasising "issues of accurate description and comparison at the expense of drawing value judgment" which means that attempts are made in such position "to bracket out, or avoid asking, all questions concerning the truth of someone's claims" McCutcheon (2005, 6).

In some instances, for example, my readers might feel that I am uncritical in my views on some of the reported findings that are presented in the articles. To a large part that is because I adopt an empathetic stance that seeks to understand the perspective and logic of my participants as a helpful tool to critically analyse taken-for-granted assumptions and often unforeseen implications of their experiences at prayer camps. Despite this stance, readers should also bear in mind that "methodological empathy does not imply sympathetic feelings of agreement with the subjects under study, but rather an effort to see things from the standpoint of those studied and to step outside that standpoint to analyse broader causal and contextual frameworks that sometimes complement and sometimes challenge the interpretations made by our subjects" or participants of the study (Brown 2011, 6). For instance, in order to understand the participants' healing practices – practices that often required considerable effort and commitment – one does not necessarily have to agree with participants on their views on what causes illness (or mental illness in this case) and their explanations on the

effectiveness of nonmedical healing methods. What is important is that "we do listen to them carefully, however, appreciating that their beliefs, practices, and experiences may operate with a different logic from that of biomedicine yet be completely reasonable" and, at the same time, not ruling out the fact that certain aspects of these practices may be at odds with biomedicine and even certain orthodox religious practices (see McGuire 2008, 137).

Again, what is important to consider in the phenomenological approach is the expression or the language used by participants in expressing their experience with the divine or object of worship. While it might be difficult to authenticate some of the claims, we should not also lose focus of the fact that a phenomenon cannot be studied in and out of itself. A particular experience is predicated on the kind of expression or language used by a supplicant and what that means in their culture. In other words, what the phenomenologist investigates are based on expressions and vocabulary used to convey a particular experience and this helps in analysing and grounding the claims made by participants.

2.2.4 Selection of the Prayer Camps

The study does not seek to capture all aspects of prayer camps and their activities in relation to mental illness. This study is limited to four selected prayer camps in the Central and Eastern regions of Ghana. These prayer camps were selected because, in contrast to others, they have well-developed administrative structures and have had a long history in taking care of the mentally ill. Another factor that influenced the selection of these prayer camps was their relationship (although unofficial) with proximate health centres to help administer medical care to psychiatric patients. Two of the selected prayer camps are located a few kilometres away from the three main psychiatric hospitals in Ghana. Thus, this study was carried out in urban centres with exposure to psychiatric hospitals or psychiatric units in hospitals.

2.2.5 Interview Process

Due to the nature and organisation of the prayer camps, I had to undergo several processes before I was allowed to interview anyone at a prayer camp. This process, however, was not followed when I had to interview other participants such as religious leaders, and other stakeholders outside of the camps. In the sections below, I explain the procedures I went through before I was allowed to conduct interviews at the prayer camps.

2.2.5.1 Seeking Permission from Prayer Camp Leaders

The process to conduct interviews began first with a visit to the camps. My visit to each camp involved administrative procedures that included seeking research approval from camp leaders and clearance to conduct the interviews. In the camps I visited, there were some levels of difficulty and resistance in getting verbal consent and approval from the camp leaders due to, according to them, the bad publicity they had received in previous times from some individuals who came to the camp with similar motives. They cited inappropriate reports, misinformation, or misrepresentation of their activities by some journalists in the media, and international bodies and human rights organisations. In consequence, they were suspicious of my intentions. However, I managed to build a relationship of trust after explaining the aims and objectives of the study to them. Thus, they understood the intended objectives of my study and subsequently granted me the permission I sought.

In each of the camps I visited, the caregivers took me on a familiarisation tour, specifically at the sanatoriums where the mentally ill were kept. The tour brought into perspective a broader picture of the conditions of persons with chronic mental illness at the camp and further informed my discussion and interviews with the patients and other participants. Particularly, it helped in providing me with questions that were conceptually and theoretically relevant to the study. This instance further helped in building rapport with the caregivers.

2.2.5.2 Selection of Participants for Interviews

Recruitment of patients for the interviews was done by the caregivers. This was because they had the knowledge of patients who had recovered and were conscious enough to express their views on their experiences at the camp. One of the challenges that confronted me in this study was the criteria to be used in selecting patients at the prayer camps for interviews. My problem was that since I did not have any background knowledge of the patients as well as the history of their illness and recovery, I was not sure who could provide me with the relevant responses to the questions I had. This challenge was surmounted through the cooperation of prayer camp leaders who helped in selecting patients that were deemed fit and were conscious enough to provide reliable and adequate responses to interview questions. All participants showed a high level of enthusiasm and willingness to be part of the study. In short, they were happy to share their experiences at the camp.

It is important to note that I am not oblivious to the fact that my inability to personally select respondents for interviews or the unmediated access to patients has several implications for the analysis or findings made in this study. To protect or safeguard the image of the prayer camps from any criticisms, it was possible that caregivers would only select patients they knew would provide an essentialist view or credible account of their experiences at the camp. The implications are that patients would only share a one-sided or positive outcome of their experiences, and this would have a potential in skewing findings made in the study. This challenge was indeed inevitable and was thus expected.

Other interviewees, such as religious leaders, and stakeholders such as health professionals and academics were contacted directly by the researcher and interview date and time were scheduled.

2.2.5.3 Background of Participants

In all, 38 individuals were interviewed. They included religious leaders, pastors, academics, health professionals, caregivers, and patients. The religious leaders included past heads of religious institutions such as the Ghana Pentecostal and Charismatic Council (GPCC) and other larger Pentecostal denominations. They were purposely selected because of the wealth of experience and knowledge they had acquired in the activities of the prayer camps under study. Some had also written and published on the activities of the camp. The pastors, caregivers and health professionals interviewed were directly involved in the operation of the prayer camps. They oversaw the daily management of mental health patients at the prayer camps.

Table 1. Showing the list and number of interviews

Interviewees	No.	Place of interview	Age range
Patients	21	Prayer camp	23 – 60
Caregivers	8	Prayer camp	26 – 65
Pastors/prophet in charge of prayer camps	5	Prayer camp	50 – 68
Religious leaders	2	Office/home	60 – 65
Health professionals	2	Workplace	30 – 40
Total	38		

Caregivers were made up of both males and females. Their duties included daily management and welfare of the patients, which included assisting them to take their prescribed medications, ensuring their feeding, and helping those who did not have the capacity to bath due to ill-health conditions to do so. They also played a key role in the socialisation process of the patients after recovery before they are discharged from the camp. The caregivers I interviewed had had between twelve to twenty years' experience in taking care of the mentally ill at the camp. They had no formal training in psychology or psychiatry. The worth of experience and the views they shared were valuable in the general analysis made in this study.

The patients were individuals who had had a history of mental illness but had experienced some level of wellness and were still living at the camp. The period the patients had stayed at the camp differed from each other. At the time of my visit, some had stayed for a few months while others had been there for several years. Another important thing to also note is that the camps selected for this study had different regulations for in-resident patients. Whereas some had a specified period a patient could stay (usually not exceeding four months), others allowed a patient to stay until their condition got better.[34]

Patients at each of the camps I visited numbered between 10 and 150. Reports from the caregivers and a psychiatric nurse who worked at one of the camps indicated that some of the patients had previously visited the hospital and had been diagnosed with mental health conditions such as psychosis, schizophrenia, mania, bipolar disorder, and depression.[35] Others

[34] With those that had a specified amount of time each patient could stay, they allowed some patients to continue staying after the four months had elapsed and conditions had not improved. In other words, the allowance was due to the chronic or unstable condition of their mental illnesses. At the time of my visit, some of them had had experiences of wellness and had been discharged but later returned to the camp after relapse. Others had recovered but preferred staying at the camp because they felt safer and more "at home" with the care and support they received from the camp. Beyond the mental health concerns, other social and political factors, such as poverty, stigma and discrimination, added to the reasons why some individuals preferred to stay at the camp.

[35] Some of the patients also admitted, during interviews, that they had previously visited the hospital and had been diagnosed with some of these mental health conditions.

had a history with drugs such as cocaine and cannabis. The prayer camp, with the help of a nurse, also took the initiative of sending patients without any proper diagnosis to the hospital to obtain a formal medical diagnosis and to administer proper care and medication alongside the support offered at the camps. For the prayer camps, these medical reports were of much importance because they made evident the role of prayer and/or faith-based resources in helping deal with the problems of mental illness after repeated failed attempts from biomedical treatment. Thus, whereas the medical information obtained for the patient was very important in the treatment of the patient, it also became a basis for establishing the role of prayer in dealing with some mental health problems where orthodox medicine had failed.

2.2.5.4 Why Interview Patients?

Interviewing individuals who may have a history of mental illness poses both ethical and epistemological challenges. Kim Usher and Collin Holmes (2007) have argued that people with mental illnesses are seen as vulnerable research participants because they are seen as incapable or less capable of making informed decisions about their participation in research studies. However, other studies show that this is not always the case (see, e.g., Stanley at el. 1981). "In fact, people with mental illness may wish to take part in a research project despite the paternalistic view of their caregivers, advocates, guardians or family members" (Liamputtong 2007, 25; see also, Usher and Homes 1997). Stanley et al. (1981) are of the view that such negative views or labelling of the mentally ill have the tendency to compromise the independence of people with mental illness in research studies and, consequently, miss an opportunity to take part in research projects that have the potential to contribute to or improve their health and wellbeing.

In this study, I chose to interview patients because of their lived experiences of healing at the camp. Thus, the patients were regarded as "experiential experts on the subject" under investigation and were therefore "allowed maximum opportunity to tell their own story" (Smith and Osborn 2015, 31). The patients shared their profound healing experiences at the camp, something that was at least for them as real as what modern medicine had to offer. In this instance, the patients did not use the term "healing" merely as a metaphor to communicate in describing their experience (McGuire 2008; Kirmayer 2004). The expression of their experiences helped to phenomenologically ground the responses in the broader analysis of this study. Thus, the patients' experiences shared a greater light in the methodological approach adopted in this study. This helped to effectively examine the efficacy of the healing experience claimed by the participants.

It has been well acknowledged that most studies on religious healing by anthropologists, despite being tremendous in scope, are only descriptive in nature with little evidence for readers to judge the effectiveness of the claims of supplicants or the methods and procedures used (see Csordas 1994). This study, through interviews, provides not only descriptive accounts but the experiences of the effect and transformation of religious healing through the testimonies and accounts of supplicants. These accounts dwell particularly on the meaning of healing as construed by patients through their experience at the camps.

2.2.5.5 Conducting the Interviews

The interviews were conducted in two separate fieldworks. The first set was conducted from October 2019 to January 2020 while the second set spanned from February 2021 to April 2021.

In each period, I visited the camps on three occasions. These visits were mainly to conduct interviews and observe the performance of some healing rituals as well as monitor the activities at the sanatoriums. Some of the visits involved spending a maximum of 7 days at a prayer camp. At some of the prayer camps, I spent two or three days depending on the number of interviews I had to conduct and the availability of the patients and the caregivers.

A semi-structured interview schedule was used for the interviews. The choice of a semi-structured interview was influenced by the IPA approach that was employed. This type of interview allowed the researcher and the participants to engage in a dialogue. It also allowed for some level of flexibility in the interview process. For instance, initial questions were modified in the light of participants' responses, and at same time, allowed for the opportunity to probe interesting and important areas that arose during the interview process (Smith and Osborn 2015).

Informed consent of participants was sought before each interview was conducted (Appendix 1). The consent was sought in both oral and written form depending on the choice of a participant. Participants were assured of their safety in taking part in the research and were made to understand that they could withdraw at any time during the interview or refuse to answer any question. Issues of confidentially were of great importance to ensure that the principle of "do no harm" was achieved (Buchanan and Warwick 2021). Each participant was assured of their rights at every stage of the interview process. All the research sites and individuals who took part in the interview are anonymised.

All interviews were conducted by the researcher. On the day of the interviews, the caregivers at the prayer camps introduced me to the patients I would be interviewing. I explained to each patient what my research was about. Afterwards, the patients' consent was sought by using the informed consent form or acceptance was made orally and was recorded. The languages used for the interviews were English and Twi. The choice of language for a particular interviewee was dependent on the communication ability and fluency of the patient. However, in some cases, both languages were used interchangeably. All interviews were audio-recorded with permission and took place at the prayer camps and designated places of choice, especially with religious leaders and health professionals. Interviews lasted approximately sixty minutes. Patients were asked about the story of their illness experience, their personal experience at the camp, and how the camp might have helped or aided in the recovery of their illness.

For each of the interviews, an interview schedule or questions were set in advance although these were modified during the interview process depending on the response of a patient to a question. On the whole, the interview schedule can be divided into three different stages or categories. Stage one focused on the history of the patient's illness. Stage two looked at the identity of the respondents and stage three examined the coping or management strategies and their effectiveness on their illness (Appendix 2).

At the initial stage, patients were asked to give a brief history of their illness from when it started, the kind of symptoms they had and their explanation to what they thought was happening to them. They were also asked to give account of some of the experiences they had in their first episode as much as they could remember. In doing so, patients were asked to describe some of the images that came to mind about their previous situation. What was it like to be mentally ill? How their mental illness affected their everyday life in areas such as work and relationships.

At the second stage, I asked the patients whether they were happy about their current state and why? How would they compare their lives now before they became ill? Patients were asked to compare their current state before coming to the prayer camp and whether or not they would say they had changed? What contributed to those changes? I also asked them about people's attitudes towards them in the camp and outside of the camps. And whether or not they would like to come back to the camp again after they are discharged or would recommend the camp to another person. In some instances, when I asked patients how they were treated at the camps, some of them expressed positive feedback on their treatment while others did not. I tried to probe further about those who had a different view about their treatment at the camp. In doing so, I asked caregivers about how patients were treated at their camps and varied views were expressed on the ways patients were treated. Largely, the treatment depended on the cooperation of the patient regarding treatment, the severity of the illness, and inadequate resources due to financial constraints. Before conducting my research, I have read from previous literature and reports on prayer camps, the cases of abuse of patients at the prayer camps. So, these questions were aimed at establishing the claims made in previous studies about the abuse of the right of patients at the prayer camps.

At the third stage, patients were also asked to talk about the various therapeutic sources they sought, how they ended up at the prayer camps, and the benefits they had obtained while staying at the prayer camp. They were asked what would account as most effective in terms of the treatment and therapeutic interventions; some of the prompts on this question included going to the hospital, visiting a traditional healer, and seeing a prophet at a prayer camp. I asked the patients about the success and failures of each therapeutic intervention they had sought since the start of their illness and how this had influenced their views on the various healing therapies. I also asked the patients about the thoughts, feelings, experiences, and meaning they made of practices such as counselling, Bible studies, fasting, and prayers which they are engaged in at the camps. These questions were important in establishing the effectiveness of these practices in aiding their recovery. They were also done to help re-examine some of the already existing claims made by some stakeholders as well as in some literatures about the fasting and prayers done by people at the camps which, they argue, do not contribute to, or have no role in improving the lives of people that patronise the camps (See Edwards 2014; Human Rights Watch 2012).

For other participants such as the caregivers and pastor-prophets at the camps, the interview questions were mainly based on the nature of their work. Particularly, I asked them questions about how they perceived, understood, and interpreted the cause of mental illness and their various mechanisms and approaches in dealing with it. I asked them about their experiences in taking care of the mentally ill and how those experiences helped them in their work. I probed further on the kind of working relationship they had with health professionals that had oversight responsibilities at their camps.

For religious leaders and health professionals, the interview questions focused on their knowledge about the camps and their activities. For religious leaders, I asked questions about their views on the operations of prayer camps, and what they made of the activities that took place at the prayer camps. For health professionals, the questions centred on the nature of their work at the prayer camps and how they cooperated with caregivers at the prayer camps in taking care of the mentally ill. I also asked them about their views of the operations of the prayer camps with regard to the treatment of mental illness and whether or not their views had any effect on the working relationship they had with the prayer camp leaders.

2.2.5.6 How IPA was used in the Interview Process

IPA is mostly used in a small sample population. The question, however, is how much small is small in a given population? In this study, the decision was taken to interview a few patients at one prayer camp on a case-by-case basis. I started the interview with one person and then moved on to interview another person who shared similar views in a more detailed manner. That is, a particular approach was taken to explore a more in-depth experience of other people with similar cases at different prayer camps. For example, in the first instance, I reached out to one prayer camp, followed it with another to conduct more interviews of other participants in other camps. This allowed me to find out the experience of people across different camps but with similar incidences or cases. This case-by-case basis helped me to significantly delve much deeper into the life experiences of the patients to find out how much the experiences at the camp meant for them. The number of patients interviewed at a prayer camp made this approach very convenient.

Again, the interview schedule or questions, as discussed above, were structured using IPA format. In IPA, the main goal of the researcher is to learn about the participants lived experience (Smith and Osborn 2015). "It is the meaning of experience that is important, and the aim is to try to understand the content and complexity of those meanings rather than measure their frequency" (Smith and Osborn 2015, 38). During the interviews, the patients were allowed to share their experiences without minimum interruptions. This was done to purposely give the patients maximum comfort and ease to express themselves freely while simultaneously guiding the conversation.

2.2.6 Participant Observation

As indicated earlier, during the time of my fieldwork, I spent a maximum of one week at each prayer camp to observe some routine activities, which included participation in church services, prayer meetings and counselling sessions. The focus of the participant observation was aimed at gaining personal insight and first-hand information into aspects of the healing rituals and routine activities that patients and their caregivers were engaged in at the prayer camps. This was necessary because not all aspects of the healing rituals and related practices were divulged by participants during the interviews. In other words, the participant observation was necessary to gain broader insight into healing practices that were otherwise not disclosed by my participants.

During my stay at the camp, I had the opportunity to observe how caregivers related with patients as well as the lifestyle of patients at the camp. The period spent at the camp also allowed me to engage in informal conversations with some visitors at the camps to seek their views on the role of the camps in their healing. Again, I had the privilege of visiting other areas of the camps which were regarded as special sacred places or meeting points with the divine.

Participation in some of the events enabled me to build rapport with camp leaders, caregivers, and patients at the camp. This relationship contributed to building trust among my participants and helped ensure the free flow of communication between myself and the participants. Participation in prayer meetings helped me gain a broader understanding of the ritual practices that are performed or enacted as part of the healing procedures. Prayer meetings were organised on different days across the camps. However, most of these services were organised on Wednesdays and Fridays. During counselling services, some of the patients

were sent to the prophet or the leader of the camp for prayers. At these meetings, the prophets, through prayers, told the patients the likely cause(s) or what was influencing their illness. In the process, prayers were said for them and directions (*akwankyere*) were given to the patients. The direction could include a period of fasting and prayers or the performance of some rituals to reverse any curse or deal with any malevolent forces deemed to be responsible for the illness.

I recorded all the important details and highpoints of these practices during my observation in my notebook and dairy.

Some of the challenges encountered during participant observation were that I was not allowed to film or record any event or activity. As best as possible, the only thing I could do was to observe and take notes. At one of the prayer camps, the leaders did not allow me to visit the sanatoriums where the mentally ill were kept. In another camp, I was restricted access to the female sanatorium. Other challenges included having to wait for long hours or time to get to talk to caregivers because of their busy schedules. I overcame these challenges by relying on other sources of information including media reportages and written reports about the camps that were not readily accessible through my engagement with some of the camp leaders.

2.2.7 Other Sources

To provide a balanced view of the shared experiences of patients as well as the account of their caregivers, attempts were made to sample other opinions from outside the camp. In this regard, the study relied on secondary and media sources. These views included media reports (both from local and international media houses) and official documentaries on the activities of the prayer camps in Ghana. Others included medical experts, human rights activists and NGOs that have remained critical of the activities of prayer camps. There were other pieces of information from blogs and social media platforms such as YouTube. The article on "media portrayals of religion, prayer camps and persons with mental illness in Ghana" provides an account of some of these alternative views. These sources provided alternative views outside of the camps for constructive analysis.

2.2.8 Analysis

The data were analysed at two levels. First, I transcribed all the interviews independently and coded them manually using Microsoft word. Each transcript was coded two times to capture every detail of the conversation. The meanings participants ascribed to their experiences were not transparently available and they were obtained through engagement with the text. This involved coding and interpretation. The coding and interpretation enabled me to systematically analyse the data and extract emerging patterns and ideas (Lindlof and Taylor 2017).

At the second level, the transcribed interviews were analysed manually using thematic analysis while following IPA. This was done by first looking closely at one interview transcript and then moving on to examine others case by case (Smith and Osborn 2015). This followed the idiographic approach to analysis, beginning with one case example, and slowly working up to more general claims. This does not mean eschewing generalisation but rather, painstakingly working on individual cases very cautiously to more general claims (Smith and Osborn 2015).

This helped in classifying and presenting themes (patterns) that related to the data. For instance, attention was paid to aspects of the data in which participants reported on beliefs and causes of mental illness and how prayer, fasting and their stay at the prayer camps aided their recovery from the illness.

Other aspects of the coding were done to also capture their preferred treatment approach for mental illness. After this process, the identified sections were labelled. Codes were then compared across interviews for similarities and differences. Themes that reflected same ideas or focus were grouped under a unified category and were then labelled as a theme and described in detail based on their relation to participants' views on mental illness and role of the camps in treatment of mental illness. The approach enabled the researcher to inductively extrapolate themes and preclude preconceived or anticipated themes. The themes that emerged from the textual analysis are presented in the articles. In each of the articles, I have dealt with topics that emerged from a pattern of the conversation with patients and caregivers. The topics or themes of the articles were mainly drawn from the interpretations that were made from the conversations with the participants.

It is important to point out here that, although IPA was followed in coding as well as in the interpretation of the data, all articles were analysed independently from each other. This was because, the articles were written with different objectives and each of them had to stand on their own as independent papers. Again, the focus, style, and format of the choice of journal meant that several considerations were made in terms of the presentation of methodology and style of analysis as well as the framework that were used.

Two of the articles; "Prayer camps, healing, and the management of chronic mental illness in Ghana" and "healing and mental illness in Ghana: why prayer camps in Ghana are sometimes alternative to psychiatric hospitals", were analysed using IPA format. However, a discursive approach was adopted in analysing the issues in the article on prayer camps and human rights concerns in Ghana. This was necessary because I had to engage in discussion with other texts or materials that were already published on the camps on the topic of human rights in light with my own data and what those data were pointing at. This meant that IPA was not suitable for the kind of analysis as well as the approach that this article took. But notwithstanding, some of the interviews that were conducted for this particular article followed IPA.

In the article on "media portrayals of religion, prayer camps and persons with mental illness in Ghana", we adopted a discursive and narrative approach. This was largely because the article relied solely on media sources about the prayer camps. In analysing news reportages and documentaries, we focused on media language and narratology, and also the larger discourses that the productions can be said to convey. In the article, we present the narratives of the visual material and at the same time, highlight the visual conventions used and the choices made in presenting mentally ill persons and the individuals and institutions in Ghana that are in charge of the mentally ill.

The table below presents a spotlight on the article, data used and the approach of the analysis.

Table 2. Overview of research methods in the articles.

Article	Why prayer camps in Ghana are sometimes alternatives to psychiatric hospitals	Prayer camps, healing, and the management of chronic mental illness	Prayer camp, mental health, and human rights concerns in Ghana	Media portrayals of religion, prayer camps and persons with mental illness in Ghana
Aim	Investigate what people seek to find at prayer camps	Explore how faith-based resources are used in managing mental illness	Examine the role of prayer camps in mental healthcare and human rights concerns expressed	Analyse how media present and communicate issues of mental illness and mental healthcare to targeted audience and its influence on them.
Research question	Why are healing rituals at prayer camps viewed by research participants as valid and adequate alternatives to medical treatment at psychiatric or mental health hospitals?	In what ways do Ghanaian Akan traditional and Pentecostal beliefs, practices and actors serve as a vehicle in managing and dealing with mental illness?	What role do healing rituals at prayer camps offer to people with mental illness and the human rights concerns that are expressed with the performance of such rituals?	How does media narratives construct mental illness, religion, and Ghanaian society and to what extent do they provide understandings or risk causing further stigmatization and exclusion of people with mental illness?
Method	Interpretative Phenomenological Analysis (IPA)	Interpretative Phenomenological Analysis (IPA)	Discursive Approach	Discursive and Narrative Approach
Data	Interviews and participant observation	Interviews and Participant observation	Interviews, participant observation, and written reports about the prayer camps	Media reportages and documentaries

2.3 Negotiating Positionalities: Re-Entering a Familiar Field

The first empirical task I had to accomplish when I began my research was the task of re-entry into a field in which I had, to a large extent, grown up in and on which I had formed my own notions, experiences and basic beliefs and practices about aspects of life, religion, and culture. My parents are devoted Christians, and I was socialised into the Christian faith as well as into the academic milieu. My undergraduate and postgraduate degrees were both in theology and study of religions. Religion has been a natural part of me even in my adult life. I have a strong attachment to the study object as I have grown up visiting some of the prayer centres on personal pilgrimages and I had the advantage of living close to a prayer centre in 2003 and 2004.[36] My situation was thus double-edged: I have been trained as a theologian and gained considerable knowledge in the field of religious studies and the prayer camps I studied were institutions I was highly familiar with. However, this was an emic familiarity, with many of my theoretical ideas and insights embedded in experiences I had before developing a scholarly repertoire. It was reasonable to assume that many conclusions which I had come to take for granted or my preconceived notions were going to need significant revision, and that I would need to take deliberate methodological steps in order to circumvent biases. And anyway, I am not under an illusion that my personality or background has not affected my research, and I am of the view that it is worth reminding the reader about this. Indeed, this positioning affected how I conceptualised the prayer camps when I initially set out to study them. However, these experiences later made me acquire a more sophisticated theoretical and methodological arsenal. They helped me to provide an informed critique, analysis, and personal reflections from both emic and etic perspectives. For instance, at the early stages of my research, I had developed a thought and, more convincingly in my proposal through the reading of reports on the prayer camps, that they were engaged in practices that fostered social exclusion of persons seeking treatment from mental illness at their disposal. I later went on to find out that, though certain practices in some camps raised deep ethical and moral concerns, patients largely found the camps to be more receptive and engaging of their situation than the community outside. I had to re-structure my previous notions about the camps through these experiences from field surveys.

To this end, the work of James L. Cox (2010), *An Introduction to the Phenomenology of Religion,* and Smith and Osborn's (2015) IPA approach became one of my constant references because I needed to bracket all my preconceived ideas (*epoché*) in order to produce an objective description of the phenomena I was studying. Since there were a number of descriptions and interpretations from both academics and non-academics and different stakeholders on the activities of the camps (some good and others bad), I had the task of developing eidetic intuition to see into the very structure of the meaning as objectively as possible to prevent biases. It was thus necessary to devise a method that allowed my participants to open up and share experiences that they would otherwise have hidden from me.

My background as a Christian provided a relationship of trust and served as an entry point to my informants. Most camp leaders had decided they were not going to allow anyone to interview, record or conduct research on their prayer camps after a damning report by the

[36] The house I lived in was 100 meters away from the camp. This prayer camp was established by the Church of Pentecost, Ghana. The Church of Pentecost is the single largest Pentecostal denomination in Ghana claiming a membership of over 3 million (see, https://thecophq.org/statistics/). Some of the prayer camps in Ghana are affiliated to the Church of Pentecost.

media (both local and international) and human rights organisations on their activities. Indeed, this created some level of tension in how I presented myself when asked the question: "who are you, and what do you want us to do for you"?, "Have you also come to record us and make a bad publicity of what we do here?", "Are you a Christian?", "why did you decide to select us and not others?". To the question on whether I am a Christian, I responded in the affirmative and this, on many occasions, became an entry point for interviews. Somehow, I felt obliged to honour moral values that are strongly influenced by Christian ethics. My own position in the research field was, to some degree, influenced by the experience I have had with the Christian faith and spirituality beyond a theoretical and scholarly level.

2.4 Ethical Compliance

The fact that the study focuses on vulnerable groups raises, of course, several ethical concerns (Hugman, Pittaway, and Bartolomei 2011; Riandey and Quaglia, 2009; Liamputtong 2007; Atkinson and Flint, 2001). Indeed, there are issues that also border on the morality of such research since individuals with mental illness are known to lack decision-making capacity. That said, one cannot also sidestep the ethical and epistemological challenges posed by interviewing those who have had a history of mental illness but have experienced appreciable level of wellness.

The ethical aspects of this study were evaluated by the Ethics Board of the Åbo Akademi University, Turku, Finland. In addition to that, no interview or discussion was conducted at any prayer camp without the prior notice and authorisation by the leaders of the camp. Issues of confidentially were of essence since most of the participants had engaged in the abuse of hard drugs such as cocaine. Others also had the experience of weed smoking (or cannabis). Each participant was assured of their rights at every stage of the project. Thus, the study ensured individual rights, privacy, and integrity. For instance, research sites and individuals who took part in the research project are anonymised.

Participants were informed of the purpose of the research and were made to understand that their participation was voluntary and that they could withdraw at any time during the interview. The total independence of the research from the interests of government or authorities was also made clear to participants. In order not to infringe on these rights, the researcher sought both oral and written informed consent for an interview. The consent form also explained whom to contact for answers to any question that was unclear about the research.

The entire body of data is securely stored and assembled in line with the general principles of the Document, Discover and Interoperate (DDI) model of metadata management as well as on the basis of the metadata standards of the Cultura Archives of the Faculty of Arts, Psychology and Theology at the Åbo Akademi University, where all research data is archived. The archived material is available for academic research according to the guidelines of the archive and good scientific practice.

2.5 Summary

This chapter has presented the theoretical consideration, methodological approach, and the positionality as well as the ethical compliance of the study. The discussion presented under each of the sections provides an insight into how this study has been conducted. The discussion

done set the parameters upon which the findings made in this study are based. The overarching goal was to provide the reader with clarity as much as possible, the processes through which this article-based thesis was conducted and what informed the discussions leading to the answering of the key research questions that guided the study.

3 Key Findings and Discussion of the Four Articles

This chapter is divided into two sections. Section one presents the findings of the four articles. These are summarised in Table 3. Section two presents a further discussion of the findings.

Table 3: Articles in summary

Article	Aim	Theory/Concept	Findings	Contribution to the study's overarching research task
I	Investigate what people seek to find at prayer camps	Health and Healing	Belief in the cause of mental illness influences the choice of therapeutic interventions	Ways that Akan traditional beliefs and notion about health and healing influence healthcare
II	Explore how faith-based resources are used in managing chronic mental illness	Health and Healing	Prayer camps helps in managing fears, anxieties, recurrent behaviours, and restores hope in dealing with chronic illness	Role of prayer camps in providing solution to aspects of mental health problems not provided by health institutions
III	Examine the role of prayer camps in mental healthcare and human rights concerns expressed	Health and Healing	Abuse of patients at prayer camps is influenced by ineluctable belief systems and practices and logistical and infrastructural constraints	The need to examine abuse practices from a more nuanced and informed perspective in order to curtail its spread
IV	Explore how the media presents and communicates issues of mental illness and mental healthcare to audience	Stigmatization	Media reportages about mental illness and healthcare are presented differently based on targeted audience	Role of the media in influencing the perception, attitudes, and care for the mentally ill

Article I

"Healing and Mental Illness in Ghana: Why Prayer Camps in Ghana are Sometimes Alternatives to Psychiatric Hospitals." *Temenos: Nordic Journal for the Study of Religion* 59(1): 101-123. https://doi.org/10.33356/temenos.109270

This article contextualises health and healing from Ghanaian Akan traditional perspective and, through the use of empirical data, presents ways that the view expressed by participants reflect the framework of Akan traditional understanding of health and healing. The findings made in the article point to the fact that the mentally ill people who seek help or healing from the prayer

camps are influenced by explanation they offer to the cause of their illness. Very often, these explanations are underpinned in indigenous cosmology that associates illness with supernatural evil forces. The article also found that the prayer camps have had a long-standing relationship with psychiatric hospitals and, in some instances, medical practitioners have recommended prayer camps as alternatives for psychiatric care and also, as institutions or site of learning for clinicians who want to better understand the nexus between culture and psychiatry and for developing cultural competence. This article further reveals that some individuals do not attend or seek medical care at psychiatric hospitals because of the stigma attached to such therapeutic intervention or regime. This stigma does not only concern individuals who seek treatment but also health professionals who work at psychiatric hospitals. Another finding made in the article is that involuntary detentions by patients at prayer camps, as claimed in other literature and written reports, were not necessarily the case. Most patients at prayer camps were sent there by family members. Again, patients at prayer camps do not find the healing at hospital holistic enough in addressing their health problems. Finally, the article found that the decision to send the mentally ill to prayer camps is sometimes influenced by economic or financial constraints and not necessarily due to spiritual causative agents associated with the illness.

Article II

"Prayer Camps, Healing, and the Management of Chronic Mental Illness in Ghana: A Qualitative Phenomenological Inquiry." In *Spiritual, Religious, and Faith-Based Practices in Chronicity: An Exploration of Mental Wellness in Global Context*, edited by Andrew R. Hatala and Kerstin Roger, 173-194. Abingdon and New York: Routledge. 2022

Contrary to some notions that the prayer camps do not provide any hope for restoration and that they are mostly or often engaged in forms of abuse, this article found that such views or claims about the prayer camps are not wholly true. For example, this study discovered that not all prayer camps are engaged in the practice of chaining patients, a finding which questions the authenticity or generalisation of such claims in other cognate studies. Chaining of patients is not universally applied in prayer camps and the attempt to over generalise such claims only results in oversimplification of the activities of the prayer camps. Against the view that prayer camps do not help in the recovery of the mentally ill, participants found the prayer camps to be aiding their recovery and helping them to cope with the problem of stigma, discrimination, and exclusion by creating a community where they feel a sense of belonging. The study found that caregivers freely interacted with patients and such interactions, some patients argued, helped them to deal with anxieties, build their confidence level regain control, and find meaning for their lives. The study also revealed that staying at the camps helped patients to manage their fears, including lifestyle that caused them to retrogress and take away any eventual promise of restoration. The prayer camps helped people with mental illness to deal with their anxieties, recurrent or persistent behaviours, social stigma, and discrimination. The camps also helped in negotiating the dilemma and uncertainties surrounding the beliefs, causes, and treatment of the chronic aspects of mental illness. The social support provided by the camps fosters optimism and hope among the patients in the midst of crisis. It became clear, from the findings of the study, that patients usually encountered more cases of stigma outside of the camps than in the camps. The article further revealed that practices such as Bible studies,

counselling, fasting and prayers helped in the recovery of patients. This was contrary to the view in other studies that fasting was always forced on patients and did not provide any means of help in the recovery of patients.

Article III

"Prayer Camps, Mental Health, and Human Rights Concerns in Ghana." *Journal of Religion in Africa* 51 (3-4): 283-308. 2022. doi: https://doi.org/10.1163/15700666-12340207

This article addressed one of the major issues concerning the operation and activities of prayer camps: the abuse of the rights of mentally ill persons who go there for treatment. While the article does not deny the claims of abuse of mentally ill persons at some prayer camps in Ghana, the study found that the issue of abuse is more nuanced and complex and is connected to ineluctable cultural and religious beliefs and practices that limit the role of human rights legislation aimed at dealing with such abuse. Again, it was found that some of the issues of abuse are occasioned by financial constraints and infrastructural deficit to curtail and manage efficiently individuals that patronise the healing camps for their treatment. This article also brought to light the fact that there was nothing like forced or involuntary detention and that these descriptions are used by human rights observers without a proper knowledge or investigation of the activities of the prayer camps. Such descriptions only present an illusion of the reality of the cases as most people seeking treatment at the camps were sent there by their relatives. The article also observed that fasting was not at all times forced on patients. Following these findings, the article presents recommended ways that issues bordering on religious views of healing and related human rights concerns could be harmonised to address the existential challenges at the prayer camps in relation to the healing of the mentally ill.

Article IV

"Media Portrayals of Religion, Prayer Camps and Persons with Mental illness in Ghana: A Discursive and Narrative Analysis." *Journal of Religion, Media and Digital Culture*. Accepted for publication.

This article, through media narratives, presents both institutional, public, international and local perspectives about the situation of the mentally ill and their care in the Ghanaian society. The article observed that media reportages about the prayer camps are told differently depending on the target audience. For instance, regarding the issue of religion and beliefs, the various videos that were analysed expressed very different viewpoints or understandings of the role of religion and beliefs in the care of the mentally ill. It was found that in the videos for an international audience (produced by international media houses), religious institutions, beliefs, and practices are presented as part of the problem whereas in the video for local audience (produced by MHA and Ghanaian media houses), although religious beliefs are acknowledged as part of the many of the problems at prayer camps, such beliefs are rather acknowledged as complementary in the care of the mentally ill and are argued to be the underlying force that drives people to care for the mentally ill in the Ghanaian society. The

article found that a more complex perspective about the prayer camps is often missing in news reportages. It came to light also that, though there are clear issues with many prayer camps, there are also different stories to be told. For some people, these centres are their only choice and a place where they are given care that no one else is providing. The camps thus answer a need in a country that has a long way to go in developing a working mental health care sector for all. This study reveals that the problems with the camps should not be ignored, but when watching news reportages and other visual materials from these places it is always essential to ask who is telling which story and why.

3.1 Discussion of the Findings

3.1.1 The Importance of the Clan or Family (*Abusua*) in the Care of the Mentally Ill

As the finding reveals, I found out during my visits to prayer camps that no patient had gone to the camp voluntarily. Most, if not all, were either sent to the prayer camps by their parents, a relative or a family member in their quest to seek remedy for their illness. In fact, camp leaders told me they were unable to accept anyone without prior approval from a family member or parents. They emphasised that they did not go around looking for mentally ill people to bring them to the camp for treatment.[37] Sometimes, family members stayed at the camps to help take care of their relatives during periods of treatment and even went to the extent of fasting on behalf of their sick relatives.

A challenge reported by some camp leaders is the way that some family members leave their relatives on them and never came back to check on their wellbeing even after recovery. Despite this challenge, what is of concern to me is the initiative taken by the family to seek solution to a health problem of a relative. It reflects how the family, as a social unit in the society, takes a keen interest in the wellbeing of their members and the processes that are initiated to seek redress when an illness strikes. Indeed, the prayer camp environment, despite its infrastructural challenges, is organised around a similar motive of providing care and hospitality to people who are mentally unwell. Patients who visit the camps are mostly sent there by their family members and some of them stay with them until they are well and are charged from the camp (Read and Nyame 2019; Goldstone 2017).

In the Akan kinship relation, a person is a member of the *abusua* through maternal blood relation. Anyone who is a member of the *abusua* is considered as the property of the family, and the family is expected to take care of its members when they are ill. In the article titled "healing and mental illness in Ghana: why prayer camps in Ghana are sometimes alternatives to psychiatric hospitals" (similar points are also made in the 3rd article on human rights), I explained that this view held by the Akan of Ghana is the reason the family takes the responsibility of seeking solutions to health problems when a member falls sick.

In searching for the cure for the sick person, all healing modalities (including biomedicine and divinatory consultations) deemed necessary are sought with the aim of restoring the person back to normal life. After spending almost thirteen years as a Divine Word Missionary

[37] This emphasis was made by the staff at prayer camps to probably, dispel the notion that they involuntarily keep people, maltreat, abuse them or ask them to undergo ritual practices without the involvement of the patient's family.

teaching and serving in the ministry among the Akan of Ghana, Robert B. Fisher, a Euro-American Roman Catholic theologian and liturgist, rightly observed that anytime an illness strikes in the Akan communities, the affected person is not the only one who suffers but the entire family. He remarked:

> While the family and community are central to this equilibrium of wealth and health, individual achievement is the mark of life well lived. For that reason, when illness does strike, the individual suffers, but normally not alone… Elders are summoned who first observe if the sickness can be cured with herbs. With the white man's medicine, this first stage is called the social palaver… The kin group shares the expenses of the treatment… The kin group is like an 'extended patient'" (Fisher 1998, 133).[38]

As stated in the above quotation, such social concern and family solidarity during illness was demonstrable in the ways that the mentally ill, for instance, were catered for in the society during the colonial and post-colonial era. Notwithstanding the use of mechanical restraint, colonial observers did not lose sight of the ways the family tolerated and cared for the mentally ill among them. Geoffrey Tooth, a British medical doctor who was commissioned by the colonial government in the Gold Coast (now Ghana) to conduct what is now acknowledged as the first comprehensive report on mental illness in Ghana, reported: "There appears to be little social stigma attached to madness, lunatics are well treated in their homes and even when shackled to a log in the traditional manner, the madman is seldom alone for long, is well fed and enjoys the company of his children and friends" (Tooth 1950, 30).[39]

This observation by Tooth re-echoes a Ghanaian Akan maxim which states that *obodamfoɔ biara wo wura,* which translates as "every mad person or lunatic has a relative" or put differently "every lunatic has someone who takes care of him or her". This maxim depicts how families whose relatives have been affected by mental illness still value, initiate and invoke processes of restoring the individual back to his or her "normal life".

In fact, Tooth was not alone in his observation. Robert Cunyngham-Brown, a British psychologist and medical administrator was commissioned in 1936 by the British government to inspect "the care and treatment of lunatics" in their West African colonies. He began his work in the Gold Coast. Contrary to his expectation that most of the mentally ill would be confined in the asylum, he rather found out to his amazement that more mentally ill persons were instead cared for by their extended families or by "native doctors". After examining fifty "wandering lunatics", Cunyngham-Brown (1937, 24), in his final report extolled the benefits of "family care of the insane" as "a natural growth of age-long custom" and "in entire harmony with the officially encouraged strengthening of native administrators". His conclusion is very telling:

[38] In modern times, such social solidarity is perhaps akin to the welfare state practised by most European countries, especially within the Nordic. Regardless of the fact that this often becomes a political ideology, one cannot dispute or lose sight of the true motive behind such ideologies, which is to show care, love and deep concern for people, especially the sick or victims in society. Nonetheless, some of them also tend to be thoroughly impersonal and individualistically oriented, especially the KELA system in Finland (See, Eerola and Lyytikäinen 2021).

[39] The social aspect of the care for the mentally ill by family members was at the centre of care for the mentally ill patients at the Lambo's psychiatric village in Aro, Nigeria, in the 1950s and later to be seen in the Fann Hospital established by a French military psychiatrist, Henri Collomb, in Dakar, Senegal. Families were involved in the treatment process by accompanying their relatives to seek health care, a practice that was believed to have therapeutic impact on patients and minimised their sense of alienation (see, Collignon 2015; Acheampong 2015)

> The general attitude of the native peoples... to the vagrant lunatics... is one of kindly commiseration, tolerating much and giving alms as a matter of course... Elsewhere when visiting patients in their own homes, I found the same kindly bearing to the insane, and though many were chained or put in stocks, to my thinking often needlessly, it was evident that they were seldom neglected but instead were in receipt of kindly and assiduous though often ill-directed attention (Cunyngham-Brown 1937, 13).

The above quotation indeed draws attention to the ways that the family functioned as a primary unit in providing care for the mentally ill. Margaret Field, also a British anthropologist and psychiatrist, after conducting an extensive study among persons with mental illness in rural Ghana at traditional healing shrines in Ashanti, reported: "The majority of chronic schizophrenics in rural districts are treated with… patient and sustained kindness by their relatives and tolerance by their neighbours" (1960, 453). These forms of tolerance and care were deemed to be influential in the recovery of the person. Meyer Fortes, an anthropologist, and his wife, Doris Mayer, a psychiatrist, who also conducted a study on psychosis in Northern Ghana in the 1960s had this to say: "Schizophrenia, at least when treated in the family setting and with the very real support of the whole family, seems to be a more reversible process than it is in more complex societies" (1996, 40).

All that I am trying to draw attention to is the fact that the family as a social unit within the Akan cultural context and the importance it attributes to a person not as an individual entity but as one with social relation contributes to the overall concept and understanding of health, healing, and wellbeing in the society. Subsequent studies by the World Health Organisation on schizophrenia seems to have affirmed the view shared by Fortes and Mayer.[40]

3.1.2 Understanding of the Concept of the Person and Treatment Therapies

An underlying concern that runs through all the articles, is why the mentally ill are sent to the prayer camps for treatment and the role the prayer camps provide in the care of the mentally ill in the Ghanaian society. I have explained in the various article the reasons underpinning these decisions. What is important to elaborate here is how the understanding of the concept of the person as discussed in the theoretical framework provides a further explanation and understanding to the reasons behind help-seeking behaviors for the mentally ill.

While healthcare practitioners and professionals see the services offered by these religious entities as complementary and, sometimes, even help in speeding the recovery process of patients, they still remain critical and sceptical about the services of traditional and faith healers. In a recent webinar organised on 29th July, 2022 by the Mental Health Authority of Ghana on the topic "Schizophrenia: balancing our beliefs and appropriate knowledge to manage the condition,"[41] the panellists, a clinical psychologist and a psychotherapist, shared their experiences about the kind of beliefs people bring to the consulting room when they are affected by schizophrenia. Among other factors, it became clear from their responses that patients and family members regularly attributed the cause of schizophrenia to supernatural

[40] For further reading, see Jablensky et al.'s (1992) article on "Schizophrenia: Manifestations, Incidence and Course in Different Cultures. A World Health Organization Ten-Country Study"; and Cooper and Sartorius' (1977) "Cultural and Temporal Variations in Schizophrenia: A Speculation on the Importance of Industrialisation." Hopper (2004) "Interrogating the Meaning of 'Culture' is also relevant here.

[41] See this link for a full seminar discussion, https://www.youtube.com/watch?v=dgyDaZ4Oy3I&t=11s

evil forces, a situation the panellists think was as a result of the influence of cultural notions and beliefs about mental illness.

Despite their openness to complementary approaches (involving both biomedicine and religious resources), the panellists still saw religion and the belief system as an obstacle to mental health care. Some of the statements that were made by the panellists during the webinar such as "lack of understanding of the disease" and there is "real treatment for the disease" to show their displeasure about the manner in which patients and their families resort to traditional and faith healers show their level of mistrust for such resources. The statements also reveal the dismissiveness and ambiguity in the adaptation of religious approaches as complementary resource by clinicians for effective mental healthcare therapies. Again, it also depicts the projection of colonialist conception or understanding of mental illness unto local context without giving recognition to the dynamics in the interpretation of mental illnesses based on different cultural context and understanding of what mental illness could mean.

While I am not trying to romanticise religious and cultural approaches to the treatment of mental illnesses, the current situation shows the suspicion and disbelief people have of the overall impact of such resources in mental health care. Where cultural and religious beliefs are seen as becoming an obstacle to the treatment of mental illnesses, psychotherapists can engage in psychological interventions and cognitive behaviour therapy that aims at reconstructing some of the negative thoughts or worldviews patients have about their mental health condition. Clinicians can spend time to study the cultural context they are engaged with, understanding the ways or "common-sense" interpretation of mental illness so that they could meet patients midway during treatment. This may help and guide clinicians in adopting the appropriate use of various forms of psychotherapy.

In a recent book, *Psychopathology and Religion: Structural Convergences between Mental Disorders and Religion,* Damian Janus, a Polish and a psychotherapist by profession, argued for the adoption of the "hermeneutics of disorders" to unpack the blurring conceptualisations of mental disorders that often give rise to different interpretations and meanings to mental illnesses. According to Janus (2019), this approach, which is phenomenological, will help in providing a "non-reductionist" view of mental disorders than the reductively centred approach of biomedical model of the disease. In his own practice as a psychotherapist, Janus argues that such method allows him to observe the lived experiences of patients and by "empathizing" with their stories, he manages to intuitively extract information from patients which, he believes, "makes it possible to synthesise the information and reach a conclusion that would not be available in a purely rational way of thinking" (Janus 2019, 14). Such an approach, he argues, "changes the understanding of mental illnesses, and consequently affects the style of the physician's or therapist's contact with patients" (Janus 2019, 13) and this "has serious consequences in the preferred treatment method, ways of informing and cooperating with patients' families… perhaps most importantly dealing with patients" (Janus 2019, 7). A balanced view and approach that integrate different causal and healing epistemologies will go a long way in ensuring a holistic and all-encompassing treatment interventions.

3.1.3 Implications of the Akan (Cultural) Concept of the Person for Mental Health

In the articles (I, II & III), I drew attention to the folk orientation of the Akan concept of the person and its association to cosmic order. I mentioned that a void among the components that

form the human person results in the destabilisation of identities and relationships and creates social disequilibrium. In most African societies, mental illness and emotional disturbances are mostly linked to social, economic, and spiritual entities impinging on one's life (Kpobi and Swartz 2019; Kyei et al. 2014). Such occurrences normally affect the person's somatic and psychological equilibrium and smooth functioning of the self, family or even the society.

Within the Akan setting where this study is situated, a pertinent question that arises from the findings made in this study, are the implications of the concept of the person for mental health.

Arguably, if mental illness or disorders are interpreted as behavioural disturbances and dysfunction of human cognitive abilities, or disruptive, abnormal behaviour, then, of course, an understanding of the concept of the person is important in establishing a dissociative disorder and what constitutes normality and abnormality. In an article published in the journal *Theory and Psychology*, Stephen B. Adjei (2019), a Ghanaian cultural and development psychologist, highlights the implication of the African concept of personhood for psychological science and practice. He notes that in Africa, for instance, "psychological phenomena such as mental health, interpersonal aggression, enemyship, friendship, and suicidal ideations have been empirically studied and associated with communal self-perceptions and embedded social referencing in Africa" (Adjei 2019, 492; see also Osafo 2012). The concept of the person as a relational being and its relationship with the cosmic order as perceived in the African worldview influence wellbeing and mental health (Adjei 2019). On a broader perspective of the concept of personhood and its implication for mental health, Adjei (2019, 492), aptly describes as follows:

> The relational sense of personhood in Africa goes beyond structural and subjective dimensions to capture the spiritual dimensions as well. That is, people do not live interdependently and derive belonging, warmth, respect, value, meaning, and purpose, but they also desire to experience a sense of transcendence by maintaining harmony and unity with an ultimate being. Thus, connectedness serves as the glue that holds the self, others, nature, and God in cosmological balance. As long as this balance is maintained, in the worldview of the African, there is wellness and mental health.

For any clinician, psychotherapist, or therapist working in such a context, gaining an understanding about the concept of the person is important in clinical diagnosis and psychological assessment because in the context of illness events or episodes of disturbance, the implicit premise about the nature of the person and ordinary social experience may become a doorway or incisive entry point into the native construction of the self or knowledge system aimed at explaining, diagnosing, and treating the disorder (Hammack 2008). This is necessary since the notion of the concept of the person encompasses a cultural inventory of the psychosocial universe, together with forms of reasoning employed in interpreting events in that universe (Kpanake 2018; White and Marella 1982).

Scholars in transcultural psychiatry have argued that any attempt to comprehend someone's behaviour without a background knowledge about the cultural, linguistic, and philosophical models employed in the society that the person belongs to is a flawed endeavour (Cox 2018; Kirmayer 2007; Kleinman and Good 1986). Indeed, "both clinical ethics and effectiveness demand careful attention to potential discrepancies between the concept of the person inherent in any given therapeutic practice and the cultural models that underwrite patients' self-construal" (Kirmayer 2007, 251). In fact, around the world, mental health

problems, ranging from depression, anxiety, and somatic and dissociative symptoms, have received a wide array of explanations across cultures some of which may be viewed, not as health problems *per se* but as personal challenges or moral issues or as imports of dissonance or disharmony in family or community (Kirmayer and Swartz 2013). Thus, "expressions of psychiatric illness in thought and behaviour are of necessity mediated by the symbolic forms of language and culture" (White and Marsella (1982, 3). In other words, "cultural theories of mental disorder lie at the intersection of conceptions of personhood and conception of illness, both of which are probably universal aspects of cultural knowledge" (White and Marsella 1982, 14). It is important to note here that relationality or the interconnectedness of personhood is reflected in the ways that health and illness are understood in the Akan concept as well as in most African communities.

In the article, "Cultural concepts of the person and mental health in Africa", Lonzozou Kpanake (2018, 198), an African and Canadian-based psychologist, reinforces the view that:

> Many African cultures promote a relational-oriented personhood, in which an individual manifests his or her personhood through connections to three distinct forms of agency: a) spiritual agency including God, ancestors, and spirits that influence the person; b) social agency, including the family, the clan, and the community, with extension to humanity; and c) self-agency, which is responsible for the person's inner experience.

These forms of agency, as explained by Kpanake (2018), influence the way the concept of the person is understood, and it has implications on the mental wellbeing of people.

3.1.3.1 Social Agency and its Implications on Mental Health

Social agency in the context of this discussion can be defined as the agency experienced through the effect of a unified relationship and interdependence among persons in a society. In terms of social agency, a person cannot be regarded as a discrete entity to be understood and dealt with individually but must always be seen as embedded in a social context or social relation (Kpanake 2018). This is somewhat different from the Euro-American concept of the person that places much emphasis on individualism and personal autonomy as unique characteristics in pursuit of life goals (Kirmayer 2007). John S. Pobee, a Ghanaian theologian, has argued that "if Descartes' *cogito ergo sum* represents the Western person's understanding of reality i.e. individualism[42], *homo Africanus* would rather say '*cognatus sum, ergo sum'* i.e. 'I am because I am related to others by blood'" (Pobee 2001, 59-60). This is reflected in the widely cited statement of Kenyan philosopher John Mbiti, who stated that "I am, because we are, and since we are, therefore I am" (Mbiti's 1970, 141), emphasising an understanding or assessment of the status of the person in African culture. Mbiti (1970, 102) further emphasised that the African is one that "can be only understood as a being characterized by interrelationships".

[42] Descartes expression which is translated as "I think, therefore I am", has been argued to have informed the basis of the Cartesian dualism in medical practice in the West. Cartesian dualism refers to the separation of the mind from the body. Such philosophy was regarded as not holistic in healthcare and ignored aspects of the social, environmental, and spiritual aspects of disease and health. Biomedicine was thus criticised for not been able "to adequately incorporate (and synthesize) the connections between a patient's thoughts and feelings and physical symptoms and the physiological aspects of disease" which prompted "emphasis on the demand for more 'holistic' therapies connecting mental, physical, spiritual, and environmental aspects of disease and health" (Cohen 2006, 10).

Writing on how community epistemology and ontology relate to health among the Akan, Fisher observed from the viewpoint of the Akan that "physical or mental illness is not merely biological but is more appropriately psychosocial in both etiology and diagnosis. Misunderstanding of this viewpoint by colonial governments and Christian missionaries has resulted in ineffective denouncements of sorcery and traditional medicine as pagan and unscientific" (Fisher 1998, 113, see also Mohr 2013). Among the Akan, "the human person in community is where the cosmos lies. Akan and most African cosmologies are therefore anthropocentric, human-centered" (Fisher 1998, 65). Every individual is expected to maintain good social relation with people in the society including the environment in order to ensure societal equilibrium. The maintenance of the social equilibrium does not only concern living peacefully with neighbours but also ancestors, deities and other spirit beings. For instance, one is expected to obey certain taboos and observe the performance of certain rites to ensure peaceful co-existence between the living and the non-living. Failure to do so may result in consequences not only to the individual, but also the family and the entire community. The manifestation of some of the consequences may include the inflicting of mental disorder as a form of punishment.

Writing in the context of Africa, Kpanake (2018, 2017) has, for instance, argued that mentally ill persons "typically dwell in a threatening world in which they feel in disharmony with entities belonging to one of the ontological realms or levels of personal agency". Among the Akan, it has been argued that a "lack of balance and harmony between the human, the physical and the spiritual has in its trail all forms of psychological and social strains that may eventually result in psychological and mental disorder of individuals" (Amoah 2014, 210).

Another social implication of the Akan concept of the person on mental illness is expressed through the Akan maxim *ne safoa ayera,* which translates as "has lost a key" or "his or her key is missing". It is thought that the reference to the key here is the key to life, that is, all necessary tools for achieving one's dream and total wellbeing in life. The key could also refer to the mind of a person which is needed for proper functioning of human behaviour (Amfo et al. 2018; Amoah 2014). When a person's "key is missing", it results in the malfunctioning of the brain that prevents the person from forming any meaningful social relationships and loses any sense of harmony needed to ensure his or her wellbeing in the society. This includes the failure to live in harmony with oneself and the individual members of the community, being in tune with the spirits, fulfilling social, moral and spiritual obligations as well as a sense of achievement that sometimes leads to an altered state of confusion, disorientation, ill health and the loss of the will to live (Amoah 2014).

Such forms of understanding of mental illness through the lens of social agency and disharmony invokes the reconciliatory aspect of healing rituals at healing centres to deal with any hurting relationship and restore harmony. So, at healing centres, persons with mental illness are taken through healing rituals that involve confession and reconciliatory processes, and in traditional healing centres, sacrifices to the spirits. If it is found out that the person has committed some kind of sin or wrongdoing, or that the illness is as a result of a broken relationship which has resulted in guilty feelings, the person is encouraged to openly confess. After confession, the appropriate reconciliatory rituals are performed, including prayers to ask for forgiveness to restore the broken relationships and removal of guilt from one's life.

3.1.3.2 Spiritual Agency and its Implications on Mental Health

A key finding presented in the articles (I, II, III, & IV) is the association of mental illness with supernatural evil forces by both pastor-prophets, caregivers, and people afflicted with mental illness at prayer camps. This notion as argued in the articles has implication to the understanding of mental illness and the remedies that are sort in dealing with the illness (see Benyah 2022; 2023).

With the notion of spiritual agency, the incorporation of the supernatural or invisible entities into the everyday life of the people cannot be disregarded. Kpanake (2018, 202) argues that "cosmology in many African cultures represents life as such a tragedy that the self alone, as a vulnerable and mortal entity, could never achieve its aspirations." As a result, personhood needs the intervention of other spiritual entities that will provide a form of protection and security against malevolent spiritual forces, whose actions on human life could be harmful or beneficial (Kpanake 2018).

In Akan religion and culture, as already argued, there is a strong belief in impersonal forces that exist within the cosmos. Since human beings are part of the cosmos, the activities of humans are believed to have a repercussion on the spiritual as well as the physical events. The powers within the cosmos can also be harnessed by people for good or for ill-intended purposes. Among the Akan, there is a strong belief that an individual, out of jealousy, can consult spirit mediums and through that inflict sicknesses on their target. The sickness can include mental illness (Kpobi and Swartz 2018; Opare-Henaku 2013). The jealousy can come as a result of someone being envious of another person's progress in life in either education, business, marriage, etc. The jealousy can also emanate from witchcraft activities (Benyah 2022). Not only that, one can also receive punishment in the form of mental illness for failing to respond to an invitation from a deity to serve that deity as its priest or priestess or the failure to perform certain rites or rituals expected from him or her (Amoah 2014)

Previous studies have pointed out that the belief in spiritual agency as responsible agents for mental illness is held by people within Akan Indigenous Religions and Pentecostal traditions (Yendork et al. 2018: Kpobi and Swartz 2018). As a result, both Pentecostal healers and indigenous healers adopt a practice of casting out evil spirits that are perceived to influence a mentally ill person.

The pervasive belief in the power of supernatural forces to cause sickness either as a result of punishment for wrongdoing (whether intended or ill-intended), or through the malicious activities of living human agents sometimes forces people to seek supernatural means of protection against malevolent practices. The practice of seeking additional protection and security against evil forces is what Pobee (2001) refers to as a "double insurance", where some Africans will, in one breath, consult a medical doctor or seek help from biomedicine and, in the same breath, consult traditional shrines and prophets or healers. The appropriation of different healing modalities with the aim of seeking help raises, of course, different paradoxes of the notion of patterns of causality that need to be taken very seriously in order to gain an understanding and offer a balanced solution to individual problems.

Thus, an understanding of the African medical terrain should be preferred to an outright rejection and dismissal due to the persuasive nature and attitudes of those seeking help, who usually invoke different causality patterns depending on the context of the healing space they find themselves in. Bernhard Udelhoven (2015, 64), writing on pastoral care for the afflicted in the context of Zambia, has, for instance, argued that "Spirits are usually felt in disruptive, negative and afflicting ways, but the metaphysical thoughts about their nature easily change within the context of healing. One and the same person may call his/her

afflictions 'demonic' when seeking help from a Christian pastor, 'witchcraft' when going to a traditional healer who analyses family constellations, and 'virus' when seeing treatment in a modern hospital". A good understanding of such worldview or patterns of interpreting causality is needed to provide culturally salient responses to the afflicted person.

3.1.3.3 Agency of the Self and its Implications on Mental Health

Aside the social and the spiritual, another important aspect of personhood in African cultures is the self, which differentiates an individual from others and is usually expressed in deictic terms such as "I" or "me" (Kpanake 2018). Kpanake states that "this self is a locus of agency that is responsible for introspection, feeling, and questioning, and an entity that one is proud of and seeks to improve". He continues to argue that "the self is responsible for the individual's social presence and, accommodates the life essence".[43] However, the self is also seen as the extension of oneself and transcends beyond "its bodily, anatomical, and physiological substrate" (Kpanake 2018, 205). Thus, in some African cultures, *the self* may take the form of an invisible self or an environmental self.[44]

This explains why, sometimes, an item used by a person could be used by another person in perpetrating an evil act against that individual. This is what James Frazer (1958), in his classic book *The Golden Bough,* referred to as the law of similarity and the law of contact or contagion. The law of contagion works on the principle of contiguity, where things that have been used by a person can be manipulated to cause harm to the person until the contact is broken. Examples include hair, towels, shoes, jewellery, footprint, etc. Kpanake (2018, 206) notes that "each of these agencies is associated with particular ways of self-understanding and self-representation that are invoked in causal explanations and interventions of actions and events." Illness or any misfortune that happens to people are either interpreted as the result of the activity of malevolent spirits such as witchcraft or sorcery or committing of offence through an immoral act or refusal to observe certain ritual practices. Thus:

> …personal misfortune, including illness, may be attributed to the actions of spirits or malign magic. These explanations are caught up in local notions of proper social and moral behavior: observing the moral code, performing the required rites, and maintaining good relations with others, including ancestors. These systems provide explanations for what otherwise might seem inexplicable and satisfy the need to maintain a coherent worldview. They may influence help-seeking and the acceptability of treatment (Kirmayer and Swartz 2013, 47).

This cultural understanding of personhood and healing is highlighted by Jean Comaroff, an anthropologist, and a scholar of African studies, when she emphasised that healing in all cultures concerns the "human intervention in disorder" and is evident in the effort of a group "to mend the physical, conceptual and social breaches entailed in illness" (Comaroff 1981, 368). Comaroff (1981, 368) thus sees illness as "a particular expression of a universal feature of human experience, that of threat to the normal state of being, or to survival" In a sense, illness thus touches upon universal paradoxes of human existence, and their symbolic expression in particular cultural schemes. Comaroff (1981) is of the view that human selfhood finds its

[43] See also the explanation of *sunsum* by Akesson (1965) and Debrunner (1961) for similar views.
[44] The invisible self refers to the unseen part of the human person or the components of the human being that is not visible to the eye. This can include the *kra* (soul) or the *sunsum* (spirit).

existence in the physical body, which is the symbolic frame through which the paradoxes of human existence are most strongly expressed. That is because:

> …the perception of the body is culturally ordered, and everyday social action serves to reinforce or transform the mutual interdependence of physical and social being. But the body…is not merely a convenient source of symbols which provides a functional image of social form. It is a scheme through which universal contradictions are shaped by historically specific values, but it also permits such values to be 'naturalised' – i.e. to achieve the status of transcendent truths, or realities which are above temporal interests (Comaroff 1981, 368).

Comaroff (1981, 368) also highlights illness or the dysfunction of the body as a result of or an indication of the disruption of the harmony which exists among the physical, social, and moral aspects of being, and this "set in motion the search for reconstitution". Since part of the human being or a person is viewed in spiritual terms, the search for reconstitution may sometimes include aspects of divination.

Sometimes, people may feel that they are not at peace with themselves because they have wronged someone. A broken relationship can also cause a person to be mentally unstable. Forster (1962b), who wrote a long and informative treatise on mental health practices and values in Ghana, identified among other factors the disintegration of social units as one of the main core factors that determined complex psychiatric profiles of the people. Aside social disintegration, a disconnection between a person and his or her higher power relation can create anxieties and disturb inner peace. All these can create emotional traumas and mental health problems that sometimes need both a restoration of strained relationship within the social body or performance of some ritual in order to make the person feel forgiven or cleansed if the person feels that the source of his or her sickness or not being well has spiritual connotations.

3.2 Understanding the Causality Pattern for Effective Collaboration between Healthcare Professionals and Prayer Camps

From the findings in the articles (I & II), we can see that the choice of a therapeutic intervention by patients is influenced by the "explanatory model" applied to their illness. Even in cases where there are clear indications of non-metaphysical realities involving an illness, prayers or rituals are sought with the belief that God is the ultimate healer. An understanding of such healing landscape presents clinicians with the tools to engage meaningfully in therapeutic processes. Writing on the significance of religious beliefs and traditions for therapy in Ghana, Araba Sefa-Dede, a renowned Ghanaian clinical psychologist has recommended to psychiatrists and clinical psychologists to:

> Understand the belief system and to be willing to explore the individual thoughts, emotions and behaviours concerning it...This is essential within a belief system where only the religious is highlighted. However, it is possible and essential that this expertise be integrated into the original belief system in order that there is consonance between some aspect of the religious world view and the help being offered (Sefa-Dede 2001, 3, cited in Amoah 2014, 217).

Sefa-Dede's recommendations concurs with a view shared by Kirmayer (2004, 34):

> Clinicians need some understanding of these healing practices in order to consider their implications for biomedical treatment. Some practices directly challenge the assumptions of biomedicine; others may conflict with prescribed treatments. At the same time, healing traditions offer important resources for patients. Practitioners able to work in concert with these complementary medical systems and resources of healing will be better able to serve their patients.

John Bennet and Jon Rohde's (2008) in their essay titled "Hospitals and clinics" also recommend to health workers working in Africa to find a middle ground of integrating traditional methods of treatments and worldviews into hospital or clinic centres. They argue that "the strong belief systems of most Africans make careful study of local healers and working partnership a key strategy for good health care. At a minimum, health workers must know and respect local language, beliefs, and practices if they are to succeed" (Bennet and Rohde 2008, 538).

It is important to note that these kinds of collaboration existed between medical practitioners and traditional healers as described by Konadu (2019), during the time of Kofi Donkor in Techiman. Konadu notes that medical staff and doctors who recognised, in some respects, their inadequacies in some areas of their practice were not hesitant to consult healers, especially in areas where they were known to be more decisively effective than they. Konadu (2019) referring to a film that showcase the relationship between traditional healers and medical professionals cites one Dr. Willem Boere to have conceded in the following words: "The more total approach of the indigenous healer to illness is probably best reflected in the treatment of psychiatric diseases and psychosomatic diseases… Usually, when these illnesses occur, I advise the patient also, besides drug treatment, to consult a traditional healer". Another view is also shared by Sr. Mary Ann Tregoning of the Holy Family Hospital: "For quite a while now we've referred patients to them that have psychiatric illnesses… [We] have known for a long time that [healers] are [also] very skilful in fractures" (Konadu 2019, 189). Kofi Donkor, reportedly at the end of the film, also reflected fittingly that "previously, the doctors did not understand what we were doing. But now they work with us. The doctors find that there may be a sickness of a spiritual nature that they cannot cure, and they will send that patient to us for treatment", a view reported to have been concurred by Dr. Boere in the following words: "I think it is better in the long run to cooperate with the healers than to fight them" (Konadu 2019, 189).

These experiences are similar to the current cooperation between mental health hospitals and psychiatric units of district and community healthcare centres in collaboration with some prayer camps in Ghana. Such collaborations have been noted to ensure an effective, ethical and value-laden relationship that contributes to the overall well-being of patients (Read 2019; Arias et al. 2016).

Indeed, confrontational approaches to the treatment of illness between different healing spheres have been shown to have negative consequences on the health of patients (Taylor 2003; Fadiman 1997; Kleinman 1980). Such conflicts have usually emanated from cultural differences and different "explanatory models" conferred on illness and what counts as effective or not effective. In the article, "The Story Catches You and You Fall down", Janelle S. Taylor (2003) reflects on the tragic incidence of a young Hmong girl as narrated in the book *The Spirit Catches You* by Anne Fadiman. Taylor (2003) highlights how the uncompromising stance of an American-trained medical doctor at a hospital in Merced, California, in accepting

the "explanatory model" of epilepsy (as influenced by a move of a divine spirit) by the parents of the young girl named Lia Lee, resulted in a catastrophic effect on the 4-year-old girl. Recounting the destructive consequences of the situation on the girl and the family, Taylor (2003) argues that a compromise on the side of the doctor could have led to effective cross-cultural communication to effectively deal with the situation and, perhaps, prevented the eventual comatose that befell the young girl. It was, as she argues, a clash or "collision of cultures" that produced a destructive effect on the health of the child. Taylor (2003), therefore, highlights the importance and need of "cultural competence" in the field of medical practice. That is, the need for physicians and medical practitioners in general to be trained to understand "cultural difference" in their line of work. This allows for the production of cultural sensitivity and adoption of mediation and negotiation procedures by health professionals that results in overall and effective medical care and prevent negative consequences on the health of patients.

In Ghana, for instance, most of the tensions or opposing views between prayer camps and international human rights organisations and some health professionals could be attributed to the lack of proper understanding of the complexity of cross-cultural medicine and ineffective communication in the context of healing and medicine in relation to the "explanatory models" of the causes of mental illness. An overall understanding of the Ghanaian (Akan) cultural context by clinicians would contribute to effective collaboration between them and prayer camps. This is very important specially to augment the decentralisation agenda of the Mental Health Authority of Ghana to make the delivery of mental health care easy and accessible to all.

3.3 The Effectiveness of Healing of Mental Illness at Prayer Camps

One of the findings presented in the articles (I &II), is the claim by patients to the effective role of the prayer camps in providing healing to their illnesses. Such finding or claim on many occasions, became the centre of discussion during presentation at conferences or seminars.

Referring to claims of religious healing, these questions are not surprising. Such questions have been at the centre of scrutiny by researchers and scholars in anthropology and religion whose focus is on religious healing. Notable among these are the anthropologist Thomas J. Csordas and the Nigerian historian of religion and scholar of Pentecostalism in Africa, Ogbu Kalu. Csordas (1994), in his book *The Sacred Self: A Cultural Phenomenology of Charismatic Healing,* set the plot of the study in the introduction by asking these questions: "How does religious healing work, if indeed it does? What is the nature of its therapeutic efficacy? What is actually being healed by the performances of… medicine man, or the faith healer?" (Csordas 1994, 1). Kalu (2008, 263), writing about the discourses of the efficacy of healing among Pentecostals, asks similar questions: "What exactly do the churches mean by healing? Can healing always occur? Can healing occur without physical cure? Are the claims sustainable or fraudulent?"

Both scholars, in attempting to answer these questions, limited the discussion to the religious communities they studied and focused on what counts as healing and how it is understood and the kind of modalities that are used in determining or establishing its efficacy. For instance, Csordas (1994, 2) notes that "it has become commonplace to observe that efficacy is contingent on the nature of problems addressed by different forms of healing, how those problems are defined in cultural practice, and what counts in cultural terms as their successful

resolution". The transcultural psychiatrist, Kirmayer, has also dealt with the problem of efficacy in healing. In his arguments, he states that "the effectiveness of a healing practice is embedded in a larger cultural system that identifies types of malady or affliction and prescribes appropriate interventions". As a result, "evaluations of outcome are always made with reference to specific problem definitions, hierarchies of values and contextual frames" (Kirmayer 2004, 43). Kirmayer notes that the effectiveness of a particular healing modality can be assessed against many different outcomes, which also raises epistemological, ethical, and aesthetic concerns.

Epistemological concerns how we know that something works and ethical and aesthetic values what constitutes a positive change, improvement, health, or wellbeing. Just as the notion of causality and pattern of thought systems differ from one person to the other or from culture to culture, what counts as a good outcome may also differ (Kirmayer 2004). So, as he argues, "what counts as a good outcome may range from change in a discrete behavior viewed as troublesome, or improved 'quality of life', to the restoration of harmony between body, social order, and the cosmos" (Kirmayer 2004, 42).

For example, for someone who has visited a prayer camp, the effectiveness of his or her healing may be attributed to the ability to sleep at night devoid of any previous vision of being tormented by an unknown person in dreams or hearing of voices at night while sleeping. Although these outcomes could be self-confirming, they count as a good outcome since the person's problem has been solved. Similarly, health professionals may also invoke different criteria and definitions for what counts as a successful outcome.

Thus, in answering these questions, attention must be paid to how people define their illness, both culturally and socially, and what counts as effective in dealing with the perceived causes. Thus, focus must be placed on why people seek a particular method of healing when they are ill and how effective these methods of healing are to them. Particularly, what counts as an effective method in counteracting any of the causes of illness that are presumed or defined? Erica Bourguignon (1976) gave her assessment on the effectiveness of religious healing, when she stated that one of the key questions to ask in assessing any religious healing is: how is healing related to diagnosis in a specific case, or more generally, to the diagnostic categories or nosological systems employed in a given culture? In other words, what is to be understood by illness? (Bourguignon 1976, 5). According to her, these questions are fundamental, especially in areas where religious healing has proved to be very effective and "there is much evidence to show that religious healing is successful and efficacious in the view of its clienteles" (Bourguignon 1976, 18).

A further probe on some of the questions I was asked by people who were interested in my work would reveal that, most at times, people ask such questions from an ill-informed perspective or they intentionally ask such questions to undermine or cast doubt on a particular religious or social context on what counts as important to them, especially when they juxtapose such practices in the light of scientific and technological development in their own social world or contexts. With such thoughts, the question then becomes simple: why on earth will people still believe in these kinds of things or resort to such practices in a modern-day environment with its attended scientific knowledge advancement and development?

Indeed, similar questions seem to have guided the recent research project on the activities of prayer camps in Ghana, leading some international NGOs to produce a damning report on the prayer camps (Human Rights Watch 2012). Other independent writers and human rights organisations have also raised criticisms on the viability of prayer camps in dealing with the problems of mental illness (Goldstone 2017; Edward 2014). While some of

these concerns may be legitimate and need considerable attention, a broader examination of the report exposes a gross misunderstanding of the phenomenon they sought to study, or they decided to commit a similar blunder by wearing the spectacles of their donors who are mainly from the Western countries or to continue the colonialist project of imperialism by asserting their own values into one culture or society and expected people to behave or conform to a particular form of practice as they would in their own context.[45]

3.4 Human Rights Abuse at Prayer Camps in Ghana

In the articles (III & IV), I have discussed and referred to some of the abusive practices that undermines the rights of person's seeking treatment at prayer camps in Ghana. Indeed, the abuse of the rights of persons with mental health conditions is a global issue and several scholars, activists and various advocacy groups and healthcare institutions, including the World Health Organisation (WHO), have made several attempts to address such conundrum on a global scale (Cosgrove and Shaughnessy 2020; Broberg et ak. 2020; WHO 2018; Wildeman 2013; Dudley et al. 2012).

Despite these efforts, it is evident that the problem persists on a larger scale in some contexts. In Ghana, for instance, the abuse of the rights of persons with mental health problems seeking treatment at prayer camps has been on the radar of both local and international agencies and organisations such as Basic Needs Ghana, an NGO that focuses on addressing the challenges of mental healthcare in Ghana, Human Rights Watch (2012), and the United Nations Human Rights Council.[46] Several scholars have also attempted to address the issue in their work (Benyah 2022; Read 2020; 2019). The issue has also attracted media attention both in Ghana and outside of Ghana (BBC 2018; GHoneTV 2017).[47] These media reports have exposed some of the harsh conditions and inhumane treatment that patients go through as part of the healing process or treatment performed at prayer camps in Ghana. Such attention on the camps within the global political discourses on health and healing has generated provocative actions and interventions aimed at ameliorating the situation and reducing its impacts on affected individuals.

Yet, the question remains as to what extent have these actions or interventions contributed to improving the life and conditions of patients seeking treatment at prayer camps as well as improving the working conditions and environments under which some of these prayer camps operate. Although some notable achievement could be cited[48], the current

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[45] Mohr (2013, 40), for instance, reports a similar case of Roman Catholic missionaries in East Africa who "systematically misrepresented African religion and culture in the missionary press, embellishing African misery and savagery in order to increase their funding by patrons troubled by these images". Atiemo (2014) also notes how current assessments and critique of prayer camps by human rights organisations are mostly based on global north privileges that miss the local and cultural nuances in the discourses relating to the care of the mentally ill. See for example, "Filling the gap: why prayer camps in Ghana are sometimes the only option", available at https://www.opendemocracy.net/en/openglobalrights-openpage/filling-gap-why-prayer-camps-in-ghana-are-sometimes-only-option/ (accessed on 7 November 2022).

[46] United Nations Human Rights Council. Ghana's criminal justice and mental health practices needs critical attention to be more humane. 2013.
Available: http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=13990. 2388859.

[47] See the report on "the state of mentally ill persons in Ghana" by GHOne TV, a television station in Ghana. Available at: https://www.youtube.com/watch?v=f7-cKyVDdgo (accessed on 25 August 2021).

[48] Some of the studies conducted on prayer camps by some group of clinical psychologists recommended stationing of mental health professionals at one of the camps I visited. This has contributed to, for example, reducing some

situation suggests that such calls only remain in documented reports and are much a lip service than real action to alleviate a deteriorating condition. In other words, inasmuch as these reports are good in terms of their ability to point out the weaknesses and challenges on the field, the problems that are highlighted are left unsolved. Or there is much less effort to address some of the existential challenges identified in these reports. Some of these challenges highlighted so far include infrastructural and logistical constraints, inadequate financial resources, inability to reconcile divergent views on health and healing, especially those that pertain to culture, religious views, and belief systems, etc. (Arias et al. 2016).

Thus, while human rights abuse is self-evident in the work and activities of prayer camps in Ghana (see Benyah 2022), efforts to curtail the situation have only seen little results. This is due, in part, to the one-sided or conventional approach employed by human rights activists, NGOs, and other stakeholders in addressing the issue. I have argued in the article "Prayer Camps and Human Rights Concerns in Ghana" that, the human rights concerns in the activities of prayer camps in Ghana are far more complex and are interlaced with issues of religion, culture, and monetary constraints (Benyah 2022). Any attempt to address such concerns that side-step these factors is likely to be a non-starter.

To an extent, some of the reported cases of abuse at prayer camps could be located within a broader frame of ineluctable belief systems and culturally laden values that underpin its legitimacy. This is not to justify or make claim to the fact that abusive practices could be excused by reference to cultural relativism. However, in a context where religion and culture continue to maintain a powerful hold on most people, such issues cannot be ignored in any attempt to implement human rights legislations that seek to protect the right of people.

People's attitudes to matters of health and healing are largely shaped by the combined forces of the indigenous cultural practices and belief systems that have found it continued expression in Christianity in the context of the prayer camps. Religion is very dominant and appeal to the Ghanaian citizenry, and this means that any attempt to address an issue that is bordered on religiosity needs to be soberly approached with care than an approach that is confrontational. The confrontational approach, which has been the norm for some time now, has proven to achieve no results despite several interventions including the quest by state institutions and human rights organisations to forcefully remove people from prayer camps.[49] The prayer camps continue to enjoy popularity in the face of criticisms and backlash. Though one does not have to be overly optimistic about the therapeutic strategies on offer at these prayer camps for mental health patients, it is important that we find common ground to engage the two healing modalities – biomedicine and spiritual care – and thereby reduce the tensions and conflicts that seem to characterise current intervention strategies.

There is no doubt that there is a longstanding competition between biomedicine and religious healing, and this has generated different political and medical ideologies that will substantially create binary views of the effectiveness of one medical modality to the other based on different explanatory models of illness (Meincke 2015). What is important about these kinds of competition is the ability to spot the differences and map out a common ground to engage different views for effective and holistic healthcare.

practices such as caging. Regular training has also improved standard of healthcare treatment at the camp (See Yaro et al. 2020; Ofori-Atta et al. 2018; Arias et al. 2016).

[49] See the report "Ghana: Oversight Needed to Enforce Shackling Ban".
Available at: https://www.hrw.org/news/2018/10/09/ghana-oversight-needed-enforce-shackling-ban (accessed on 15 November 2022).

3.5 Media Reportages and Stigmatisation of the Mentally ill

Media, in many ways, influence our perception about realities. It is also very significant in affirming attitudes and opinions about already established facts. The media can also be used to convey meanings or interpretation of issues that can either be injurious or risk producing negative tendencies or perception about a phenomenon.

In the article on media portrayals of religion and mental illness in Ghana, we found that media reportages and documentaries on mental illness were influenced by the targeted audience of such productions. Although news reportages from Ghanaian media houses and documentaries from state institutions such as MHA are critical of the religious approach to the healing of mental illness, they also view religious institutions as providing a very important but missing element in the healing of mental illnesses, that is, they are very wholistic in their approach to healing. This includes how the underlying religious beliefs of the causes of mental illness drive some people to care for the mentally ill in the Ghanaian society among others.

However, reportages from international media houses sort of categorise religion as problematic, outdated and not useful to the care of the mentally ill. In doing so, they only produce a one-sided account of the role of religion in the care of the mentally ill. Such biases in news reportage have a potential of crusting the realities and only result in sensationalising the excesses of the healing practices without providing a roadmap in addressing the challenges found. The sensationalising aspects have the tendency to influence public attitudes and risk reducing the effort made in addressing the exclusion and stigma associated with the mental illness in the society. While it is good to expose the excesses and/or the negative aspects of the healing practices that go on in some prayer camps, it is also important to engage thoroughly with a phenomenon that has for a long time been part of or been one of the avenues through which the people have coped with their problems.

One of the key pointers of the media coverage of people with mental illness on the streets of Ghana is that not everyone is supposedly "mad" or "insane" as the public views them to be. As media report and findings show, some of them are only on the streets as a result of broken homes and financial constraints to secure for themselves a proper accommodation. This portrays a rather different outlook and presents an opportunity to examine broadly some of the factors contributing to the mental health problems and vagrants on the streets of Ghana. What the media can do is to provide a platform that will seek to make public some of the misconceptions and realities surrounding mental illness in Ghana and, through that, embark on several educative campaigns aimed at altering the social stigma and stereotypes for the mentally ill in the Ghanaian society. This will help to reduce some of the existing challenges as well as open the opportunity to raise the needed awareness in addressing mental health challenges and calling these challenges out of their destructive consequences. The stigma and stereotyping of persons with mental illness in Ghana continue to affect the wellbeing of those affected with mental illness, and what the media can do is to portray a reflective and well-balanced view of mental health situation and not to resort to narratives that jeopardise and undermine efforts in dealing with a problem whose consequences have social and relational repercussions.

3.6 Summary

This chapter has presented and discussed the findings made in the articles. The discussion points out the importance of the family in the care of the mentally ill in Ghana. The role of the

family in the care of the mentally ill is significantly influenced by the concept of relationality as exemplified in the Akan concept of personhood. Individual members of the clan or the family are considered properties of the family and the family takes the responsibility and wellbeing of their members when they fall ill. These traits explain the reasons family members take their relations to the prayer camps to seek healing when they are suffering from or are afflicted with mental illness. Substantially, the social role of the family in the care of the sick has been shown to play a pivotal role in the recovery of patients with mental illness, for example. The discussion has also pointed out how the concept of the person, in relation to health and healing, influences treatment when one is sick. The discussion on the treatment options sheds light on how the understanding of health and healings and the theory of disease causation influence therapeutic interventions and draw an understanding to the binary distinction between religious healing and biomedicine.

Furthermore, the discussions in this chapter have provided an insight into the implications of the concept of the person for mental health. The social agency, spiritual agency, and self-agency, as articulated in the concept of personhood, provide a lens to the understanding of the theory of disease causation and what influences help-seeking behaviours. The discussion indicates that health professionals' holistic understanding of these agencies and their role in health and healing, especially for the mentally ill, may contribute to an effective collaboration between health professionals and prayer camps. A follow-up on this is a discussion on the effectiveness of healing at prayer camps as claimed by participants in the findings. The inference drawn from this discussion is that a claim to the effectiveness of a healing modality could be very subjective and is dependent on the definition of the problem of illness and what counts as a solution to that problem.

The last section centred on the question of human rights concerns and media portrayals of the prayer camps. The discussion revealed the issues surrounding the prayer camps about human rights, for example, and called for a more nuanced approach in addressing some of the concerns expressed.

4 Implications of the Findings and Contribution to Knowledge

This chapter presents the implications of the findings of this study and my contribution to knowledge. Several implications can be drawn from the findings made in this study. What is important for the purposes of this study is presented in this chapter. The first implication I discuss is the collaboration between prayer camps and health centres or psychiatric hospitals. Despite the fact these issues have been discussed in previous literatures (Ofori-Atta et al. 2018; Arias 2016), they have become more prominent due, in part, to the current decentralisation and de-hospitalisation agenda of the Mental Health Authority of Ghana aimed at taking mental health care to local communities or the doorstep of the people. The prayer camps have been included as part of this agenda, making these religious institutions a key focus of attention in mental healthcare delivery in Ghana. In the second section, I discuss the need for the decolonisation of psychiatry. This discussion is also important in line with the findings of the study in order to make way for and adopt strategies that are peculiar to people's cultural context so that one can do away with the transporting of illness ideas and philosophies that are either alien or imposed on groups due, in part, to colonial missionising. In the third and fourth sections, I discuss the methodological and theoretical contribution of this study to knowledge. I argue particularly for the need to interpret mental illness through indigenous knowledge frameworks and also propose a new theoretical approach out of the existing ones to make way for a further re-examination and adoption of new approaches and strategies that are universally sensitive and applicable to different diverse and cultural settings.

4.1 Collaboration between Prayer Camps and Health Centres

During my fieldwork in Ghana, I found that one of the ongoing practices at the prayer camps is the collaboration between the camps and mental health professionals working in the districts where the camps are located. This collaboration provided the opportunity for some of the camps I visited to combine both prayer and biomedicine in the care of the mentally ill. One of the camps, however, did not subscribe to the use of biomedicine and solely relied on their belief in the method of divine healing. Speaking to some of the health professionals, they admitted that the collaboration was a step in the right direction, since it helped them to monitor the situation of some of the patients at the camp so that they could administer medication and injections. In fact, one of the health professionals I interviewed had spent seven years working at one of the camps as a resident nurse.

The collaboration between the camps and healthcare centres is part of the decentralisation agenda of the MHA. One of the main aims of passing the Mental Health Act in 2012 was to decentralise mental health care in Ghana. Part of this objective included the de-institutionalisation of mental health care for a community-based approach to mental health care. This included collaboration with traditional and faith-based healers (including prayer camps and Islamic-based healers) across the country who, reportedly, oversee a large proportion of persons suffering from mental health disorders in Ghana (MHA Mental Health Policy, 2018). The decentralisation agenda was also in line with the objectives of the World Health Organisation's mental health policy and the Global Health Movement for Mental Health in the 2000s (Read and Nyame 2009). Indeed, decentralisation has been an important factor in

health policies in Ghana since the 1980s, following the recommendations of the 1978 WHO Conference in Alma-Ata, USSR, in September 1978. Apart from giving birth to the concept of Primary Health Care (PHC), the Conference also (and most importantly) advocated the use of indigenous healers in national healthcare systems in the developing world (Senah et al. 2001).

It is important to mention that this kind of collaboration between health professionals and traditional healers, for example, is not the first of its kind in Ghana. Ghana, in 1960, through its first president, Dr. Kwame Nkrumah, established the *Ghana Psychic and Traditional Healing Association* (GPTHA) to act as an assemblage point for the practices of both psychic and non-psychic healers. Part of the Association's aims included collaborating with health professionals and establishing clinics in all the regions of the country to help treat diseases and ailments that biomedicine could not cure (Warren et al. 1982). Although the organisation's plans were short-lived, this culminated in the passage of the Traditional Medicine Practice Act (No. 575) to act as a rallying point for the work of traditional healers in Ghana.

Current collaboration of the intersection of biomedicine and spiritual care for mental health patients in Ghana points to a new promising relationship and collaboration between biomedical care and prayer camps. For instance, this may provide avenues for clinicians or healthcare professionals to develop cultural competence in the field of practice. For the prayer camps, such collaboration will help them cater for some of the shortfalls and provide solutions to the latent function of the healing practices at prayer camps.

In this regard, this study recommends that the collaboration between prayer camps and biomedical care should not be looked at as a mere potentiality but rather a key strategy in addressing a very important healthcare challenge in a pluralistic medical economy. What is important is finding a common ground in merging the differences in the interpretation, meaning and treatment of illness and finding solutions to existing problems such as chaining and other practices that are injurious to people seeking treatment at both healing camps and healthcare centres. As mentioned earlier, the combination of both spiritual care and biomedicine does not hurt but rather serves as a complementary mechanism in holistic healthcare approach. They are both desirable to patients in many instances.

A possible challenge I anticipate in the ongoing collaboration is the question of the ability of the religious resources, in this case the prayer camps, to provide a valuable resource for individuals with mental illness and other ailments in general, a platform for re-envisioning themselves. This is because, although religion has, to a very large extent, served as a coping strategy and, in some cases, produced a positive result for some people, it has on the other hand, through some negative practices, produced regressive self-narratives of victimhood and loss of social stature (Gergen 2009).

In my observation, the question of the viability of religion as a resource for mental health patients still lurks in the minds of some health professionals, NGOs and other stakeholders who are still suspicious of the activities of prayer camps and thus, sometimes, influence the knee-jerk approach some of them take towards calls for collaboration. To minimise this challenge towards effective operationalisation of the collaborative agenda, healthcare professionals may adopt a strategy of organising educational campaigns, workshops, and training sessions for leaders and staff of prayer camps to ensure good management practices of mental health patients at healing camps.

4.2 Decolonising Psychiatry and Mental Health

In this section, my aim is to interrogate further the ways that the findings made in this study has implications for examining and re-examining the literature on the history of psychiatry and medicine in colonial and post-colonial Africa especially on the links that are established between health beliefs and medical practice. The question is, how have the narrative and the desire to reconstruct colonial discourses and approach to dealing with mental illness shaped and produced current forms of healing practices as we see in the context of the prayer camps in Ghana?

Recent historical scholarship on the development of post-colonial psychiatry in Africa has pointed out how colonial psychiatry asserted ideas and ideologies that had broad implications for all aspects of life for colonised subjects (Heaton 2018; 2013; Sadowsky 1999). Given the pervasive influence of colonial psychiatry and its role in reinforcing social order, including health and medicine for colonised subjects, it is no surprise that many historians of postcolonial psychiatry have tended to revise our understanding of both colonialism and the social history of medicine through their writings on colonial psychiatry for indigenous populations in Africa from the early nineteenth century to decolonisation (Kilroy-Marac 2019; Pringle 2019; Linstrum 2016; Keller 2001). These studies respond not only to the colonial construction of psychiatry but also attempt to look at the processes or change that have taken place after colonialism. In so doing, the literature complicates the discourses on the colonial approach to the treatment of mental illness vis-à-vis African traditional frameworks.

It is no revelation that colonialism has had a significant impact on African medicine by offering solutions to health problems facing Africans. Nonetheless, colonial ideologies, methods, and systems of practice of medicine and health administration meant that not everyone had access to preferred treatment (Heaton 2018). Consequently, indigenous health systems which had existed before colonialism "continued to compete effectively with biomedicine for the trust and care of African patients" (Heaton 2018, 315). Indeed, African reception to European medicine varied depending on context, and scholars have grappled and continue to grapple with this dimension of medical history by examining the political, social, technological and professional aspects of the medical taxonomy, especially in the area of psychiatry. Works on transcultural psychiatry, medical anthropology, and social history of psychiatry in Africa have revealed some of the troubling and competing relationships between biomedicine and traditional systems of healing in mental health care (Pringle 2019; Heaton 2018; Mohr 2013). This was very much particular in the ways narratives were formed about African psychiatry. Matthew H. Heaton (2020), for instance, notes how the history of psychiatry in Africa was connected to the processes of European colonialism and imperialist ideologies. He observes that a limited but coherent historiography has remarkably shown how European ideas about mental illness and the methods to treat them were subsumed in "racist and paternalistic ideologies of European imperialism in the early twentieth century" (Heaton 2020, 82). One of the attempts to address this concern is what Heaton (2013) describes in his work *Black Skin, White Coasts,* when he suggested that Nigerian psychiatrists, for example, positioned themselves as "gatekeepers who negotiated and blurred the boundaries between indigenous/colonised and Western/colonial knowledge bases and power structures" (2013, 15).[50]

[50] A similar case is the establishment of the Fann Hospital that aimed at bridging the gap between culturally-bound symptoms or interpretation of mental illness and western conception of mental illness (see Kilroy-Marac 2019 for further reading).

To reinvert the narrative, African scholars who started writing during the colonial and post-colonial era were confronted with the challenge of not only deconstructing the Eurocentric approach to the writing of the history of African healing systems and medicine but also training African physicians to address the medical needs of Africans (Heaton 2018). In Nigeria, for instance, Heaton (2020) argues that one approach that was adopted to decolonise mental health was spearheaded by indigenous Nigerian psychiatrists with the nationalist agenda that aimed at reconstructing colonial knowledge and practices regarding mental health. A similar example could be cited in Ghana in the case of Emmanuel B. Forster, who was the first African psychiatrist to work in Ghana with a similar vision (Read and Doku 2013). This agenda saw the implementation of culturally sensitive methods of research and practices. The aim of the African writers and practitioners was to reconstruct or reformulate the cabinet of ideas, bodies of technologies, and theories destroyed by the colonial intelligentsia, or to reconstruct ethnoscience or philosophy. However, one thing was clear: the African scholars seemed to have also adopted "an approach similar to the North American or Western European one: that science and religion are at one level rigorously separate domains, while at another level [they] all struggle with zones of tension and interpretation" (Feierman and Janzen 2011, 244).[51] Indeed, "one cannot maintain that there is a common field of medicine but rather that there are parallel medical worlds that compete, overlap, and clash" (Vähäkangas 2015, 5). What post-colonialist African writers or scholars sought to do was to provide a mechanism or synthesis of ideas within a larger scientific-religious field with many different points of view that aimed at integrating traditional knowledge systems of healing and medicine with those of biomedicine (Feierman and Janzen 2011).

Following this consensus, one hurdle that remained a challenge was the processes to ensure a mutual imbrication of a healthcare system that incorporates traditional knowledge systems of healing with biomedicine. Feierman and Janzen note this challenge and argue that many of the scholars in Africa reflected on the larger scene and responded by attempting to "forge an original and characteristically African synthesis of science and religion" to that of biomedicine (2011, 244). They were of the view that "any attempt to reconnect historic knowledge with modern science in Africa must be part of a universal science in order to be credible" (Feierman and Janzen 2011, 244). While this idea seemed laudable, inherent tendencies such as mistrust and scepticism among different treatments and healing modalities obstructed a universally accepted ground for cooperation and collaboration. This was to be seen in the later conflicts and tensions that emanated in the field of practice as mentioned in the introductory chapter 1.

Feierman and Janzen (2011) have noted that the Ghanaian philosopher, Kwame Gyekye, who studied the history of the relationship of thought, technology and religion in pre-colonial and post-colonial Africa, has ably provided a roadmap on how to connect or harmonise African sciences with Western Science. They remarked that Gyekye notes from his study of pre-colonial history, how the extensive and original developments of African medicine and technologies are all embedded in empirical innovations and adaptations.

However, what seems to be the missing focal points in the pre-colonial tradition of African science when examined from the perspective of Western science, according to Feierman and Janzen as reflected by Gyekye, "is the emergence of scientific theory that builds

[51] Such tensions were as a result of the fact that most of the early African-trained psychologists were trained in the West and had been influenced by some of the ideologies of western science and had a challenge, sometimes, in reconciling their previous known traditional beliefs and those of medical science.

knowledge for its own sake and allows for the variety of abstract reasoning characteristic of modern science" (2011). From Gyekye's perspective, the prevalence of secrecy in African traditional knowledge is a hindrance to scientific development. Feierman and Janzen note that, although Gyekye acknowledges "the rich empirical observations and practical techniques of African arts", he is of the view that "the tendency to ascribe knowledge to spiritual agents must be dealt with in order to reconcile this knowledge with the hallmarks of modern science, namely experimentation and sustained investigation" (2011, 245). In other words, Gyekye is of the opinion that belief in the supernatural or the attempt to use spirit mediums in diagnosing or proffering treatment to sick people is deleterious or has negative implications. Gyekye's view concurs with the one shared by Candy Gunther Brown in her introduction to the edited volume on *Global Pentecostal and Charismatic Healing,* when she emphasised that "spiritual causes and cures for human suffering do not always produce unequivocally healthful results. Supernaturalism can obscure the pathogenic impact of political and economic globalisation and deflect attention from engaging in constructive reforms of a more material nature" (Brown 2011, 10). Brown notes further that, "at its worst, a supernaturalised model of sickness and healing encourages already-suffering individuals to internalise blame for failures that could instead be traced to systemic oppression of those very individuals by more powerful individuals, groups, and impersonal material forces, many of which are external to but act upon their local situations" (2011, 10).

While I find the concerns raised by Gyekye and Brown (2011) to be germane in the context of some of the reported practices of healing rituals that are considered injurious and take away any eventual promise of restoration and hope in religious healing (Edwards 2014), I also disagree especially with the argument advanced by Gyekye. This is because Gyekye's view does not seem to map neatly onto distinctive African ways of diagnosing and proffering solutions to sickness and medical conditions. For most Africans and, more particularly Ghanaians, the ascription of diseases and the use of spirit mediums have always been pervasive. This is the pivot that seems to drive healing practices most of which have been criticised by westerners (See Benyah 2022). Kwasi Konadu, in his study on Akan medicine in Ghana, argues that the "understanding and interpretation of cosmology informs or almost determines the conception and understanding of therapy and disease causation." A reviewer of Konadu's work, Sandra Amponsah, reiterates the point that the "…fundamental nature of the human being is spirit and any attempt at healing the human body should be spirit-oriented. By such a design, traditional healers serve as experts of the complex cultural system and its spiritual conventions" (Amposah 2009, 1-2). A corpus of literature has described traditional healing as a form of African psychotherapy (Field 1960; Forster 1962) where, through the spirit mediums, information is extracted from sick people during the healing process.

In Ghana, the practice of *abisa* (meaning, divine consultation) at indigenous healing shrines or cults (Field 1960) and, in the case of the prayer camps, the practice of *akwankyere,* evince much of these practices (Onyinah 2012). As mentioned earlier, in "Revealed medicine as an expression of an African Christian lived spirituality", Sundberg (2020) discusses how spirit medium practices such as revelation and dreams play a crucial role in the prescription and use of medicine in the form of leaves or herbs for the treatment of various ailments.[52]

In examining the views expressed by Konadu and Amposah, Azevedo raises the point that if the understanding we get from African conceptions of the human is that the human being

[52] An example of this has been cited earlier in the case of Kofi Donkor and how he healed patients through revelation and the use of herbs.

is a spirit being, then "how intellectually suspicious are the theories claiming that Africans always invoke supernatural causes for diseases, when their actual iteration refers to the natural, that is, the man 'spirit-encapsulated' and not to a spirit in the skies, in the tomb, or in the realms of the ancestors" (Azevedo 2017, 95). From this perspective, Konadu raises questions about the views of western researchers who overlook "the nature of workings of traditional systems, divorced from their indigenous cultural reality and values, and uncritically accept and identify with Eurocentric conceptualisations of Africa to the extent that they have created African versions of things" (Konadu 2008, 179). It is important to emphasise here again that most African theories of disease causation do not disregard the natural or biological causes of illness. In fact, Opoku Onyinah (2012) has observed that, among the Akan of Ghana, people only resort to supernatural means of cure when all attempts to seek medical care, including biomedicine, have failed and consequences of the disease become enormous.

Noticeably, the nexus between African indigenous knowledge systems of health care or traditional medicine and biomedicine has been one of antagonism, mistrust, and suspicion (Anyinam 1997). Nonetheless, an examination of the two reveals various converging points that could be harnessed, integrated, and implemented to provide a much needed universal and holistic health care. In some parts of Africa, "traditional medicine" has, for instance, been appropriated into the general healthcare system and reformulated as a new system of scientific knowledge to augment the development of biomedicine and healthcare as well as support the progress of modern scientific expertise (Meincke 2015). As a primer of sorts, this allows for "culturally sensitive" approaches, mediation, and negotiation rather than opposing and intolerable stance that sometimes produces negative consequences on the health of patients (Taylor 2003). Understanding of one's cultural past and history and methods of healing is an important starting point that could shape discussion and provide a platform for cross-cultural negotiation and dialogue necessary for the incorporation and integration of traditional and faith healing and biomedicine for effective and holistic health care.

In the volume *Medicine, Mobility, and Power in Global Africa* (Dilger et al. 2012), the authors present essays that examine the changing landscape of health and healing in Africa occasioned by the mobility of patients, treatments, and experts that produce new therapeutic modalities and silhouette access to care across the continent. From an ethnographic perspective, the authors take as a point of departure the "everyday encounters of Africans and their practical efforts to communicate, care for a loved one; relieve discomforts; address misfortunes; and attend to the health and future communities, nations and regions" (Dilger et al. 2012, 23).

Significantly, the methodological approach employed helps to undo the myriad of oppositions between traditional healing and western biomedicine, and between Africa and its relations to the diasporic environment in the context of health care. There is a need to appreciate the complex and plural cultures of healing in contemporary Africa. In doing so, we must develop frameworks that seeks to better understand health needs in their own context and adopt approaches and systems that are suitable in addressing specific health needs and challenges.

4.3 Methodological and Theoretical Implications

4.3.1 Indigenous Knowledge Frameworks as a Cultural Model in Mental Health Research

A significant feature this study has pointed out about illness is the way illness experience is shaped by cultural understanding and interpretation of illness. This finding has also been established in previous studies on health and healing in Africa and across the globe. A key factor about the interpretation of illness is the philosophy that underpins the theory of causation and the approaches in dealing with them. This points to the ways that indigenous knowledge systems play a significant role in illness interpretation and mental health in particular (see for example, Danto and Zangeneh 2022; Amin 2022; Wambebe 2018; Stewart et al. 2017).

According to the UNESCO (2021), indigenous knowledge refers to the ways that a society develops its own understanding, skills and ideologies over time through an interaction with its own surroundings or environment. These knowledge systems become the basis upon which decisions are made in day-to-day life situations. In other words, they are the fulcrum upon which life and situations in the society are addressed and mitigated. This knowledge is central to the cultural complexities that cut across areas such as language, systems of classification, ritual, and spirituality, etc. The ritual and spiritual aspects may include the worldviews and different religious practices and spirit mediums, and other intermediaries that guide the economic, political, social and health matters. These fundamental aspects of knowledge formation and systems of knowing, UNESCO (2021) argues, are part of "cultural diversity, and provide a foundation for locally-appropriate sustainable development" in all areas of life.

This study has shown that indigenous perceptions of worldviews of illness play a crucial role in healthcare systems, communication of health matters and the resolution mechanisms that are employed. Thus, an understanding of indigenous knowledge systems of illness is essential in communicating illness experience and at the same time, present the bedrock in expanding, in a broader manner, matters in relation to mental health.

The implication of this finding is that research studies and projects that seek to or aim at addressing health-related matters, whether in the field of psychiatry or not, need to take significant measures in understanding local knowledge systems and how that shape the understanding of health and healing in the health economy of the people that are the subject of such studies. A particular example is the concept of the person, as discussed in relation to the understanding of health and healing, and how that guides people's understanding of health and the healing approaches that are employed.

Despite the accumulating evidence that the concept of the person is gradually gaining traction in the discourses on culture, religion, and mental health, current studies in Ghana show that such concepts have generally been secondary to broader ethnographic and clinical objectives of research conducted in Ghana on mental health (Ofori-Atta et al. 2018; Yendork et al. 2018). While individuals occupy a central and integrative role in mental healthcare, the question remains as to how much of the understanding of the person do those who seek to engage or treat people with mental illnesses know about the people they treat, their understanding or interpretation of illness, or the perceived causes of their illness.

Methodologically, there is the need to develop approaches that are able to adapt to local contexts and understanding of illness. The concept of the person, as explicated in Akan thought for example, provides an understanding of how health, wellbeing and the causes of diseases

are derivative of or are an articulation of the construction of personhood. The question is, how do we adopt definitions and methodological tools that will help to elicit from people's own understanding and meaning of health and healing? Any methodology or approach divorced from indigenous cultural realities and values stands the chance of uncritically imposing views and conceptualisations of illness that may be alien to specific contexts and risk undermining potential outcomes that can help deal with existential challenges in mental health care and health care in general. In sense, developing indigenous knowledge framework or systems as a model for research in religion, mental health and culture may serve as a schema and provide alternative approaches in understanding mental health and healing in different cultural settings. This model needs to be developed further.

The development of this model will be crucial for not only highlighting the significance or the importance of the indigenous knowledge systems of health and healing but also, the knowledge and/or the philosophical underpinnings that seeks to describe the meaning, root cause or explanations of the diseases. This is because the existential meanings of illness differ from one culture to another. In the knowledge of the traditional Ghanaian or, to be specific the Akan of Ghana, for example, a disease condition is more than physical condition. This points to the need to examine, in a broader perspective, a range of factors within indigenous knowledge that explains the cause and/or meanings of diseases including mental illness. But beyond mental illness, other illness for example HIV/AIDS as the narratives surrounding such illness have also been subsumed in religious and cultural views.

4.3.2 Proposing the *Intermediate Continuum Approach*

Previous studies on culture and mental health have been influenced by ideological positions and frameworks that have determined how people understood, interpreted, and dealt with issues of mental health as a global issue of concern. Three of the most important approaches or frameworks that have influenced such thinking and attitudes towards treating and caring for mental health include the *absolutist* approach, the *universalist* approach and the *cultural relativist approach* (see, Eshun and Gurung 2009; Berry 1995; Fabrega 1989).

Table: 4. Showing a summary of the differences between different theoretical approaches of culture in mental healthcare

Theory/model	Core construct /Theoretical Position	Limitations	Strengths
Absolutist Approach	Symptoms of mental illness are the same across cultures and hence, mental illness can be understood and treated in the same way across cultures, using standardised measures.	1. Impedes and disallows effective cross-cultural communication for effective diagnose and treatment. 2. Poses the challenge of reconciling illness explanation in different cultures.	Helps in the provision of global response to common symptoms of mental illness with the aid of psychotropic medications.
Universalist Approach	Mental illnesses are universal or common to all people. However, the development, expression and response to mental illnesses are influenced by culture.	1. Lack of or inappropriate idioms to describe certain mental disorders. 2. Tendency to overlook culturally specific articulation or expression of illness experience.	Relies on scientific objectivism by following a biological sequence and use of symptoms categories, rationalised illness criteria and diagnostic inventory protocols.
Cultural-Relativist Approach	Symptoms of mental disorders may be context specific. That is, mental disorders differ from one culture to the other and their expression and articulation are shrouded in a cultural web of meaning.	1. The challenge of reconciling illness with biological factors. 2. Treat culture as *sui generis* - does not lend itself to any analysis, interpretation, or evaluation in a more objective way.	Focuses on the use of qualitative behavioural and phenomenological data that seeks to elicit the ways in which psychiatric illness is constructed by probing the ways in which self (personhood) and behaviour are interpreted.
Intermediate continuum Approach	Address the difference and merge diversity for a holistic and all-encompassing mental healthcare delivery in different cultural settings.	1. The possibility of encountering challenges in the attempt to address and merge diversity. 2. The attempt to address mental health issues through the utilisation of both universalist and cultural relativist or cultural knowledge and scientific approaches could create tension between patients and clinicians if not handled properly.	1. Undo with the sharp contrast that exists between two different spheres of understanding, interpreting, and treating of mental illnesses. 2) Address the seeming challenges that confront physicians at health institutions in different contexts due, in part, to migration and globalisation.

The absolutist approach maintains that as the symptoms of mental illness remain the same across cultures, mental illness can be understood and treated in the same way everywhere using standardised measures. In other words, "the absolutist view assumes that culture has no role in the expression of behavior" (Eshun and Gurung 2009, 5). This view, according to Eshun and Gurung (2009, 5), implies that "the presentation, expression, and meaning of mental illness are the same, regardless of culture". This perspective of mental illness dominated the academic discourse and the field of practice of psychiatry in the 1950s and 1960s. It shaped the nature and understanding of mental illness and somewhat watered down the importance of cultural differences for psychiatry and nosology. However, such an approach, in my view, derails any meaningful collaboration that could support illness classification cross-culturally and offer effective treatment for sufferers because the imposition of diagnostic categories impedes and disallows an effective communication. The absolutist approach could also pose "many challenges, ranging from the theoretical issues of reconciling illness explanations and interventions based on incompatible ontologies (e.g., molecular pathology versus angry spirits), to the practical issues of identifying skilled practitioners and ensuring access to and quality of care" (Kirmayer and Swartz 2013, 49).

Arguably, the theoretical position of the absolutist approach is not so much different from that of the universalist approach in terms of the emphasis both approaches place on the sameness and commonality of mental disorders across cultures. The universalist approach assumes that mental illnesses are universal or common to all people. However, the development, expression and response to mental illnesses are influenced by culture (Eshun and Gurung 2009; see also Berry 1995). The universal framework dominated the way transcultural psychiatrists viewed mental illness in the second half of the twentieth century. Antić (2021, 364) notes that for early transcultural psychiatrists, "the universalist framework meant that the core of mental illnesses remained the same across different cultures and societies, while cultural differences simply constituted a 'veneer' of symptoms and expression". Despite the promise in this framework, particularly in giving attention to cultural differences, Prince (2013, 64) admits that the framework contains errors that "arise through the confusion of culturally distinctive behavior with psychopathology on the basis of superficial phenomenological similarities". The confusion arises where there is lack of or inappropriate idioms to describe certain mental disorders that are common in the USA, where the DSM classification was developed, to another context. In this situation, mental illness becomes a culturally-bound syndrome (Eshun and Gurung 2009).

The cultural relativist approach portends that every individual gets sick in his or her own unique way and the ways they respond to it are based on their singular bodies, the strength of their immune system, cultural orientation, and historical position. In other words, sickness is an individual experience and that applies to the way societies or different cultures around the world perceive, react, or treat sicknesses. From this perspective, the cultural relativist approach stipulates that symptoms of mental disorders may be context specific. That is, mental disorders differ from one culture to the other and their expression and articulation are shrouded in a cultural web of meaning. This also shapes the sufferer's interpretation of the disease and advocates the application and use of treatment that are culturally meaningful (Fabrega 1989; see also, Patel et al. 1995). One significant feature of this theory is the way that the concept of the person or personhood is invoked to espouse its relevance to psychiatry. Thus, the concept of the person gave an impetus to the development of the cultural relativistic theory and enforced its scheme to the ways that illness is constructed. Culture and personality

theorists, who occupied themselves with the characteristics of persons in diverse cultures, emphasised the importance and centrality of the understanding of personhood in psychiatry.

The cultural relativist approach is nevertheless important in many ways to the central arguments made in this thesis. The absolutist and universal frameworks are both products of Western epistemic hegemonies or from Euro-American intelligentsia that superimpose their categorisation on descriptions of illness through a particular cultural notion and, in most cases, miss the importance of illness experience in disease categorisation and treatment, forgetting that "the practice of biomedicine is not uniform, and it is shaped by the unique historical and cultural traditions of each country" (Whitaker 2003, 349). Such theorists often also miss the point that "illness experience is mapped onto a symbolic space created by the models and metaphors of the medical system. This mapping imbues illness with specific meaning for both clinicians and sufferer" (Kirmayer 2004, 37). This calls for a reflection or possibly a new theoretical and methodological lens that employs or maps practices within the scope of particular cultural context or approaches that seek to deploy an intermediate framework in addressing mental health issues and health care in general. What is important in this case is the central understanding of those who are the focus of such treatment or healing. A combination of two parallel approaches will not hurt but will rather provide a holistic perspective that eschews monoclinal approaches to health care. This will also mediate the challenges in the field of health care and strengthen cooperation and provide an all-encompassing health care for patients.

I propose the new theory of *Intermediate Continuum Approach* for three reasons. One, previous studies on religion and mental health, especially those that focus on Africa, rarely discuss issues bordering on theoretical frameworks. Mental health research, especially, has been conducted using a top-down approach process. In most of the literature, it is evident that the need to employ innovative approaches that recognise the culture and individuals' understanding of their environment to interpret illness has been particularly keen. The adoption of an intermediate continuum approach or, better still endogenous techniques, to broaden the scope of mental health care may be helpful. Two, we need a framework that takes into consideration the cultural sensitivity and diversity of treatment regimens and local setting. This will help to reduce imposition of strange concepts and interpretation of sickness that are not meaningful to a given a population or a person. And three, as the society or the world becomes more progressive due to migration and globalisation leading to multi-culturalism, we need approaches that take into consideration the cultural diversity of people in a multicultural setting.

While the universalist framework or approach has been criticised as being culturally insensitive and very unfitting, and also runs the risk of leading to a homogenisation of the diagnosis and treatment of mental illnesses across different cultural settings, it is evident that common traces of symptoms of mental illnesses could be found in patients across the globe despite different explanatory models, cultural diversity, and traditional ways of dealing with mental illness. For example, the attitude of someone suffering from mania and showing signs of delusion, hallucination, illogical thinking, having a feel of great energy and expression of new and great ideas seems to be common in patients regardless of their cultural settings, although the reason for them showing these signs may be interpreted differently based on cultural knowledge, beliefs, and history. A review of the literature on global mental health and transcultural psychiatry reveals the tension that exists for those who argue mainly for the

cultural relativist as well as the universalist approaches. I take a shift from these two opposing views and propose a new theoretical approach: the *intermediate continuum approach*.

I define the *intermediate continuum approach* as an *interactionist cross-cultural process* of understanding, interpreting, and diagnosing mental illness that gives recognition to the diversity and nuances to the meaning conferred on mental illness based on different cultural, social, and historical background of patients. In offering this approach, I do not seek to present myself as a psychologist or clinical psychologist with expertise in that discipline or to seek to claim a place within it. Rather, I offer this model from a theoretical standpoint in order to open up a discussion that interrogates the relevance of existing approaches that are still saddled with challenges in their implementation and, at the same time, widely criticised. I do understand that my own model will also not escape such criticisms.

Peoples' descriptions of illnesses, symptoms and causes of ill-health, is embedded in their context specific cultures. The question, however, is, does how people describe their 'illnesses' in differently situated cultures discount the universalist or absolutist argument? The intermediate continuum argument is not to discount the accuracy or otherwise of the existing approaches underpinning the study of mental illness but to proffer another that embed all approaches. The main arguments of the intermediate continuum approach is that there are mental illness categories that are universal and there are those that are better explained with a cultural relativist lens; however rather than employing the two extremes, we can explore mental illness as a continuum of intermediate categories. This attends to both the universality of the categories of mental illness as well as enable the explanation of unique experiences if they are found in the one mental illness situation.

The theory is germane to understanding the complexity or realities of mental illness as something that is bound to both context and outside of context. With the intermediate continuum approach we can explore categories that are not exclusively universalistic or exclusive to specific culture. This framework is not to suggest some interactional effects between categories but about finding both universal categories and relativistic categories in one patient. Exploring this possibility will enable the development of several intermediate categories that straddle both extremes in different proportions. Thus, various combinations would make practitioners sensitive to how treatments are done. The experience and meaning of mental illness can be qualitatively different for people in different cultures but may exhibit levels of similarities. Previous efforts to explore mental illness with the existing approaches are thus all true but this new theory suggests that they can all be true in one situation. For example, ten mental health patients can be at different intermediaries of the continuum straddling both the universal or absolute and the cultural relativistic symptoms.

Thus, my proposed framework is a continuum of the two previous approaches - the universalist and cultural relativist framework, that seeks to combine both categories and leans towards the extreme ends of these two categories but at the same time, not exclusively universal or relativist. This is because, the heavy-handed emphasis on either side (universal or cultural relativist) lead to an uncritical transposition from the global context to hyper-local level situations and vice versa. The emphasis on hyper-local cultural explanations leads to unrecognition of solution that may otherwise help. This is the gap the intermediate continuum approach seeks to fill. It is not a way of claiming a superiority or better position than the already existing framework but rather, present an alternative approach to the way mental illness are examined or interpreted cross-culturally.

From my own perspective, this proposed framework is important for two main reasons: 1) to undo the sharp contrast or reduce the tension that exists between two different spheres of understanding, interpreting, and treating of mental illnesses and 2) address the seeming challenges that confront physicians at health institutions in different contexts due, in part, to migration and globalisation. In the context of globalisation and migration, these points are necessary in addressing the health problems that physicians face from different patients at hospitals due to migration. Obviously, a patient whose racial/cultural/ethnic origins differ from his or her host country might have a different interpretation or explanation to an emotional distress or mental disturbance. The continuous increase in population growth and mobility means that clinicians will continue to serve clients or patients from a variety of geographical, language and cultural backgrounds (Johnson et al. 2009). However, the divergences that exist between universalist and cultural construct present an ethical dilemma for clinical psychologists and psychotherapists. This is because "despite the changing demographic and cultural landscape worldwide, mainstream psychological theories and practices and the make-up of professionals within the field remain far from reflective of a diverse, multicultural population" (Johnson et al. 2009, 116).

This presents a challenge to clinicians whose ethnic and cultural backgrounds even in terms of training are different from such a patient. Is it possible to use, adopt or extend the same methods that are considered effective in diagnosing and treating common mental illness for the general population in a host country to migrants from diverse cultural backgrounds? Perhaps, for effective health care, it will be important to pay attention to various contextual explanations as well as issues that influence illness behaviour. These kinds of challenges demand dynamic observation and approaches to the history and anthropology of psychiatry and psychiatric illness. They call for the need to examine processes, networks, moral economies, cultures of healing and therapeutics, which are shaped by a number of factors such as the cultural understanding and concept of the person.

Health care in whichever form is constantly changing and evolving due to globalisation, advancement in modern technologies and migration. Sharing or using pharmaceutical products such as psychotropic medications (some of which are produced in the West) that are used for the treatment of mental illnesses in Ghana, for example, shows a level of the global in the local. Will an extreme hypostatisation of cultural nosology also forbid the use of such medications produced in Western context? I am aware that one of the likely questions to be raised against this proposition is: what will be the use of psychotropic medication to someone who thinks his or her illness is caused by angry spirits? Whichever way one intends to look at this, there will always be a diffusion of knowledge and understanding of mental illness across cultures even if different interpretations of causal narratives are offered.

The finding of a problem definition that seeks to address the diverse views or interpretation of mental illness across different cultural settings is long overdue. A good attempt in solving this problem was the introduction of the Outline for Cultural formulation in the fourth edition of the *Diagnostic and Statistical Manual* (DSM-IV), which provided a set of guidelines aimed at making clinicians aware of the need to understand symptoms and behaviour in a cultural context.[53] The Cultural Formulation makes a case for a systematic assessment of five distinct cultural categories which include "Cultural identity of the

[53] See American Psychiatric Association (2013) Cultural formulation. Diagnostic and statistical manual of mental disorders, 5th edition. American Psychiatric Association, Washington, DC, pp 749–759, for a revised edition of the cultural formulation.

individual; cultural conceptualisation of illness; psychosocial stressors and cultural features of vulnerability and resilience; cultural features of the relationship between the individual and the clinician; and overall cultural assessment" (APA 2013). The revised edition has added an interview segment as a clinical tool to help improve diagnostic assessment by aiding clinicians to collect data that relate to the social and cultural aspects of illness experience. The Cultural Interview is made up of a 16-item semi-structured interview containing 4 assessment areas: cultural definition of the problem; cultural perceptions of the cause, context, and support; cultural factors affecting self-coping and past help-seeking; and cultural factors affecting current help-seeking.

While these efforts are appreciable, they still will not provide unequivocally useful results across the globe. Having just the tools or method to elicit information from patients may not at all times provide the expected outcomes. An effort aimed at training clinicians to be culturally competent by inculcating, as part of their training, a theoretical framework such as the intermediate continuum approach may help to strengthen individual knowledge and expertise in the field of practice. This will also promote intercultural understanding that is recommended as important in clinical practice in psychiatry (Prince 2013: Kleinman 1980).

4.4 Summary

This chapter has presented the implications of the findings made in this study. As mentioned above, there are significant implications that one can draw from this study. What is presented in this chapter is meant to provide a starting point into a conversation that is aimed at changing and transforming the operations and activities of prayer camps both pragmatically and theoretically. So far, the question remains as to how much of change can be brought into the operation of prayer camps through the ongoing collaboration between prayer camps and health centres? And what can health professionals learn about culture, religion, and mental health as they engage with the prayer camps? Already, some studies have begun to discuss some of the positive results of this collaboration (Yaro et al. 2020). The way mental health research is done also needs to be reconsidered both theoretically and methodologically. Many of the criticisms against prayer camps seem to miss a very important component and understanding about their operations. To undo some of these criticisms, there is the need to adopt approaches that are holistic and encompassing to the understanding of health and healing. While excesses resulting from healing practices need not be overlooked, there are also culturally-salient factors that give these healing centres their legitimacy among the local populace. In studying about them, it is important to adopt tools and approaches that seek to understand what, why and how certain practices relating to healing continue to gain traction and not uncritically dismiss and undermine such practices. This is where the discussion on decolonising mental health and psychiatry needs to be also considered in this debate. In this discussion, I have examined how the findings made in this study as well as the attempt to reconstruct colonial discourses and approach to dealing with mental illness shape and produce the current forms of healing practices as we found in the context of the operation of prayer camps and/or Pentecostal healing centres in Ghana.

5 Conclusion and Recommendations for Further Research

This chapter presents the conclusions of the study and recommendation for further research.

5.1 Conclusion

Some of the findings made in this study confirm or reaffirm the findings made in previous studies, particularly on those that relate to the role of religion in health and healing. Significantly, the findings made in this study concretise the beliefs people have in religion to provide a source of therapeutic intervention when they are ill. The belief and diagnoses conferred on illness influenced a help-seeking behaviour of patients and their relatives. In this study, patients and caregivers at the selected prayer camps were positive about the role of religion in dealing and coping with mental illness. These resources such as prayers, Bible studies, counselling, and communal relationship at the camp between caregivers and patients helped the patients to deal with anxieties, fears, recurrent behaviours and hope in the management and healing of their sicknesses.

The positive outlook on the belief in religious and spiritual resources in dealing with mental illness did not make them shy away from the use of other methods such as biomedicine. Leaders of prayer camps collaborated well with health professionals and allowed for the intervention of other healing options when it became necessary. This effort in integrating other healing modalities into the activities of prayer camps provided a platform to augment scientific interventions into spirituality as a way of complementing and satisfying people's notions and ideas about healing. Thus, such effort was crucial in providing a holistic approach to healing that satisfied the beliefs of the people. As a progressive society, these efforts are profitable in contributing to government's effort in providing holistic welfare in the face of limited resources, especially in the area of health care.

The discussion of the findings points to the fact that the overall understanding of the ways that the Akan understand the concept of the person and its ontological relationship with the cosmos has implications on mental health. While good health is dependent on the harmony of the mind, body and soul within oneself, there is the need for one to have a relationship with the society to be considered healthy. Apart from that, the general understanding of, and belief in the existence of supernatural beings in the cosmos make the human being very susceptible to the environment. On the one hand, people are sometimes afraid of the afflictions that might befall them if they go contrary to society's sanctioned moral codes or established norms. On the other hand, there is a strong belief in the manipulation of the powers in the cosmos by some individuals for evil purposes resulting in the affliction of sicknesses, including mental illness. All these, in one way or the other, affect the way people relate to their environment, to one another in the society and the ways that illness, in this case mental illness, is constructed. The construction of mental illness by participants at prayer camps needs to be understood within this framework. This is because such understanding is cast within the framework of Akan traditional interpretation and worldviews about the causes of illness and healing. In seeking solution to the problem of mental illness, the Akan do not resort to only biomedical treatment but also to other treatments or healing interventions such as religious healing, which are in sync with their culture and belief system.

As the findings show, in present-day Ghana, such belief system and understanding continue to guide people's attitudes and approach to the treatment of mental illness and other

illnesses in general. Post-colonial writers who wrote on African psychiatry sought to decolonise the discourses on the understanding of mental health in Africa and help integrate views that resonate with psychiatric practice in post-colonial societies. Prayer camps in Ghana are one of such institutions or sites that one can conceivably learn about the integration of belief systems in the care of the mentally ill. Another inference that can be drawn from the discussion of the findings is the understanding of the cultural context and its importance to health and healing. There is the need to appreciate the way of life of people without prejudicing what counts as important in other settings. In Ghana, the traversing of different healing boundaries in search for a cure by sufferers and their families not only reveals the urgency in coming to the terms with their illness, but also reveals the endemic and enduring nature of cultural meanings associated with illness. What needs to be understood is that the different understanding of the concept of health and healing as found in various parts of the world would ultimately lead to the production of different medical taxonomies that might not be universal across the globe.

Though the prospects of any medical or healing system, whether scientific or unscientific, cannot be denied, such prospects, to a large extent, are dependent on the value placed on them by the people who are the beneficiaries of that medical or healing system. In other words, what could count as positive in terms of medical care depends on the outcome derived from it by the patients who receive those services. Despite the improvement in knowledge in medical science and healthcare treatment, there are those who still utilise traditional, religious, or spiritual and alternative forms of medicine for healthcare purposes. Even in the so-called developed countries with all the sophisticated medical systems, people still resort to the use of alternative medicines, including those of religious healing (Brown 2013; McGuire 2008). Largely, these forms of practices, as the findings show, follow from the cultural and traditional notions and conceptions of health and healing. While there are scientific ways of treating illnesses, the religious approaches to healing utilise other forms of divinatory and ritual practices that are meaningful and provide participants the forms of emotional and transformational experience they desire.

Of course, one may not be able to measure or quantify the outcome of healing received by a person following a prayer or religious rituals, but it is possible to assess the curative value obtained from such ritual practices. The crux of the matter is the seeming conflict that exists between biomedicine and religious healing. However, there is no irrationality in integrating diagnostic processes that blend scientific and religious healing if they produce the desired outcome. After all, people negotiate between different healing spaces in Ghana in search for a cure for an illness. This shows how people can maintain a parallel set of orientation towards different medical systems and still remain positive to both systems of practice.

Despite the fact that scientific development in the area of medicine has achieved quite unequivocal results, there are still parts of the world which are yet to experience or even encounter some of the sophisticated technologies in medical treatment. In limited resource countries, for instance, there are still opportunities for improvements in enhancing the delivery of medical care and practice. In such contexts, one cannot afford to totally scrap practices that, for a long time, have provided the needed solution to medical conditions. The side-lining of religious and indigenous cultural practices as backward, primitive, or archaic in the face of contemporary technological and scientific development can wrought a potentially increasing damage to health care. Regarding mental health care, the World Health Organisation

has recognised this need and has made several efforts to integrate cultural knowledge and experiences in the treatment of mental illness as part of primary health care needs.

While culture has emerged as a salient and unique category to be explored in mental health care, it has also generated an empire of nosological hegemony whereby different conceptions of mental disorders become the centre of academic enquiry and clinical practice. Consequently, this has produced, as I have discussed in the implications of the findings, different epistemic frameworks to foreground positionalities in the categorisation, understanding and interpretation of mental illness. This presents both a challenge and a resource. This is a challenge because such approaches present a competing system in an already heightened medically pluralistic environment. As a resource, the different frameworks present an opportunity for researchers and practitioners to reassess their own standpoints and perhaps look out for appropriate channels that can serve as unifying ground in terms of the treatment and assessment of mental illnesses. To that end, the proposed *intermediate continuum approach* might provide a platform and serve as a starting point in reassessing already existing frameworks to provide globally acceptable healthcare services that help in the treatment and convalescence of mental health patients. Although I understand that this newly-proposed framework needs to be developed further, it offers a starting point to begin to rethink about the ways that previous and existing framework can be improved and developed further to address their inherent challenges.

Another issue worth mentioning is the challenge of religious beliefs and practices to the healing of mental illness and the collaboration between prayer camps staff and health professionals. The arguments made point to the fact that the prayer camps in their current state are serving as a source of support and social care alternatives for people who are left uncared for by the state due to its limited resources in providing care for the mentally ill. Nonetheless, the work of the prayer camps is also interlaced with practices that produce self-regressive narratives which sometimes undermine their work. These challenges need to be altered through educational campaign and needs assessment programmes that will help provide the needed and appropriate response to such problems. In fact, for better treatment and healthcare practices, mental health professionals have instituted measures aimed at collaborating with prayer camps, through the decentralisation programme of the MHA, to help address some of the existing challenges found at prayer camps. The collaboration takes place in the form of visitation to the camps and administering medication for patients at prayer camps, and also organising workshops and educational training programmes for prayer camp staff. These activities have been reported to be yielding good results (see, for example, Yaro et. Al. 2020). This collaborative effort helps to reduce the tensions and conflicts that often characterise the tackling of the human rights issues at some of these prayer camps. At the same time, it presents opportunities to address some of the entrenched religious positions. Not least is the ethical dimension this collaboration presents to both faith-based healers and health professionals in resolving healthcare challenges.

Finally, media narratives about the prayer camps provide an alternative view outside of the camps about the activities of the camps. However, such narratives should be constructed in ways that do not risk undermining the activities of the camps but also, at the same time, not uncritically scrutinising their practices. In other words, effort must be made to produce a balanced representation of the prayer camps devoid of negative aspersions. Audience of such media narratives, regardless of their background whether foreign or local, must be informed of the different ways the camps are helping to provide a response to a problem that is left

uncared for by the state. This is because, though there are undoubtedly, many problems associated with the prayer camps, there are also different stories or narratives to be told.

5.2 Recommendations for Further Research

This is one of the few studies that have started exploring or examining the healing activities of the prayer camps on mental health from the point of view of religious studies. Previous studies done so far have been carried by out by psychologist, clinical psychologists, and anthropologists. Therefore, following the findings and discussion, I recommend the following for further research:

a) Further research is needed to explore more whether mentally ill patients fared better or worse in jurisdictions in which religious and/or spiritual healing is integrated into healthcare for the mentally ill in the context of the prayer camps.

b) Cultural elements and historical events combine to form attitudes towards health care. These practices are seldom highlighted in current studies. Indeed, historical events either reinforce or suppress certain cultural practices. A detailed study is needed to point out ways by which historical events and practices have shaped modern forms of healing practices and traditions as we see in Ghana today in the context of the prayer camps. In taking an inventory and a cursory look at the current literature on the prayer camps, the questions that remain unanswered are, how much of what we know in the past pertaining to the practice of healing are reflected in the current practices of prayer camps in Ghana? How do our previous forms of knowledge about healing practices help in understanding or shaping the healing traditions we see in Ghana today? What important historical events or epoch are fundamental to the call for the collaboration between biomedicine and traditional and faith healing, especially in view of the fact that people's historical past shapes their preferences and choices. What can we learn from the dynamic interface between traditional, faith healing experiences and events that have taken place in people's lives during the last six decades?

c) While there are media narratives and official materials about the activities of prayer camps, there is also rich material produced by religious institutions focusing on religion and mental illness in Ghana that needs further notice. Indeed, religion plays a significant role in Ghana and religious institutions have a great deal of awareness of how media works and use this to their ends. That said, the stories about religion that the media highlights and the media outlets of religious groups should be noted more in future research, particularly in research on mental illness and religion.

d) It will be important to also study how the current collaboration between prayer camps and health professionals provides a unique ground for the development of cultural competence for clinicians and how that can potentially influence curriculum development and teaching syllabus in the departments of psychology, psychiatry, nursing and medical schools in Ghana.

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Appendix I

Informed consent form

Prayer Camps and Mental Health: A Study of the Religious, Human Rights, and Media Dimensions of the Healing of Persons with Mental Illness in Ghana

Dear participant,

Thank you for volunteering for this interview. The purpose of this research project is to explore the role of religion in the healing of mental illness in Ghana. This is leading up to my ongoing doctoral dissertation at the Åbo Akademi University, Turku, Finland. All the interviews will be recorded and transcribed for the purpose of my analyses in the dissertation. The results will be published in academic articles and a doctoral dissertation.

Voluntariness and protection of personal data

This document is an agreement that is formed between you and the researcher. The purpose of the agreement is to ensure that you have been properly informed about the research as a whole, your own participation it in, and that every step will be taken to ensure you the protection of your personal data. Before you sign the agreement, it is important that you know and are informed about the following:

- You have the freedom to choose the time and location of the interview.
- You can refuse to answer any question during the interview.
- You can decide to stop the interview any time you want.
- This research project is totally independent from the interests of government or any official authorities.
- The interview data (recording and transcription) will be used solely for research purposes.
- The recordings and transcripts will be archived at the Cultura Archives of Åbo Akademi University.
- Every step will be taken to protect your personal data:
    - Your name and identity will never occur in the transcript of the interview.
    - If you wish, all personal data and information that you may disclose will be removed from the transcript of the interview.
    - In the first instance, only the researcher will be allowed to read the material. After the research project is finished, the material will be archived anonymously. Access to the material will be provided by the archivist upon an application.
    - No publications or other reports from this project will include your name or any other information identifying you as a person.
    - The transcripts and recordings will be filed securely and separately from this agreement where your name occurs.
    - You can participate anonymously, in which case you will be given a pseudonym.
    - You can choose to give your consent orally, in which case the consent to interview will be obtained orally through recording.
    - You can choose to withdraw from the study at any time after the interview, in which case the interview and all of your personal data will be erased.

Protection of personal data

On the basis of your consent (below), your personal information will be included in a separate, secured register. The register is created and maintained solely for research purposes. The personal data in the register will only include your name, your contact details, your position as interviewee (e.g. pastor, caregiver, church representative, etc) in the research project, and the time and place of the interview. The register is stored separately from the recorded and transcribed interview. Only the researcher has access to this register and is bound by confidentiality. The information in the register will not be shared with any other parties and will not be disseminated outside the Åbo Akademi University, the European Union or the European Economic Community. The register is maintained only for so long as needed for research purposes, after which it will be destroyed. These principles and restrictions are secured by the amanuensis of the Cultura Archive at Åbo Akademi University. If you choose to participate in the interview anonymously, your personal information will be included in the archive under a pseudonym. You have the right to:

Deny the inclusion of your personal information in the register.

- Decide what kind of personal data that may be included in the register.
- To withdraw your consent at any time without this affecting the lawfulness of the processing of personal data conducted before the withdrawal.
- To at any time lodge a complaint with the supervisory authority if you think that the handling of your personal information breaches the European Union's General Data Protection Regulation (2016/679).

If you cannot obtain satisfactory answers to your questions or have comments or complaints about your treatment in this study, please share you concerns or questions with the researcher:

Researcher

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Information about the participant (please text, in case of anonymous participation, a pseudonym is provided by the interviewer)

Family name and given name: _____

Position: ----------

Phone number or e-mail address: _____

NOTE! This information will **NOT** be filed with the recording or the transcribed interviews. The form and actual interviews are connected by the archive reference number, i.e. each interview is given a code.

Informed consent statement

I hereby certify that:

1. I have been informed about the research titled "Prayer Camps and Mental Health: A Study of the Religious, Human Rights, and Media Dimension of the Healing of Persons with Mental Illness in Ghana" and that the results of this project may be published in academic journals and doctoral thesis.
2. I understand and confirm that my participation in this interview is voluntary. I understand that the discussion may be both interesting and thought-provoking. If, however, I feel uncomfortable in any way during the interview session, I have the right to decline to answer any question or to end the interview. I may withdraw and discontinue participation at any time without prejudice or penalty, and no one will ever be told about this.
3. I understand that my confidentiality as a participant in this study will remain secure. Subsequent uses of recordings and data will protect my personal data. Researchers will not identify me by name in any reports or publications using information obtained from this interview. No other persons except me and the interviewer will be present at the interview nor have access to recordings or transcripts. This precaution will prevent my individual comments from having any negative repercussions.
4. I have been informed about the inclusion of my personal data in a separate, secured register, my rights concerning this information, and my right to deny that my personal information is included in this register.

I have been given satisfactory information and answers to my questions concerning the research procedures and other matters. I agree that any information obtained from this may be used in any way thought best for this research project. I hereby agree to participate in this digitally recorded interview.

_____ _____

Place and date of interview Signature of interviewee

I hereby agree that my personal data is included in a separate register

_____ _____

Place and date of interview Signature of interviewee

I hereby agree to follow all that here has been stated regarding confidentiality, the securing of personal data and handling of the material for the project:

_____

Signature of interviewer

Name of interviewer: _____

Phone number/e-mail address: _____

Archive reference no (interviewer fills in): _____

Appendix II

Interview Guide

Stage 1: History

1. Can you give a brief account of your illness from when it started?
2. What kind of symptoms did you have? Do you remember any of them?
3. What were your explanations to what happened to you or how did you explain what happened at the time?
4. Can you give an account of some of the experiences you had at first if you remember?
5. What kinds of images came to your mind about their previous situation?
6. What was it like to be mentally ill?
7. How did your mental illness affect your everyday life?

Stage 2: Identity

8. Are you happy about your current state and why?
9. How would you compare your current life before the illness?
10. How has your stay at the prayer camp contributed to how you feel now?
11. What contributed to your current development and changes? How do you explain them? Prompts: fasting, prayers, Bible studies, counselling, social relationships, etc.
12. How are you related to by people in the camp and outside of the camps?
13. If given the advantage, would you like to come back to the camp after you are discharged or would you recommend the camp to another person?

Stage 3: Management Strategies

14. What healing intervention did you seek when you became ill?
15. How did you end up at the prayer camp?
16. How would you account for your stay at the prayer camp? Any benefits?
17. What would you account as most effective in terms of the treatment and therapeutic interventions? Prompts: going to the hospital, visiting a traditional healer, and seeing a prophet at a prayer camp.
18. How would you compare the healing practices at prayer camps to other places such as the hospital or the traditional healers?
19. Has that influenced your views about the healing options?
20. What do you make of practices such as counselling, Bible studies, fasting, and prayers?
21. Do you have any experiences to share about prayers, fasting, counselling and Bible studies, and how have they influenced your healing or wellbeing?

Francis Ethelbert Kwabena Benyah

Prayer Camps and Mental Health

A Study of the Religious, Human Rights, and Media Dimensions of the Healing of Persons with Mental Illness in Ghana

This study has been conducted with an extensive interview with patients, prayer camp staff, and health professionals working in collaboration with prayer camps in Ghana. Theoretically, the study was guided by the concept of health and healing among the Akan of Ghana and how the understanding of health and healing in Akan traditional framework is recast in Pentecostal interpretation of healing at prayer camps in Ghana. Through an Interpretative Phenomenological Analysis of in-depth interviews with patients, staff of prayer camps and mental healthcare practitioners, this study points out the varied ways in which prayer camps have assumed an important role in the healing and care for persons with mental illnesses in Ghana. The study argues that the perceived causes of mental illness and the healing practices found at prayer camps appeal much to the Ghanaian because they resonate with indigenous worldviews.

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