INDIGENOUS AND FAITH HEALING FOR MENTAL DISORDERS: AN EXPLORATORY STUDY OF HEALERS IN ACCRA, GHANA

By

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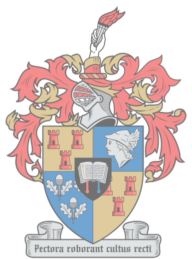

Dissertation presented for the degree of Doctor of Philosophy in the Faculty of Arts and Social Sciences at Stellenbosch University

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Declaration

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This dissertation includes eight original papers published in peer-reviewed journals and one unpublished manuscript. The development and writing of the papers (published and unpublished) were the principal responsibility of myself and, for each of the cases where this is not the case, a declaration is included in the dissertation indicating the nature and extent of the contributions of co-authors.

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Abstract

Mental health care in Ghana is not limited to biomedical care. A large number of service users are believed to utilise non-biomedical avenues in the pathway to health seeking. These non-biomedical treatments include indigenous and faith healing methods. Although some studies in Ghana have examined the reasons for and use of alternative mental health care methods, not many have examined the beliefs about mental illness and the treatment methods of the healers themselves. In this qualitative study, my aim was to examine how indigenous and faith healers conceptualised mental disorders, providing rich data on their perspectives and experiences. In particular, I questioned the perceived homogeneity of non-biomedical practitioners in Ghana by examining the nuances in mental health notions between different categories of non-biomedical healers. Thus, the objectives were to assess the beliefs and methods of different types of healers about different types of disorders, as well as to examine their views on collaboration with biomedical service providers.

Using Kleinman's Explanatory Models of Illness concept as a guiding framework, individual, semi-structured interviews using case vignettes were conducted with thirty-six indigenous and faith healers who lived and/or worked in the Greater Accra Region of Ghana. The healers comprised herbalists, Pentecostal Christian faith healer, Muslim healers, and traditional medicine men/priests.

The findings of this research suggest that unlike the perceptions of homogenous conceptualisation of mental disorders by non-biomedical practitioners, differences exist in the way different disorders are understood and treated by indigenous and faith healers, including differences in classification, perceived best treatments and perceived impact of the disorder. Although there were some similarities to biomedical concepts as well as between the healers, there were also important differences across the different types of healers. With respect to

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integration of services, the healers' views on collaboration with biomedicine varied based on their own perceptions of power and position.

These findings present further perspectives on the fluid, dynamic and often multi-faceted nature of mental health care provision in a country such as Ghana, and provide a lens to understanding the work of indigenous and faith healing in a pluralistic health care setting. The study concludes by outlining some potential next steps for developing dialogues on integration of mental health care services in Ghana.

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Opsomming

In Ghana word geestesgesondheidsorg nie tot biomediese sorg beperk nie. Daar word vermoed dat ‘n groot getal diensgebruikers nie-biomediese weë in die soeke na gesondheid benut. Hierdie nie-biomediese behandelings sluit inheemse en geloofsgenesingsmetodes in. Alhoewel die redes vir en gebruik van alternatiewe geestesgesondheidsorgmetodes al in sommige studies in Ghana ondersoek is, is daar nog nie veel ondersoek ingestel na die oortuigings rakende geestesgesondheid en die behandelingsmetodes van die genesers nie. In hierdie kwalitatiewe studie was my doel om die manier waarop inheemse en geloofsgenesers geestesgesondheid konseptualiseer te ondersoek, ten einde ryk data oor hul perspektiewe en ervarings te bied. In besonder het ek die waargenome gelyksoortigheid van nie-biomediese praktisyns in Ghana bevraagteken deur die nuanses in geestesgesondheidsopvattings tussen verskeie kategorieë van nie-biomediese genesers te ondersoek. Die doelwitte was om die oortuigings en metodes van verskillende genesers oor verskillende tipes siektetoestande te evalueer asook om hulle sieninge oor samewerking met biomediese diensverskaffers te ondersoek.

Individuele, semi-gestruktureerde onderhoude, waartydens gevalle-vignettes gebruik is, is gevoer met ses-en-dertig inheemse -en geloofsgenesers, wat in die groter Accra-gebied in Ghana gewoon of gewerk het. Kleinman se Verduidelikende Modelle van Siekte-konsep is as rigtende raamwerk met die voer van die onderhoude gebruik. Die genesers het bestaan uit kruiedokters, pinkster-christelike geloofsgenesers, Moslem-genesers en tradisionele toordokters/priesters.

Die bevindinge van hierdie studie dui daarop dat, in teenstelling met die waargenome homogene konseptualisering van geestessiektetoestande deur nie-biomediese praktisyns, daar verskille bestaan in die maniere waarop verskillende siektetoestande verstaan en behandel word deur inheemse en geloofsgenesers, insluitend verskille in klassifikasie, waargenome

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beste behandelings en waargenome impak van die siektetoestand. Alhoewel daar sommige ooreenkomste met biomediese konsepte asook tussen genesers bestaan het, was daar ook belangrike verskille tussen die verskillende tipes genesers. Wat die integrasie van dienste aanbetref, het die genesers se sieninge oor samewerking met biomedisyne gevarieër gebaseer op hul eie oortuiginge oor mag en posisie.

Hierdie bevindinge bied verdere perspektiewe op die vloeibare en dinamiese aard van geestesgesondheidsorgvoorsiening, wat dikwels uit veelvuldige fasette bestaan, in ‘n land soos Ghana en bied ‘n lens op die verstaan van die werk van inheemse en geloofsgenesing in ‘n pluralistiese gesondheidsorgomgewing. Die studie word afgesluit deur ‘n paar potensiële volgende stappe vir die ontwikkeling van ‘n dialoog oor die integrasie van geestesgesondheidsorgdienste in Ghana uit te lig.

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Dedication

This work is dedicated to the memory of my late grandfather, the Reverend Ishmael A. Sowah, who was such an inspiration to me, and whose passion for and pride in my accomplishments have come to mean so much more now than I realised while he was with us. This one is for you, Opa. I wish you could have seen me finish this, but I hope I have made you proud.

I also dedicate this to my parents and my siblings. Thank you is not enough to show how much your tireless support and constant belief in me have meant. I hope I did you proud!

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PART 1: INTRODUCTION & BACKGROUND

This dissertation is divided into five parts. Part 1 of the dissertation presents the introduction and background of the study. I also discuss indigenous and faith healing, first in sub-Saharan Africa, and then specific to the Ghanaian context in this part.

Parts 2, 3, and 4 contain eight published journal articles, making up the results sections of the dissertation. This dissertation culminates in a final part (Part 5), which present a self-reflection as well as some concluding thoughts.

Part 1 is therefore made up of the following chapters:

i. Chapter One: Introduction
ii. Chapter Two: Indigenous and faith healing in sub-Saharan Africa
iii. Chapter Three: Indigenous and faith healing in the Ghanaian context

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CHAPTER ONE: INTRODUCTION

1.0 Background

The World Health Organization's World Mental Health Survey reported a high prevalence of mental disorders in both high-income countries and low- and middle-income countries (LMICs), with an estimated 450 million people worldwide living with some form of mental illness (WHO, 2001). The majority of this number live in LMICs (Kessler & Ustun, 2008). Furthermore, mental disorders were estimated to account for 12% of the global burden of disease in 2000, with the number anticipated to increase to 15% by 2020 (WHO, 2001). In many LMICs, psychiatric morbidity is often more difficult to treat due to resource limitations. Such resource limitations result in what has been described as a treatment gap, where individuals affected by mental disorder do not receive the treatment they require (Kohn, Saxena, Levav, & Saraceno, 2004). This gap is estimated to be approximately 80% globally (WHO, 2010). Although such estimates have been found useful in assessing the mental health situations in different contexts, there have been arguments that the notion of "required treatment" often refers to biomedical requirements, and thus appears to ignore or downplay non-biomedical and community-based interventions (Kirmayer & Pedersen, 2014; White, Orr, Read, & Jain, 2017).

Perhaps partly as a response to such disagreements, there have been increased calls to identify measures for addressing resource constraints, given the perceived imbalance of needs and access to care (Lancet Global Mental Health Group, 2007; WHO, 2010). One of the suggested ways of bridging the treatment gap is by utilising available local resources to provide services (Gureje et al., 2015; Ndetei, 2007). In this regard, the WHO initiated a Global Mental Health Action Plan in 2013 (WHO, 2013) to explore the use and benefits of task sharing within the various relevant sectors of the mental health care systems in different countries (Gureje et al., 2015). This was anticipated to take advantage of the already-existing

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pluralistic nature of health systems in many LMICs, particularly in Africa (Ae-Ngibise et al., 2010; Asher, Fekadu, & Hanlon, 2018).

Of particular interest in the task-sharing approach is the utilisation of existing healing systems in sub-Saharan Africa, such as indigenous systems of care. As Quinn (2007) noted, these indigenous and faith systems of health care determine (to a large extent) the health-seeking behaviour of many people with mental disorders in Africa. This is argued to be largely due to their perceived shared cultural beliefs and values, but also to some extent, due to their availability and ease of access (Gureje et al., 2015). However, despite the reported high rates of patronage of indigenous/faith healing, efforts at formal collaboration between different health systems in many African countries have been difficult and largely unsuccessful (Ae-Ngibise et al., 2010; Tsey, 1997). One of the potential reasons for this failure is the absence of contextual knowledge and attendant scepticism on the part of biomedical practitioners regarding other forms of healing.

1.0.1 Traditional vs. complementary vs. alternative medicine

According to the WHO (2013), Traditional medicine (TM) is "the sum total of the knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness" (p. 15). The WHO further defines Complementary/Alternative Medicine (CAM) as "a broad set of health care practices that are not part of that country's own tradition or conventional medicine and are not fully integrated into the dominant health-care system." (WHO, 2013, p. 15). As indicated in the above definitions, viewing specific health systems as traditional or complementary is dependent on the specific context. The definitions also suggest that TM and CAM categorisations are dependent on the dominance of other healing systems. Given that western biomedicine (BM) has historically been considered as the "conventional" health

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care system, other systems which differ from Western biomedical methods are commonly referred to as being alternative to biomedical care, or complementary to biomedical health care systems (Miner et al., 2018; Orr & Bindi, 2017). However, the terms "complementary" or "alternative" are commonly used in reference to Western folk medicine as well as Oriental medical systems.

In contrast, health care systems which are rooted in spiritual ideas and magico-religious concepts (which are common in many sub-Saharan African countries) are typically referred to as traditional medical systems (Tovey, Chatwin, & Broom, 2007). The so-called traditional systems often contain elements of beliefs and practices which are indigenous to certain groups of people, and which influence their behaviour (Gorer, Goldblatt, Caspi, & Azaiza, 2018). Despite seeming similarities, the distinction between TM and CAM, though to a degree arbitrary, appears to also fall along socio-economic lines, with alternative or complementary methods often reportedly utilised in high-income countries, while traditional methods are more often reported in LMICs (Gureje et al., 2015; Nortje, Oladeji, Gureje, & Seedat, 2016). Thus, the use of CAM in high-income countries is often discussed as a result of choice or the desire for a second opinion (Salamonsen & Ahlzén, 2018), whereas the use of TM in LMICs is portrayed as reflecting factors such as availability, affordability, and illness beliefs.

Consequently, in many reports of health care systems in LMICs (particularly in sub-Saharan Africa), any system which is non-biomedical tends to be denoted as "traditional". This connotation does not seem to take into consideration the dynamic and fluid nature of cultural systems. As Orr and Bindi (2017) reflected, the notion of distinct, internally consistent cultures is fictitious, and fails to consider the level of influence and interaction that result in the crossing over of concepts and ideas from one system to another. Some level of cross-pollination of cultural ideas is arguably evident even in biomedical practice, as seen in

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the acknowledgement of the need for cultural competency (Jongen, McCalman, & Bainbridge, 2018) and the continued inclusion of a cultural formulation in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (APA, 2013). Thus, no medical system is without external influence, and all systems are constantly evolving (Kirmayer, 2004, 2012).

As Kirmayer (2004) argues, increasing globalisation has resulted in a transformation of the connection between what may be considered traditional healing, and the underlying cultural beliefs on which healing systems were developed. A view of traditional healing systems as rooted in fixed cultural practices is therefore problematic, as it oversimplifies the heterogeneity of knowledge systems and tends not to focus on growth, interaction and change (Orr & Bindi, 2017). Although I recognise this challenge, for practical reasons (and to simplify engagement with the literature), I use the terms “indigenous healing” and “traditional healing” somewhat interchangeably to represent systems which have been developed within specific communities, and which represent culturally accepted forms of health care practice, though recognising that these systems, and the extent to which they are culturally accepted, may change over time.

Furthermore, although indigenous practices are arguably predicated on traditional religious beliefs, for ease of presentation, the term “faith healing” is used in this dissertation in reference to the practices of healers whose faith is drawn primarily from non-indigenous religions. This decision was taken because religions such as Pentecostal/charismatic Christianity and Islam, as practised in sub-Saharan Africa, are arguably syncretic in nature, and possess distinct and acknowledged external influences.

1.1 Mental health care in Ghana

As in many LMICs, formal mental health services in Ghana are under-resourced (Ofori-Atta, Read, Lund, & MHaPP Research Programme Consortium, 2010), with approximately 1% of

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the annual health budget allocated to mental health (Roberts, Morgan, & Asare, 2014). Biomedical care is predominantly institutionalised care and limited biomedical-oriented community interventions have been developed, with lack of care being an issue particularly in the rural areas of the country (WHO, 2001). Although psychiatric care is free of charge according to government policy, challenges exist with regard to financing the mental health sector in Ghana. Ofori-Atta, Read et al. (2010) posited that the lack of clear policies and the absence of political will are largely responsible for the resource challenges.

Ghana has three public psychiatric hospitals which provide institutional services to the country. These hospitals are located in two regions in the south of Ghana. In addition to these hospitals, each of the ten regional hospitals in the country has a small psychiatric unit which provides short-term mental health care for people within that region. There are also a few privately-run psychiatric facilities located in different parts of the country.

Although mental health professionals are available at different levels in Ghana, the number of workers is still very limited. Some districts and communities have community psychiatric nurses (CPNs) and community health officers. These community workers are sometimes the only biomedical alternative available for mental health care in certain communities (Asare, 2003). Figure 1 below shows the estimated distribution of psychiatrists per 1 million people across the country (Ministry of Health, 2013).

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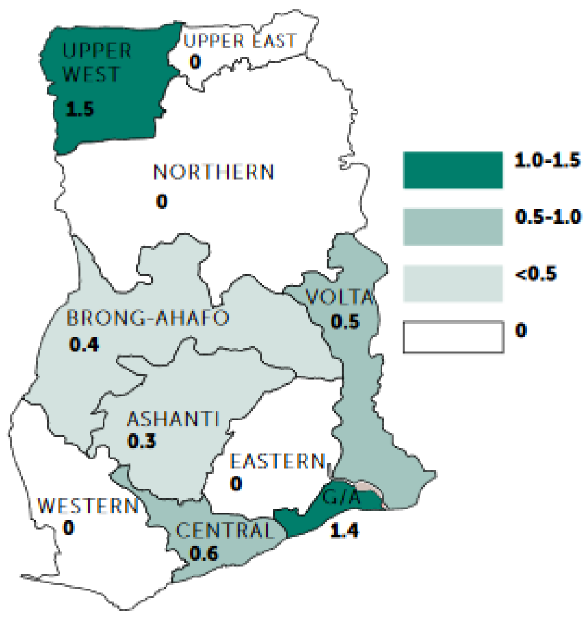

Figure 1: Distribution of psychiatrists per 1 million people (Source: Ministry of Health, 2013, p. 42)

As Figure 1 shows, there are very few psychiatrists working in rural parts of the country, with the least number serving the three northern regions of Ghana. Similar shortages exist with respect to other psychiatric staff, as is estimated in Figure 2 below (Ministry of Health, 2013).

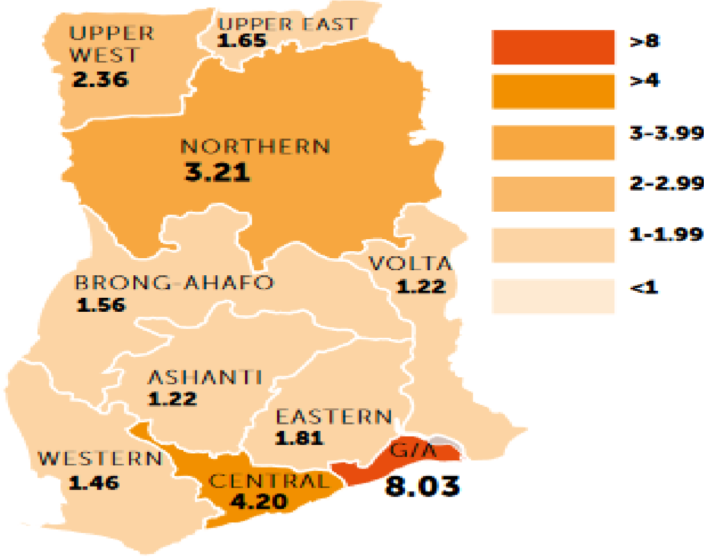

Figure 2: Distribution of mental health staff per 100,000 people (Source: Ministry of Health, 2013, p. 42)

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These human resource limitations partly account for the use of other methods of mental health care. As is discussed in other sections, a significant number of Ghanaians (in particular those in rural areas) rely on the services of indigenous and faith healers for treatment of mental disorders (Ofori-Atta, Cooper et al., 2010).

In 2012, a new *Mental Health Act (Act 846)* was promulgated in Ghana. This new Act endeavours to scale up mental health services in the country, and to protect the rights of people with mental illness in Ghana. It emphasises a decentralising of services, and an anticipated eventual integration of mental health care into primary health care (Doku, Wusu-Takyi, & Awakame, 2012). The new Act also makes provision for the recognition and development of alternative treatment methods (such as indigenous and faith healing), as well as informal community-based interventions (Kpobi, Osei, & Sefa-Dedeh, 2014). It aims to facilitate the provision of multidisciplinary mental health care at every level in Ghana. The Legislative Instrument also spells out goals for integrating indigenous and faith healing, particularly through educating healers on the Act and the parameters for compliance (Walker, 2015). These are important steps to be taken in order for the service delivery in mental health care in Ghana to be transformed.

However, the integration of indigenous healing into mainstream mental health care that has been proposed appears to emphasise a top-down approach, with biomedical practitioners training non-biomedical practitioners. There does not appear to be provision for mutual learning and exchange of beliefs and ideas. This is perhaps due, not only to the hegemony of biomedical practice in Ghana, but is also possibly a reflection of the limited understanding that exists about the work of non-biomedical mental health care providers. In this study, I hope to make a step in the direction of broadening understanding of indigenous and faith healing in Ghana.

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1.2 Rationale for the present study

Given the alleged high patronage of non-biomedical health care, indigenous and faith healing are key components of health care in many LMICs. Furthermore, the experience of illness is shaped by cultural and social factors, which influence health-seeking behaviours (Swartz, 1998). One of the reasons that has been cited as accounting for the widespread use of indigenous or faith healing in mental health care is the perceived similarity of the healers' illness beliefs with the patients' beliefs (Gureje et al., 2015). In order to understand the work of indigenous healers, it is therefore necessary to examine how they conceptualise illness experiences, and the approach they take in treating them.

As was mentioned earlier, and I shall discuss this in more depth in Chapter Three, there are few biomedical mental health professionals in Ghana, and thus it has been estimated that approximately 70–80% of Ghanaians rely on the services of indigenous and faith healers for mental health care (Ofori-Atta, Read et al., 2010). Various categories of non-biomedical practitioners are involved in health care in Ghana. According to Addy (2005), traditional medicine practitioners in Ghana may be classified into three broad categories: those who use herbal methods exclusively in diagnosing and treating diseases; those whose focus is on the spiritual components of disease and treatment; and those who adhere to a combination of the two methods. For those who use spiritual methods, these are often related to faith and religion, hence, depending on their religious identification, they may use different methods. However, there is little information on the methods and practices of the different categories of healers whose work includes mental health care. In this study, I examined the mental health work of healers in different categories.

There are some reports of the use of alternative methods of care for mental disorders in Ghana (e.g., Ae-Ngibise et al., 2010; Appiah-Poku, Laugharne, Mensah, Osei, & Burns, 2004), as well as some research on establishing collaborative pathways between biomedical

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and non-biomedical health care systems (e.g., Ofori-Atta et al., 2018). However, there is very little documented about the beliefs and methods that are used by the healers to treat mental disorders. The few that do report on the work of healers (e.g., Osafo, Agyapong, & Asamoah, 2015) have been limited to only one category, or have grouped non-biomedical healers into one homogenous category without taking into consideration the potential differences which may exist in their approach to healing based on the different illness beliefs of the healers. Furthermore, an exploration of the reasons why previous attempts at collaboration has failed is important for understanding the help that is available for mental health care in Ghana.

Given that culture influences how illness is expressed and experienced (Helman, 2007; Kirmayer & Swartz, 2013), this influence cannot be ignored in an attempt to understand illness and well-being within specific contexts. An appreciation of the meanings of illness is also useful in assessing the health care interventions that are available for specific conditions within those contexts. Thus, in order to gain a clear understanding of the work of indigenous healers with regard to mental illness, it is important to examine their own perspectives about illness. One way to do this is through an exploration of the explanations they have for mental illness.

1.2.1 The concept of Explanatory Models of Illness (Kleinman, 1980)

A useful way of examining the illness beliefs of different categories of people is through the Explanatory Models of illness concept (Kleinman, 1980). According to Kleinman, Explanatory Models (EMs) are “the notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process” (p. 105). These beliefs about illness ascribe personal as well as social meaning to the experience of illness. Kleinman distinguishes five core areas that EMs seek to explain. These areas are:

1) The aetiology of the illness;

2) The timing and mode of onset of the symptoms;

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3) The pathophysiology of the illness;

4) The course of the sickness; and

5) The treatment options that will bring about recovery.

By examining the healers' EMs, a clearer understanding of what is considered most important about the illness can be gained (Kleinman & Benson, 2006). According to Callan and Littlewood (1998), in understanding an individual's explanatory models for a specific illness, a thorough process of enquiry is required. Through this process, the complexity of the belief systems can be unearthed, and the multi-layered context of the illness of interest can be explored. This unpacking of notions about what really matters in an illness experience provides explanations of the perceived significance of the illness for the patient and/or their social networks. As Frank and Frank (1991) assert, understanding patients' acceptance of a method of healing is a key determinant of success.

Since indigenous healers are regarded as cultural custodians (Okello & Musisi, 2015), their beliefs about what matters are an important reflection of social norms, rituals, cultural artefacts and indigenous knowledge concerning the illness (Patel, 1995). In addition to this, the treatment regimens that they perceive to best treat an illness may also reflect beliefs about wellness and behavioural norms which are considered necessary or reflective of healing (Kirmayer & Bhugra, 2009; Okello & Musisi, 2015).

In light of the widespread use of non-biomedical methods in treating mental disorders in Ghana, there is a need to better understand the beliefs and practices of non-biomedical practitioners, and the contexts within which they operate. According to Williams and Healy (2001), explanatory models are rarely a single set of beliefs, but often sets of simultaneous beliefs which are either strengthened or dismissed based on factors such as illness progression and social circumstances (Williams & Healy, 2001). Illness beliefs should, therefore, be constructed as highly fluid, and rarely fit into mutually exclusive categories.

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This point supports the notion of non-static and evolving cultural connotations of healing. The concept of explanatory models of illness has been applied to research in health care with participants from various backgrounds (e.g., Katz et al., 2015; Keikelame & Swartz, 2015).

In this study, I used this framework to examine the beliefs about, and treatments for, mental disorders as held by different categories of indigenous and faith healers in Ghana. I scrutinised the explanations that healers held for different types of disorders, to explore the potential diversity of their explanatory models.

1.3 Research questions

The research questions for this study sought to understand how mental illness was viewed by indigenous and faith healers in Accra, Ghana, and how such beliefs influenced the kind of help that they provided. Specifically, I sought to answer the following questions:

1. What do indigenous/faith medicine practitioners consider as mental illness?
2. What are their concepts of mental illness causation?
3. What are their methods of identifying and diagnosing specific mental disorders?
4. How do they think mental illness can (should) be treated?
    a) What differences (if any) exist between the various categories of healers with regard to diagnosis and treatment?
5. What are the attitudes of the healers towards collaboration with biomedicine?
    a) To what extent do these attitudes differ based on the category of healer?

1.4 Research objectives

The main aim of this study was to examine how indigenous and faith healers in Ghana conceptualised mental illness. In order to achieve this aim, the specific objectives were:

1. To examine indigenous and faith healers' beliefs about different forms of mental illness;

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2. To assess their methods of diagnosing and treating mental illness;
3. To explore the differences (if any) which exist between the various categories of healers with regard to mental health care; and
4. To understand their views about collaboration between biomedical and non-biomedical health systems in Ghana.

1.5 Structure and layout of thesis

This dissertation has been carried out in the "thesis-by-publication" format. This format provided several advantages, including the experience of scholarly writing, external review and publishing. In addition to the above factors, this format was also chosen partly because of the underrepresentation of African authors in scholarly work about Africa. Understanding the mental illness beliefs of indigenous and faith healers is necessary in contexts such as Ghana where literature (and thus data) are scarce. Discussing this information through African eyes is an important means of facilitating self-awareness. Such data, when brought to the public domain, could potentially inform practice and policy (Francis, Mills, Chapman, & Birks, 2009).

This dissertation therefore contains eight articles which have been published in international peer-reviewed journals. Each of the articles is presented in this dissertation as a separate chapter, with a short discussion of how it is linked to the larger study presented at the beginning of the chapter. Thus, the traditional Methods, Results and Discussion chapters of dissertations have been omitted in this case as each article contains these components. Because each chapter is a complete article, there is some inevitable overlap and repetition in the introductions, relevant literature reviewed and methods sections within each article and chapter. There may also be some overlap in the cited references.

With the overarching aim of understanding how mental illness is conceptualised by indigenous and faith healers, the chapters are arranged in a way that seeks to facilitate a

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scrutiny and discussion of mental health beliefs, treatment practices, and attitudes towards collaboration. Thus, this dissertation is divided into five broad parts:

1. Part 1 comprises Chapters One through Three, and presents the introductory and background information for the study;
2. Part 2 comprises Chapters Four through Six, and discusses the explanatory models of the healers;
3. Part 3 comprises Chapters Seven through Ten, and examines the practices of each of the different categories of healers;
4. Part 4 assesses the participants' views on collaboration, and is presented in Chapter Eleven; and lastly,
5. Part 5 (comprising Chapters Twelve and Thirteen) presents my self-reflection and concluding thoughts of the study.

In Part 1, this introductory chapter is followed by a literature review of indigenous and faith medicine, which focuses on what has been reported in the sub-Saharan African context. I discuss the nature of health care pluralism in many sub-Saharan African countries, and the implications for alternatives to biomedical care. I also describe the different types of healers that work in mental health care. The chapter concludes with an assessment of collaboration between biomedical and indigenous health care systems, looking at views and attitudes about collaboration, as well as the strategies that have been implemented for collaboration.

In Chapter Three, I examine indigenous and faith healing within the Ghanaian context by looking at the beliefs about mental illness that are purportedly held by indigenous healers, and the reported use of non-biomedical mental health services in Ghana. I also discuss the organisation of indigenous and faith healing services in Ghana, by examining the history of this process. The chapter concludes with an analysis of collaborative attempts between biomedical and non-biomedical sectors of mental health care in Ghana.

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In Part 2, Chapters Four to Six each contain one published or in-press peer-reviewed article. Chapters Four, Five and Six describe the explanatory models of participants about mental disorders, epilepsy and intellectual disability respectively. In these papers, I aimed to examine the healers' beliefs about the nature, cause and impact of the above conditions, as an answer to research questions 1 and 2. Following these, Part 3 presents Chapters Seven, Eight, Nine and Ten where I describe the diagnostic and treatment methods of the different categories of healers, in answer to questions 3 and 4. Chapter Eleven tackles research question 5 by examining the healers' attitudes towards collaboration with biomedicine, to constitute Part 4. Together, Chapters Four to Eleven present the eight articles which form the results of this dissertation. At the beginning of each chapter, a short discussion on how the article fits into the bigger picture of the research is provided.

The final two chapters of this dissertation make up Part 5. Chapter Twelve is a reflexivity chapter. It is a space where I reflect on my experiences during the research process, and examine the potential influence of my identity and position in the decisions I took during this research. My concluding thoughts are presented in Chapter Thirteen. In this chapter, I connect the findings of all the articles, and make recommendations for future research.

Table 1 below provides more details about the chapter layout and the publication status of each article:

Table 1: The layout of thesis chapters and their publication status

<table>
<tr><th>Part</th><th>Chapter</th><th>Topic</th><th>Publication status</th><th>Authors & title</th></tr>
<tr><td rowspan="2">Part 1</td><td>1</td><td>Introduction</td><td></td><td></td></tr>
<tr><td>2</td><td>Indigenous and faith healing in sub-Saharan Africa</td><td></td><td></td></tr>
</table>

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	3	Indigenous and faith healing in Ghana	Manuscript submitted to *African Journal of Primary Health Care & Family Medicine*	Kpobi, L., & Swartz, L. Indigenous and faith healing in the Ghanaian context: A review of the literature. (in preparation).
Part 2	4	Explanatory models of mental disorders	Published in *International Journal of Culture and Mental Health* (Online version)	Kpobi, L., & Swartz, L. (2018). Explanatory models of mental disorders among traditional and faith healers in Ghana.
	5	Explanatory models of epilepsy	Published in *Epilepsy & Behaviour, 84,* 88–92.	Kpobi, L., Swartz, L., & Keikelame, M. J. (2018). Ghanaian traditional and faith healers' explanatory models for epilepsy.
	6	Explanatory models of intellectual disability	Published in *Journal of Applied Research in Intellectual Disabilities (JARID)* (Online)	Kpobi, L., & Swartz, L. (2018). Ghanaian traditional and faith healers' explanatory models of intellectual disability.
Part 3	7	Diagnostic and treatment methods of traditional herbalists	Published in *Transcultural Psychiatry* (Online version)	Kpobi, L., Swartz, L., & Omenyo, C. (2018). Traditional herbalists' methods for treating mental disorders in Ghana.
	8	Diagnostic and treatment methods of Muslim healers	Published in *Journal of Religion & Health* (Online version)	Kpobi, L., & Swartz, L. (2018). Muslim traditional healers in Accra, Ghana: Beliefs about and treatment of mental disorders.

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	9	Diagnostic and treatment methods of traditional medicine men	Published in *International Journal of Social Psychiatry, 64*(4) 309–316.	Kpobi, L., & Swartz, L. (2018). "*That is how the real mad people behave*": Beliefs about and treatment of mental disorders by traditional medicine men in Accra, Ghana.
	10	Diagnostic and treatment methods of Pentecostal Christian healers	Published in *International Journal of Mental Health Systems, 12:* 40	Kpobi, L., & Swartz, L. (2018). "*The threads in his mind have torn*": Conceptualization and treatment of mental disorders by neo-prophetic Christian healers in Accra, Ghana
Part 4	11	Healers' views about collaboration	Published in *Global Health Action, 11*:1, 1445333	Kpobi, L., & Swartz, L. (2018). Implications of healing power and positioning for collaboration between formal mental health services and traditional/alternative medicine: The case of Ghana.
Part 5	12	Research experiences and self-reflection		
	13	Concluding thoughts and directions for future research		

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1.6 Methods

1.6.1 Research design

In conducting this study, I chose to use qualitative methods to examine the work of non-biomedical health care practitioners in Ghana. This approach was useful because it allowed me to interrogate specific aspects of the healers' work, as well as to explore their interpretations of different phenomena, while at the same time allowing my engagement with and reflection on their responses to be acknowledged and utilised (Leavy, 2014). Through qualitative methodology, knowledge is subjective in nature, and is seen as co-created by the researcher and the participants.

The research design was both descriptive and exploratory in nature. This approach involved an inductive process which allowed me to obtain an in-depth understanding of the participants' working experience (Hollway & Jefferson, 2013). Such exploration was particularly useful given that my topic included examining aspects of culture, beliefs and values. The qualitative design therefore enabled the use of different methods such as individual interviews, informal observations, as well as field notes to capture a fuller picture of the work experiences of the healers.

1.6.2 Recruitment of participants

The recruitment of participants was done primarily through the healers' associations. While doing the initial preparation for the research in Stellenbosch, I intended to identify potential participants through the Traditional Medicine Practitioners' Council at the Ministry of Health's Traditional and Alternative Medicine Directorate. However, numerous emails and phone calls did not yield any response. As a result of this initial difficulty, I subsequently searched for information on the healers' associations. This was also somewhat challenging given the fact that most of the groups do not have much of an online presence. Fortunately, my sister was able to go to the offices of the Traditional and Alternative Medicine

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Directorate, where she was informed that the best way to access different categories of healers was through the Ghana Federation of Traditional Medicine Practitioners' Associations (GHAFTRAM; a more detailed description of this group is provided in Chapter Three). I was given the address of one of GHAFTRAM's executive members to send formal requests for participation.

The executive committee of GHAFTRAM was more than happy to work with me in this research, and invited me to attend their annual general meeting when I returned to Ghana for fieldwork. At this meeting, I was introduced to the members and given the chance to explain what my research entailed. I provided my contact information and invited interested members to contact me for further information and potential participation. Some of the members sought me out after the meeting and expressed interest in being interviewed for the study. They appeared to be very keen to "teach me about their work". However, in subsequent weeks, I had not received responses from most of the members whom I had contacted. Many of them stated that they were busy and did not provide concrete schedules to fit in an interview. This led me back to GHAFTRAM's offices, where I was given access to the member registry to identify further potential participants. Through this method, I was able to recruit some initial healers for participation. Snowballing and enquiries through my personal networks provided access to further participants.

The participants recruited through GHAFTRAM comprised mainly herbalists, Muslim healers and shrine priests. Pentecostal pastors were recruited through the Ghana Pentecostal and Charismatic Council (GPCC). Although the GPCC provided me with a cover letter of introduction, they explained that not all of the churches were registered under them. It was, therefore, not possible to access a member registry to determine which pastors performed faith healing. In order to identify churches which performed faith healing, I scanned posters, billboards and television advertisements which mentioned healing. Through

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these media, I obtained phone numbers and addresses of different churches, and called for appointments, or walked into their premises to request interviews. However, the first three churches which I approached balked at the idea of participating in this research. Some of the leaders I spoke to felt that I was there with nefarious intentions. Due to these initial difficulties, I sought a suitable gatekeeper to facilitate introductions to the leaders of subsequent churches. Through my network of friends, family and colleagues, I found appropriate gatekeepers who introduced me to pastors of various charismatic churches where healing was done. Two gatekeepers also assisted with snowballing other participants.

The recruitment process for the participants in this study was therefore multi-layered, and required continuous re-grouping, and periodic refinement of my methods of approach. I limited the inclusion criteria for participation to the Greater Accra Region of Ghana. This region is cosmopolitan in nature, and contains the capital city, Accra. It is a small region and thus was chosen due to the ease of access to different communities. Its cosmopolitan attributes also meant that I had access to inhabitants who hailed from communities across the country.

1.6.3 Research participants

The final number of healers interviewed in this study was thirty-six, made up of ten Pentecostal/charismatic pastors, ten Muslim healers (called *mallams* in local parlance), eight traditional herbalists, and eight traditional medicine men (often called “fetish priests”). They were made up of 31 males and 5 females. Their ages ranged from 31 to 76 years, with a mean age of 54.6 years. The mean number of years they had practised was 28.1 years. Table 2 presents a summary of the details of the participants. The real names of the participants have been replaced with pseudonyms except in cases where the participants requested to be identified by name.

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Table 2: Demographic characteristics of participants

#	CODE	NAME	GENDER	CATEGORY	AGE	YEARS OF PRACTICE
1.	H1	Lizzie	Female	Herbalist	56 years	29 years
2.	H2	Wofa Kissi	Male	Herbalist	62 years	45 years
3.	H3	Jibril	Male	Herbalist	47 years	27 years
4.	H4	Andam	Male	Herbalist	50 years	25 years
5.	H5	Asiama	Male	Herbalist	53 years	33 years
6.	H6	Yusuf	Male	Herbalist	59 years	31 years
7.	H7	Nana Ansah	Male	Herbalist	49 years	23 years
8.	H8	Eno Afia	Female	Herbalist	54 years	25 years
9.	M1	Aremeyaw	Male	Mallam	52 years	-
10.	M2	Dauda Mahama	Male	Mallam	76 years	47 years
11.	M3	Issahaku	Male	Mallam	60 years	29 years
12.	M4	Awudu	Male	Mallam	63 years	38 years
13.	M5	Abdulai	Male	Mallam	71 years	40 years
14.	M6	Ibrahim	Male	Mallam	50 years	23 years
15.	M7	Sulemana	Male	Mallam	54 years	27 years
16.	M8	Konnenee	Male	Mallam/Imam	51 years	16 years
17.	M9	Jubail	Male	Mallam	59 years	23 years
18.	M10	Yakubu	Male	Mallam	66 years	36 years
19.	F1	Dodowa Togbui	Male	F. Priest	54 years	30 years
20.	F2	Togbui Agbedeki	Male	F. Priest	73 years	60 years
21.	F3	Chief Bakana	Male	F. Priest	61 years	45 years
22.	F4	Numo Owula	Male	F. Priest	67 years	50 years

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23.	F5	Chief one	Male	F. Priest	59 years	40 years
24.	F6	Nana Ababio	Male	F. Priest	53 years	38 years
25.	F7	Naa Ashia	Female	F. Priestess	63 years	48 years
26.	F8	Obosomakutere	Male	F. Priest	70 years	51 years
27.	P1	Asante	Male	Pastor	32 years	10 years
28.	P2	Opoku	Male	Apostle	66 years	41 years
29.	P3	James	Male	Seer/prophet	48 years	25 years
30.	P4	Narh	Male	Prophet	56 years	20 years
31.	P5	Mary	Female	Prophetess	52 years	7 years
32.	P6	Bernard	Male	Prophet	41 years	13 years
33.	P7	Ohemeng	Male	Pastor	38 years	8 years
34.	P8	Sackey	Male	Prophet	42 years	20 years
35.	P9	Teinor	Male	Pastor	31 years	9 years
36.	P10	Owusua	Female	Prophetess	39 years	9 years

1.6.4 Data collection

For this study, I made use of Kleinman's (1980) Explanatory Models of Illness framework to elicit the healers' views about mental illness and its treatment. The semi structured interview schedule was constructed around the eight core EM questions (see Appendix A for interview schedule). In order to facilitate the discussion, I used case vignettes of different disorders as a means to elicit responses from the participants. The use of vignettes is a useful way to introduce discussions of a topic which is sensitive or stigmatised (Gourlay et al., 2014). It was also a useful way to elicit the participants' conceptualisations of different disorders in order to compare them with biomedical classifications of those disorders.

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The vignettes that were used consisted of one each of a serious mental disorder (schizophrenia), a common mental disorder (depression), and one which reflected a mental disorder consequent on trauma (posttraumatic stress disorder), which has been shown to have different prevalence rates in low-income versus high-income contexts (Atwoli, Stein, Koenen, & McLaughlin, 2015). In addition to the vignettes about mental disorders, I also included a vignette on epilepsy and one on intellectual disability (see Appendix A for vignettes). Although not typically classified as mental disorders in themselves, the latter two vignettes were included because such disorders are often connoted as related to mental illness, and are commonly treated by indigenous and faith healers. Much of the literature on mental disorders and mental health care provision in Africa includes intellectual disability and epilepsy issues as falling under mental health concerns (e.g., Beletsky & Mirsattari, 2012; Mirsattari, Gofton, & Chong, 2011; Molteno, Adnams, & Njenga, 2011).

I conducted most of the interviews personally; however, I enlisted the assistance of a male research assistant for some of the interviews. This was necessary because of specific cultural and/or religious rules. For instance, the *mallams* informed me that by Islamic rules it was frowned upon for them to interact with me (as a female) unaccompanied by a male. Similarly, one of the fetish priests indicated that the deity he served did not permit him to speak to a female directly while in the shrine. I therefore went for subsequent meetings with a male assistant. This assistant was a psychology graduate whom I trained for the study. I was present at each interview that he conducted and closely supervised him. The interviews lasted approximately 40 to 90 minutes in general. They were conducted either in the homes or in the workplaces of the healers (in most cases, these were the same place).

Most of the interviews were conducted in English, or in one of the local languages based on the participant's preference. The dominant local languages spoken in the Greater Accra Region are Ga and Twi. However, there is much code switching between English and

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either Ga or Twi. I am a native of the Greater Accra Region, and thus a native speaker of the Ga language. However, the largest ethnic group in Ghana is the Akan ethnic group. Their language, Twi, is widely spoken across Ghana, particularly in Accra given the high rate of in-migration of people from other regions. I am fluent in Ga, Twi and English. I am also familiar with linguistic practices in Accra. Similarly, my research assistant was fluent in all three languages.

In addition to the initial interviews, as a form of respondent validation, I went back to some of the participants (those who were willing and/or available), to present a summary of my preliminary findings to them. Through this validation process, I was able to clarify and expand on some of the ideas I had unearthed. A total of 23 participants made themselves available for validation meetings.

1.6.5 Data analyses

All the interviews were audio-recorded with the consent of the participants. All interviews were then transcribed verbatim in the language that they were conducted in. The interviews that were done in Ga or Twi were subsequently translated into English, and then back translated by an independent linguist to ensure they were consistent and accurate translations of the respondents' views. I checked the translated and back translated transcripts for correctness and any areas of disagreement were discussed and resolved.

The data were analysed thematically using Braun and Clarke's (2006) six-step model of thematic analysis. This was an inductive process which allowed me to unearth patterns of meaning and to classify them into themes. More details of the steps are explained in the individual articles in Chapters Four to Eleven of this dissertation.

1.7 Ethical considerations

Ethical approval for this study was provided by the Stellenbosch University Humanities Research Ethics Committee (Protocol ID: SU-HSD-002388; see Appendix B1), as well as the

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Ghana Health Service Ethics Review Committee (Protocol ID: GHS-ERC-03/07/16; see Appendix B2). I also obtained permission from the Traditional Medicine Practice Council (Appendix C1), GHAFTRAM (Appendix C2) and the GPCC (Appendix C3). All the procedures which contributed to this research complied with the ethical standards and requirements of these institutions.

In order to obtain consent for participation from my participants, an information leaflet was included in the informed consent form (Appendix D). The information leaflet explained the purpose and objectives of the study, what participation entailed, the possibility of harm or risk, as well as the potential benefits of the study. The leaflet also outlined how confidentiality and anonymity would be maintained, and the participants' right to withdraw from the study. Contact information for all those involved in the study were also provided, including my supervisor and the details of the contact person at the Division for Research Development of Stellenbosch University, should they have any further questions (please see Appendix D for information sheet and consent form).

1.8 Chapter summary

In this chapter, I presented the background and rationale for the research. I also discussed the research questions and objectives which guided the process. Lastly, I described the structure of the thesis, the methods which I employed in carrying out the study, and the ethical considerations. In the next chapter, I discuss some relevant literature on indigenous and faith healing in sub-Saharan Africa.

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CHAPTER TWO: INDIGENOUS & FAITH HEALING IN SUB-SAHARAN AFRICA

2.0 Introduction

Every society has systems of care for ill health (Amzat & Razum, 2014). Each system has beliefs about what constitutes illness, what the expected role of patients and healers should be, and what processes and outcomes constitute healing (Frank & Frank, 1991). Thus, health care is built on culturally held values, and may vary from one context to another.

In the previous chapter, the background and rationale, as well as the research questions which guided this study, were introduced. In this chapter, I review literature on alternative medicine in sub-Saharan Africa. The field of alternative medicine is a broad area with much differentiation. As such, it is not possible, within the extent of this dissertation, to discuss in full detail all the issues within the field of alternative healing globally. Therefore, in this chapter, I focus on discussing indigenous and alternative medicine within sub-Saharan Africa, and on issues germane to my central concerns.

Discussions of complementary/alternative medicine in non-African countries (such as traditional Chinese medicine, Ayurveda, traditional Maori medicine, or European folk medicine) are available elsewhere for the interested reader (see for e.g., Adib-Hajbaghery & Rafiee, 2018; Kemppainen, Kemppainen, Reippainen, Salmenniemi, & Vuolanto, 2017; Lotfi, Adib, Shahsavarloo, & Gandomani, 2016; Shields et al., 2016; or Şimşek et al., 2017). Furthermore, in this chapter, I examine literature from sub-Saharan African countries without discussing the Ghanaian context. A discussion of indigenous and faith medicine in Ghana is covered in the next chapter. As was discussed in Chapter One, my use of the terms “indigenous” or “traditional healing”, refer to systems of health care which are predicated on indigenous cultural beliefs about illness and well-being, and have been developed within specific contexts.

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Recent estimates by the WHO suggest that approximately 80% of people living in low- and middle-income countries (LMICs) use traditional or alternative medical care (WHO, 2013). Various reasons have been given for this perceived high patronage, and there is much research on non-biomedical medicine in Africa, written from a number of perspectives. In this chapter, I first look at some of the reported reasons for the use of different healing systems. Next, I examine the literature on the different types of healers that are involved in mental health care in Africa. Finally, the chapter concludes with a discussion on collaboration between traditional and biomedical health care systems, exploring research on views about collaboration, as well as the strategies which have been used (or could be used) to foster integration.

Although I try to give a balanced discussion on alternative medicine in this chapter, there are a few areas which fall beyond the scope of this study. In particular, I have not discussed in detail some of the criticisms that have been levelled at alternative medicine. For instance, there is some research which has questioned the prudence of using indigenous medicine, given that there is a lot of uncertainty and some level of mystery surrounding it (e.g., Byard, Musgrave, Maker, & Bunce, 2017; Munyaradzi, 2011). Other authors have also questioned the scientific veracity of claims to their effectiveness, given the purportedly less stringent scientific methods allegedly used in testing herbal and other folk medicines (e.g., Moreira et al., 2014). However, some authors have argued that the use of these alternatives to biomedicine is unlikely to cease in the near future, thereby making it necessary to work towards mutual understanding and integration (Rathod et al., 2017).

In this dissertation, I examined the work of indigenous and faith healers, by looking at their beliefs and methods, and not the perceived effectiveness of their methods. I have therefore not discussed in detail the literature on perceived effectiveness of indigenous and/or faith medicine in sub-Saharan Africa. As Nortje et al. (2016) argued, it is difficult to establish

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effectiveness of a particular system of care in a highly pluralistic medical setting. This is an issue to which I shall return at the conclusion of this dissertation.

Additionally, this review does not discuss the literature on the potential toxicity of herbal medicines. This, too, falls outside of the scope of the study; however, Lee et al. (2016) have discussed this in some detail. Related to this, are the concerns about the interaction of herbal supplements, like green tea and St. John's Wort, with prescribed pharmaceutical medications (see for e.g., Brewer & Chen, 2017, for a review of these interactions). Although these interactions are important to examine, they fall outside of the scope of this current study. Therefore, the literature reviewed in this chapter does not include a discussion on these criticisms.

2.1 Pluralism in health care

Globally, illness and disease have historically been treated through various systems of care. From simple household remedies for treating common ailments, to complex biomedical surgical procedures, people make use of different health care methods in a bid to restore good health (Amzat & Razum, 2014). In some instances, different systems of care are used concurrently. The different systems may hold the promise (real or imagined) of providing avenues and options for achieving wellness, particularly when methods in one or more systems are perceived to have failed. Various reasons have been suggested for this pluralistic nature of health seeking behaviour. Stanifer et al. (2015), for instance, examined the preference for traditional medicine over biomedicine among lay people in northern Tanzania. These authors identified five key determinants for choosing between the two medical systems:

1. The structure and perceived cost of biomedical care delivery;
2. The users' understanding of disease or illness;
3. The service users' current health status;

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4. Their cultural identification; and
5. The users' perceptions of the effectiveness of one system over the other.

Similar determinants have been reported in other studies in other sub-Saharan African countries (e.g., Adeosun, Adegbohun, Adewumi, & Jeje, 2013; Adewuya & Makanjuola, 2008; Ikwuka et al., 2016; Kayombo et al., 2007). Despite the fact that such studies report on the use of different health care systems, the data from these studies tend to be limited in scope in terms of identifying singular use of one specific system versus pluralistic use of a range of systems. As far as can be determined at present, there are no robust data from LMICs to draw conclusions about strict preference for any one medical system (Gureje et al., 2015).

This notwithstanding, inferences can be drawn that decisions to use multiple medical systems depend on illness beliefs, the availability and accessibility of some health care systems over others, as well as financial and economic factors associated with particular systems of care, such as shortages in human resources (Cooper, 2016; Nortje et al., 2016; van der Watt et al., 2018). The use of different health care systems thus varies based on the context of the individual, comprising national, social and cultural variables, although biomedical methods retain a hegemonic role in what is considered modern or conventional medicine (Amzat & Razum, 2014).

2.1.1 Indigenous medicine and mental health care in sub-Saharan Africa

Different authors have written about indigenous medicine in different cultures around the world (e.g., Bhui & Bhugra, 2007; Gureje et al., 2015; Helman, 2007; Kleinman, 1980). Furthermore, studies have been conducted on indigenous medicine and practice in relation to chronic medical conditions such as cancer (e.g., Damery et al., 2011; Olaku & White, 2011); HIV/AIDS diagnosis and management (e.g., Gyasi, Tagoe-Darkoe, & Mensah, 2013; Orisatoki & Oguntibeju, 2010; Zuma, Wight, Rochat, & Moshabela, 2017) and tuberculosis

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care and management (e.g., Famewo, Clarke, & Afolayan, 2017; Sharifi-Rad et al., 2017), among others.

Similarly, indigenous medicine has been examined in mental health care along various dimensions. In some cases, the use of indigenous medicine for the treatment of mental disorders in different African countries has been explored. While several studies have suggested that the preference for non-biomedical treatments for mental disorders was primarily due to the limited availability of biomedical facilities in many African communities (Agara & Makanjuola, 2006), there are arguments that such explanations fail to acknowledge the agency of individuals in health seeking. Accordingly, reasons that are more comprehensive must additionally be considered as potentially accounting for the popularity of alternative medical care. For instance, a study by Mbwayo, Ndetei, Mutiso, and Khasakhala (2013), in three districts in Kenya, found that one of the foremost factors cited by patients was the mode and flexibility of payments at traditional healers' versus biomedical facilities. Although not all healers' fees were cheaper than hospital fees, the patients cited the option of paying in instalments or bartering for care through goods and services, as a more favourable (and affordable) alternative than the purportedly rigid monetary payment structure of biomedical facilities.

As a result, patients in such contexts would likely sometimes choose to go to a traditional healer even when biomedical care is available (Falisse, Masino, & Ngenzebuhoro, 2018). Other structural factors concerning biomedical care include the high cost of medication, as well as relatively longer waiting times at hospitals as compared with indigenous or faith healing centres (Rathod et al., 2017; Stanifer et al., 2015). All these factors may exert an influence on patients' choice to access one type of care over another.

This is not to suggest that choice of care is always possible. In some communities, the absence of biomedical care facilities restricts the options available for seeking health care. In

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such situations, even when service users perceived biomedicine to be the most appropriate avenue for health care for the symptoms they experience, limited resources prevent that option from being available to them for use (Burns & Tomita, 2015; Ikwuka et al., 2016).

Another major factor reported to account for the popularity of indigenous/faith healing is the illness beliefs of patients and/or their caregivers. According to Tocco (2010), for many people in sub-Saharan Africa, illness is seen as an undesirable circumstance which needs to be corrected or removed. Thus, every illness is believed to have a cure and the idea of a chronic illness which requires continued management (as is practised in biomedicine) is not recognised. Therefore, in some cases when biomedical methods were perceived as being unable to cure a specific illness, the assumption was that it was ineffective in treating the condition (Tocco, 2010). This could result in the use of alternative medical systems to obtain the expected cure (Tocco, 2010). Adekson (2003), however, argued that in most indigenous African concepts of illness, distinctions are made between congenital conditions (which have no "cure") and non-congenital conditions (which are "acquired"). The recommended treatment is therefore based on the perceived nature of the condition.

On the other hand, according to Kajawu, Chingarande, Jack, Ward, and Taylor (2016), the search for avenues of healing is heavily influenced by beliefs about the aetiology of the condition, and not only the expectations of a cure. That is, people would seek help from different places based on their beliefs about what caused their illness. Thus, in their Zimbabwean study, people who believed that mental illness had spiritual origins also believed that they would get better only if spiritual means were used to attain healing. The choice of faith healing over biomedicine was therefore not necessarily due to lack of availability, nor was it due to lack of belief in the methods of biomedicine. Instead, people appeared to choose spiritual methods based on their own beliefs and explanations of their condition's origin. This appears to be a major determinant of choice of care, as has been

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frequently discussed by participants in other studies (e.g., Mbwayo et al., 2013 in Kenya; Monteiro & Balogun, 2014 in Ethiopia; Sorsdahl, Stein, & Grimsrud, 2009 in South Africa).

Beyond individual illness beliefs, the beliefs of practitioners are also important in the conversation on choice of care (Schierenbeck, Johansson, Andersson, Krantz, & Ntaganira, 2016). There are indications that the causal beliefs and explanations for mental disorders as held by non-biomedical practitioners tend to be similar to those of the people who patronise their services (Mpofu, Pelzer, & Bojuwoye, 2011). Given the healers' perceived positions as custodians of culture within their specific communities (Zuma et al., 2016), as well as their familiarity with cultural expectations and social circumstances, the likelihood of the healers' holding congruent beliefs is to be expected. These include beliefs about the nature of illness and misfortune, the origin or cause of illness, and the potential impact of the illness on the individual and their family (Mpofu et al., 2011; Zuma et al., 2017).

Although congruence between healers and patients has been shown to be an important component of successful treatments (Sakallaris, MacAllister, Voss, Smith, & Jonas, 2015), the idea of healers as custodians of culture presupposes a narrow and static view of culture and its transmission. It ignores cultural fluidity and the dynamism of philosophies, as well as of individual external influences. Similarly, the concept of "mental illness" as a category is in itself a cultural construction which may not be universal (Swartz, 1998).

In some literature, indigenous healers' ideas about what constitutes mental illness has been described as limited to what in biomedicine would be seen as psychosis; with other forms of mental illness not being viewed as such in indigenous systems (e.g., Ventevogel, Jordans, Reis, & de Jong, 2013). Local nomenclature and symptom descriptions portray "madness" as manifested through symptoms which are consistent with hallucinations, delusions, aggression and other forms of disorganised behaviour (Mzimkulu & Simbayi, 2006). Thus, names such as *amafufunyana* from South African Zulu culture (Ngubane, 1977),

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and *moul* or *mamali* from South Sudanese culture (Ventevogel et al., 2013), which characterise "madness" in these cultures, are typically used to describe individuals with psychotic conditions.

On the other hand, there is also an awareness of other forms of (milder) psychological distress, as seen in the concept of *kufungisisa* ("thinking too much") among the Shona people of Zimbabwe (Patel et al., 1995), as well as *okweraliikirira* or *omutwe omutambuse* ("head mixed up by too many worrisome thoughts") among the Baganda people of Uganda (Okello & Ekblad, 2006). These names suggest that, despite the assumption that in sub-Saharan Africa mental illness is traditionally recognised only in psychotic behaviour, there is an acknowledgement of non-psychotic conditions.

The nature of care that is provided by indigenous/faith healers is also thought to play a significant role in the preference for traditional healing over biomedicine. For instance, a study by Gureje et al. (2015) on the role of indigenous systems for the treatment of mental disorders, argued that patients perceived indigenous medicine to be more holistic as compared to biomedicine. According to these (and other) authors, the overall perception of patients was that indigenous methods sought overall wellness, which included physical, mental and social components, whereas biomedicine tended to focus on alleviating symptoms to attain physiological wellness (Mpofu et al., 2011; Truter, 2007). Further, the nature of biomedicine seemed to patients to be less focused on reassurance and building relationships with patients. Indigenous/faith practitioners were described by patients as being less hurried, paying more attention to patients and actively listening to their concerns (Mbwayo et al., 2013). These are perhaps a further reflection on the effects of human resource limitations on the perceived outcomes that biomedicine afforded patients.

Closely related to the nature of care that is received by patients, is the type of treatment that traditional medical practitioners provide. As was mentioned above, traditional

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medicine has been reported to be perceived by patients as being more holistic. Thus, diagnoses and treatments could include protocols which targeted healing from a physiological, spiritual and/or a social dimension (Sodi et al., 2011). In many cases, a combination of these dimensions could be utilised, and these are often argued to be dependent on the beliefs about the cause of the disorder. Treatments are determined through various diagnostic processes, including divination, patient or informant interviews, and physical observations/examinations. Based on the problem that is diagnosed, the treatment protocols may involve herbal remedies, psychosocial counselling, prayer and exorcism, as well as recommendations for lifestyle and behavioural changes (Agara, Makanjuola, & Morakinyo, 2008).

Given the reported emphasis on complete wellness, as well as the beliefs about the causes of mental disorders, much emphasis is typically placed on achieving more than symptom-alleviation. According to Truter (2007), indigenous healing usually did not end with the patient, but could often be found to include behaviours and processes to be followed by significant others or family members. This inclusion of the patient’s community in the healing process corresponds with what is considered an African notion of disease or illness (White, 2015; Xaba, 2002), which is an extension of the African notion of community. That is, an illness in the family or community potentially affects all individuals within that community, and thus requires the input of both the patient and others within his/her circles for complete wellness (Aghukwa, 2012; Moshabela, Zuma, & Gaede, 2016).

2.2 Types of traditional medicine practitioners

Although alternative medicine practitioners are often collectively referred to as traditional healers, there is actually considerable heterogeneity in what constitutes alternative healers within different local contexts (Sorsdahl, Flisher, Wilson, & Stein, 2010). These differences are largely based on the orientation of the healer (which includes their beliefs about illness

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and health care), the type of training they receive, and their local cultural context. Much of the literature on alternative medicine in Africa describes three broad categories of non-biomedical medicine practitioners within mental health care (Sodi et al., 2011), namely, the herbalists, the indigenous diviners or spiritualists, and the faith healers. As was discussed in the previous chapter, for this study faith healing is used to refer to Pentecostal Christian and Muslim religious healing practices. Although I acknowledge the presence of some elements of faith in the work of diviners, because of the foundations of non-African religions which underpin Pentecostal Christianity and Islam, healers whose work draws from these religions were viewed separately (Graveling, 2010).

Although I recognise that other types of traditional healers exist (such as traditional birth attendants and traditional circumcisers or surgeons), these types will not be discussed as the primary focus of the present study is on the healers who specifically provide mental health care. It is also worth noting that the healer categories are not necessarily mutually exclusive categories, such that there may be some overlap in the methods and beliefs of some of the healers (Sorsdahl et al., 2009). For instance, some diviners may also employ herbal methods in their work, even though they identify as diviners and the core of their work is spiritual, not herbal. In the sections to follow, each of these categories is discussed in more detail.

2.2.1 The traditional herbalists

The traditional herbalists are sometimes referred to as traditional doctors. Various local names exist for this category of healers, such as *onisegun* among the Yoruba of Nigeria (Adekson, 2003), *inyanga* for the Zulu of South Africa (Washington, 2010), and *twabibu* among the Swahili of Kenya (Gearhart & Abdulrehman, 2013). According to Amzat and Razum (2014), they are the most visible of the indigenous healers in some contexts due to their professed ability to treat many common illnesses. Herbalists are often present within the

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community and thus are known to members of the community, making them easily accessible for care. These healers are believed to possess extensive knowledge of various purportedly curative processes, and specialise in the use of herbs for healing (Sodi et al., 2011). They use their knowledge and understanding of plant parts and plant properties in their work. In some cases, preparations made from certain animal parts (such as snakes and scorpion parts, etc.) are included in their treatment regimens (Abdullahi, 2011; Amzat & Razum, 2014).

The herbalists' methods may include processes viewed as both curative and prophylactic. Their herbal preparations may be in the form of powders, infusions, decoctions, emetics, herbal soaps, or pomades. In addition, they may or may not include spiritual processes to complete healing. The healing processes typically align with cultural beliefs and expectations of health and illness. The entire treatment process would seek both individual and family/social wellness (Hewson, 1998; Kale, 1995). Most herbalists may treat a wide range of diseases; however, some specialise in one or two conditions or systems of the body. Therefore, there may be herbalists who are specialists in treating ailments relating to the stomach, or to the heart, etc. (Sodi et al., 2011).

According to Truter (2007), unlike other types of healers, herbalists are often not "called" to be healers. Instead, most herbalists reportedly choose healing as a profession because such knowledge is often passed down to them through their families. They learn aspects of their craft through observation and assisting an older family member during their childhood, and subsequently may undergo a process of apprenticeship to formally be recognised as an herbalist (Truter, 2007).

2.2.2 The diviners/spiritualists/shrine priests

The diviners/spiritualists (sometimes referred to as shrine priests or shrine devotees) are the category of healers that are often referred to when indigenous healers are spoken of (Zuma et al., 2016). These healers reportedly serve or represent specific deities or ancestors, through

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whom they ostensibly have power to diagnose and heal illness (Sodi et al., 2011; Truter, 2007). The diviners mostly specialise in identifying and treating spiritual conditions. Thus, their diagnostic processes usually involve determining which spirit is responsible for the patient's ill health, while their treatment processes may involve ridding the patient of the identified spiritual influence (Sorsdahl et al., 2009). According to Sodi (2009), the patient is not always required to be present during the diagnostic process. Given that the healer divines the nature of the problem through purported communication with a spirit, the presence of the patient or their family member is not always necessary to be able to identify what has caused the problem.

To a large extent, diviners/spiritual healers are reported to be perceived as highly respected individuals within their communities, and are often considered to be a connection between the living and the dead or the spirit world. They may be recognised by their distinct mode of dress, and reportedly work through spirit possession, trance states and ritual divination processes such as throwing bones (called *ditaola* in southern African contexts) or counting beads (as in Yoruba *Ifa* divination). These are believed to allow them to communicate with the gods and/or the ancestors for directions. Some literature is available which describes the divination process for traditional healers in more details (see for e.g., Adekson, 2003, for a description of Nigerian healers; Sodi, 2009, for a description of South African healers; and Abbo, 2011 and Teuton et al., 2007, for healers from Uganda).

The shrine devotees typically live in the shrines created for the deity or ancestor that they represent. In some communities, the healers do not undertake any other form of employment (Field, 1960). Their livelihood is therefore provided through the various means of remuneration for their work. This remuneration may be monetary but may also include the patient offering farm produce, animals, fabric, etc., as payment for the services of the healer. In other instances, such products may be offered as thanks to the spirits or ancestors through

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the healers. As was mentioned above, these means of payment may not necessarily be cheaper than the cost of hospital care; however service users perceive them as more flexible, and thus, they may be preferred (Mbwayo et al., 2013).

Many of the diviners are also viewed as possessing extensive knowledge of cultural medical approaches (Bantjes, Swartz, & Cembi, 2018; Chavunduka, 1994). These approaches may include knowledge of local herbs and animal properties, as well as appropriate behaviours. In instances where the identified cause of illness is not spiritual, they may prescribe herbal medicines to treat patients. However, even for spiritual conditions, the treatments could include herbal regimens. The specific methods are determined by the healer through communication with the gods or ancestors (Crawford & Lipsedge, 2004).

Becoming a diviner or shrine priest is often considered to be a special “calling” from either the ancestors or the gods of the community (Mokgobi, 2014; Semenya & Potgieter, 2014). Unlike the herbalists, shrine priests are believed to be called to become healers. The calling to become a diviner is perceived to manifest in different ways depending on the cultural context. The calling may come in the form of a dream or, more commonly reported, through an illness which is not responsive to biomedical interventions (Mlisa, 2009; Sorsdahl et al., 2009).

Not much literature was found on the process of becoming a diviner in African countries apart from South Africa. In contrast, much has been written in the southern African context about the process of becoming a *sangoma* (the Zulu word for diviner) (Bakow & Low, 2018; van Binsbergen, 1991). Zuma et al. (2016), for instance, describe a three-step process of training to become a traditional healer. These steps include being called by the ancestors (referred to as *ubizo*), followed by the process of training or initiation by an older healer (called *ukuthwasa*), and lastly, the “graduation” process where one is formally recognised as a diviner (this is called *ukuphothula*). Similar processes of becoming a healer

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have been described for the Shona people of Zimbabwe (e.g., Chavunduka, 1994; Matsika, 2015), the Basotho people of Lesotho (Louw & Duvenhage, 2016), and among Tanzanian healers (Gessler et al., 1995).

2.2.3 The Christian faith healers

Christian faith healers form another category of non-biomedical healers. They are often classified with other faith healers, even though differences are recognised among the different types of faith healers based on their beliefs and/or creed. Even within the Christian faith, there are differences in the classifications of the churches based on their doctrine and origin. Much of Christian faith healing is undertaken by leaders of so-called new religious movements (NRMs) (Kealotswe, 2014). For instance, the group of churches referred to as African Independent/Initiated Churches (or AICs) developed in the late 19th century and early 20th century as a response to the difficulties apparently experienced by some African converts in reconciling their world view with the teachings of the Western mission churches (Kealotswe, 2014). According to Molobi (2011), this view of Christianity as “foreign” created dissatisfaction for many new converts, particularly given the fact that the indigenous way of life was styled as primitive, anti-Christian or even demonic by the missionary churches.

This eventually resulted in the development of churches which sought to teach Christian doctrine within the framework of the everyday known lives of the converts. Thus, the AICs practised a syncretic religion which included elements of African traditional beliefs fused with Christianity (Bediako (1994) and Kealotswe (2014) discuss the origins of AICs in greater detail). These new religions preached exorcism, faith healing and other rituals as key components of Christian worship. The AICs were called by different names in different contexts, including *aladura* in Nigeria, spiritualist churches in Ghana, *arathi*, *roho* or *akurinu* in Kenya, and Zionist churches in southern African countries (Padwick, 2018). They often

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made use of candles, oils and herbs in their worship, and were often identified by a distinct mode of attire during services (Kealotswe, 2014).

Developing as something of an offshoot of the AICs was the Pentecostal/charismatic movement, which gained popularity in Africa during the mid-20th century. Pentecostalism is believed to have started in the United States at the turn of the 20th century. This new wave of Christianity emphasised the work and gifts of the Holy Spirit in the lives of believers (Asamoah-Gyadu, 2013). They also emphasised evangelism and spreading of the gospel through revivals and conventions (Anderson, 2004). Their doctrine emphasised speaking in tongues, prophecy, miracles and healing as manifestations of the presence of the Holy Spirit within an individual. They frowned on the inclusion of African religious practices such as trances and induced spirit possession, as practised by AICs. The full history of Pentecostal/charismatic churches falls beyond the scope of this dissertation, but more background can be found in Asamoah-Gyadu (2013), Kay and Dyer (2004), as well as Anderson (2004).

According to Molobi (2011), one of the reasons why faith healing, as practised by the charismatic movement, became popular in African countries, was the perceived shortcomings of biomedicine in treating certain illnesses. Additionally, biomedical methods, even when perceived as being able to cure an illness, were unable to provide patients with expected explanations of why the illness started when it did, and/or who had caused it to happen. Thus, there was some perceived dissatisfaction with hospital care (Teuton et al., 2007). As a result of this dissatisfaction, people reportedly began seeking avenues which could provide them with the desired answers regarding their illness. One such avenue was the church (Larbi, 2001).

Given that the charismatic/Pentecostal church doctrines believe in healing through the power of the Holy Spirit, the churches sometimes hold services specifically for healing

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congregants (Anderson, 2004; Munthali, Mannan, MacLachlan, & Swartz, 2016). Thus, the leaders of these churches purportedly use their divinely given gift of healing to diagnose who/what caused the illness. The treatments often involve exorcism, prayer (sometimes combined with holy water, candles, anointing oils and other prayer aids), fasting, and the laying on of hands (Sorsdahl et al., 2009). All these activities are directed by the leaders' reported divine connection to the Holy Spirit.

Becoming a prophet is seen as an individual calling. Unlike the shrine priests whose calling left no choice, Christian faith healers are believed to be given a choice to accept the calling or not. Accepting the calling was seen as a step towards fulfilling their lives' purpose (Edwards, 2011). In some cases, the "called" prophet undergoes training and mentorship from a more experienced healer in order to understand how to harness the gifts that they have been given (Sorsdahl et al., 2009). To date, I have found no indication that any beliefs of adverse consequences for not accepting the call exist.

2.2.4 Islamic soothsayers/diviners

The last category of healers which I shall discuss are the Islamic healers. Not much has been written about Muslim healers in African countries, although a few authors have described Islam and health care in certain African countries (see, for example, Ally & Laher, 2008 or Parkin, 2014). The literature from other countries discussed below are, however, discussions of Islamic concepts which may be applied to the African context. Much of the African literature tends to construe the work of Muslim healers as part of traditional healing practices, rather than as faith healing, and thus there is not much written about Muslim healers separately or specifically. Furthermore, some of the healing practices include elements which reflect cultural practices, resulting in an apparent fusion of Islamic practices with indigenous practices (Nieber, 2017). However, some authors have argued that the belief in the presence

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and influence of unseen spirits and other entities on the lives of individuals suggests an element of faith in their practices (Littlewood, 2004).

According to Islamic beliefs, much of the havoc and misfortune (including ill health) that exists in the world can be attributed to the activities of unseen entities called *Jinn* (Dein, Alexander, & Napier, 2008). These *Jinn* are similar to humans in their needs, desires and behaviour; they can also be either good or evil (Lim, Hoek, Ghane, Deen, & Blom, 2018). However, the fundamental difference between the *Jinn* and humans is their origin. Islam teaches that humans were formed from clay whereas *Jinn* are formed from smokeless fire (Khalifa, Hardie, Latif, Jamil, & Walker, 2011). The *Jinn* are invisible to the human eye and are believed to have the power to possess people. This *Jinn* possession is believed to result in unusual or sometimes inappropriate behaviour. Thus, many Muslims consider mental illness to be a manifestation of possession by evil *Jinn* (Ally & Laher, 2008).

Apart from belief in *Jinn* possession, there is also the belief in other evil spirits who are agents of the devil and can be used in sorcery or witchcraft to cause harm to others. Additionally, Muslims believe in the notion of the evil eye (or *Nazr*). This is the belief that harm, or illness can befall an individual when a jealous or envious person repeatedly looks at the individual or his possessions with lust or envy (Mullick, Khalifa, Nahar, & Walker, 2013). Thus, illness or misfortune may result from either possession by evil *Jinn* or from the actions of vengeful or envious spirits and people (Bulbulia & Laher, 2013; Laughlin, 2015).

In order to obtain healing from these afflictions, patients or their caregivers who believed their symptoms were caused by non-physical circumstances would typically see a learned Muslim leader. These leaders are usually male, and may have training and/or experience in treating illness (Dein & Illaiee, 2013). In a study among Bangladeshis in the UK who utilised the services of Muslim healers, Dein et al. (2008) described the various methods that were employed by the healers to treat illness. The first was the recitation of

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specific verses from the Qur'an (a process called *ruqyah*). This recitation was believed to invoke the presence of Allah (*dhikr*) and the reciter was able to seek refuge from the spiritual attacks in him (Dein et al., 2008; Uvais, 2017).

In addition to the recitation of verses, some healers also recited the words of the Qur'an over water or wrote out the verses and subsequently washed them into water. The patients were then instructed to drink the water or wash in the water (Dein & Illaiee, 2013; Nieber, 2017). This was believed to purify the individual by making their bodies uncomfortable for continued habitation by the *Jinn* or evil spirits (Khan & Sanober, 2016). Although these methods were described among a Pakistani population, they are similar to what Ally and Laher (2008) reported from their South African sample.

Following exorcism, other processes may be undertaken to protect against misfortune, or to prevent a relapse. According to Nieber (2017), some healers included various herbal remedies in their regimens. These herbal remedies were not believed to heal in and of themselves but were believed to complete the process of healing. The ultimate source of healing is believed to be Allah (Lim et al., 2018; Mullick et al., 2013). In other cases, patients or their family members were given amulets or charms which have verses from the Qur'an written on them (called *taweez*) (Ally & Laher, 2008). These amulets (such as one fashioned into the "hand of Fatima") are believed to offer protection from the *Jinn* and evil spirits (Khan & Sanober, 2016).

2.3 Collaboration between traditional/alternative medicine and conventional biomedicine

In this section, the focus is on collaboration between biomedicine and indigenous medicine. In particular, some discussion will focus on available literature on views about collaboration, looking at the perspectives of both indigenous/faith healers and other health care

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professionals. Subsequently, I will look at the strategies or measures which have been developed to foster collaboration between the different health care systems.

2.3.1 Practitioners' views and attitudes towards collaboration

The relationship between biomedical and non-biomedical health care systems has historically been one of mutual suspicion and mistrust (Busia & Kasilo, 2010). Some studies have reported that biomedical health care professionals viewed alternative healers as charlatans who were unethical and untrustworthy, while alternative healers reportedly viewed biomedical practitioners as disrespectful and equally untrustworthy (Ally & Laher, 2008; Osafo, 2016). These sentiments have likely arisen from colonial ascriptions of indigenous practices as primitive and harmful, but also perhaps from anecdotal and media accounts of harmful outcomes of traditional health practices on the one hand, and reported disdain by biomedical practitioners of patients who have utilised traditional medicine on the other hand (Adekannbi, 2018; Schierenbeck et al., 2016).

Despite this apparently mutual distrust, some research has suggested that indigenous healers were more open to potentially working with medical doctors than vice versa (Wreford, 2005). One study, conducted in South Africa, reported that medical doctors did not believe they could learn anything from non-biomedical practitioners. Instead, they understood collaboration to be more unidirectional, with indigenous healers being "trained" on biomedical psychiatric models, and referring their psychiatric patients to hospitals and clinics for care (Campbell-Hall et al., 2010; Wreford, 2005). Indigenous and faith healers, on the other hand, were keen to work with doctors through mutual referrals, training to understand the biomedical model of care, as well as the opportunity to teach biomedical practitioners about the psychosocial and spiritual models that they used (Campbell-Hall et al., 2010).

Therefore, it appears that indigenous healers acknowledged that there were some conditions which were biomedical in nature (for which biomedical care was appropriate), and

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others which required spiritual interventions (Keikelame & Swartz, 2015). In this regard, the healers indicated their willingness to work with doctors in an environment of mutual recognition and respect (Campbell-Hall et al., 2010; Wreford, 2005). Such collaboration between the two systems was anticipated to lend some much-needed legitimacy to the practice of indigenous medicine. Similar sentiments have been expressed in other studies on non-biomedical healers' views about collaboration with biomedical doctors in different contexts (see for e.g., Akol, Moland, Babirye, & Engebretsen, 2018; Janse van Rensburg, Poggenpoel, Szabo, & Myburgh, 2014; Keikelame & Swartz, 2015; Mokgobi, 2014; Pouchly, 2012; Winkler et al., 2010).

Although much of the literature on collaboration reports negative attitudes of biomedical practitioners towards indigenous health practitioners, some research reports positive attitudes towards collaboration on the part of biomedical practitioners. For instance, Kahn and Kelly (2001) reported that psychiatric nurses and other health workers in their sample believed that patients would ultimately benefit from collaboration between traditional and biomedical practitioners. Specifically, some biomedical practitioners were reportedly open to exploring a system where biomedicine provided the psychotropic medication that was required, while the alternative healers supplemented that care by addressing the patient's illness concerns (Meissner, 2004). In the end, both indigenous and biomedical practitioners seem to hold the view that patients would welcome effective collaboration between the two systems of care, because they would ultimately benefit from such measures (Akol et al., 2018; Mzimkulu & Simbayi, 2006).

2.3.2 Strategies for effective collaboration

Another dimension of the collaboration dialogue is the question of strategies which would foster effective collaboration. Given global burden of disease and scarcity of biomedical care, the WHO has advocated for the integration of all available resources to bolster care provision

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in LMICs, especially for mental health (WHO, 2013). In identifying ways to work together, they caution that indigenous and faith healing systems should be viewed with neither uninformed scepticism nor with uncritical enthusiasm (WHO, 2001). Instead, the WHO advocates for a strengthening of policies, education, and development of structures which support integrated care (WHO, 2013).

In some studies among practitioners, a key means to achieving the desired integration of health care services was through fostering mutual trust and respect. As discussed above, indigenous healers often reported feeling disregarded by biomedical practitioners and this made working together difficult to maintain (Schierenbeck et al., 2016). The biomedical practitioners, similarly, reported a lack of trust for the methods of indigenous healers due to the limited information that was available about their methods. These sentiments suggest that the foundations of any collaborative work need to be developed by building trust and respect.

In a study by van der Watt et al. (2017) in three African countries, key participants (including indigenous healers, faith healers, service users and biomedical staff) advocated education and an acceptance of the limits of each paradigm as important for developing integrated care. Similarly, Janse van Rensburg et al. (2014) reported their biomedical psychiatrist participants suggesting the development of avenues for sharing information and mutual understanding between the different disciplines. According to them, the secrecy that enshrouded spiritual and herbal medicine did not foster an environment of cooperation, resulting in the perceived stigma that biomedical health practitioners purportedly held for alternative medicine.

Another strategy for sustaining effective collaboration lies in commitment and support from relevant government institutions. In research exploring a model for successful incorporation of indigenous healers in South Africa, Pinkoane, Greeff, and Koen (2012) recommended the adoption of a model which blended government policy and licensure with

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structured self-organisation of different types of healer, in addition to developing appropriate structures for cross consultation. For these strategies to succeed, they require government interest and commitment (Campbell-Hall et al., 2010).

Although some research described the desire for formal recognition and collaboration by indigenous healers to reportedly be in the interest of the patients, Abdullahi (2011) suggested that it was more likely to represent a desire for government funding and legitimacy. Generally however, collaboration was viewed as a means of achieving the goal of complete patient care, affording them the option of choosing appropriate avenues for help without the burden of unavailability or the fear of stigma.

2.4 Chapter summary

In this chapter, I examined various aspects of indigenous and faith healing in sub-Saharan Africa. Generally, most authors report that the majority of people believe in using indigenous methods of health care for a number of reasons. One of the most prominent reasons reported appears to be the consonance between indigenous methods and ideas about African beliefs about personhood and about illness. Although such descriptions of “African concepts of illness” are useful for understanding the individual and social factors which may influence help seeking and service provision within certain contexts (Dueck, Muchemi, & Ng, 2018), one of the challenges of such generalisations is that they maintain a view of individual and cultural identity as static and inherently dualistic. Consequently, “African” beliefs tend to be conceptualised as being fixed, and sometimes in direct opposition to biomedical views. This is a point to which I shall return in a later chapter.

As indicated earlier, this chapter focused on literature about sub-Saharan Africa. In the next chapter, I focus on literature about indigenous and faith healing in the Ghanaian context.

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CHAPTER THREE: INDIGENOUS & FAITH MEDICINE IN THE GHANAIAN CONTEXT

3.0 Introduction

As is the case in other sub-Saharan African countries, health care in Ghana is pluralistic, with people making use of indigenous, faith and allopathic healing systems for the treatment of illness (Aninyam, 1987; Evans-Anfom, 1986; Tabi, Powell, & Hodnicki, 2006). The indigenous systems often include components such as cultural norms and beliefs which have formed part of the everyday lives of people within communities (Gyasi, Mensah, Adjei, & Agyemang, 2011). Biomedicine in Ghana was introduced during the colonial era, and brought with it Western ideas of illness and healing (Twumasi, 1975). Consequently, indigenous Ghanaian notions and methods of health care were discouraged and considered ineffective.

The colonial era also included the advent of Christianity in Ghana, through whose missions many traditional and cultural practices were prohibited as they were considered primitive and/or demonic (Asamoah-Gyadu, 2014; Fink, 1990). These prohibitions included the use and the practice of indigenous methods of health care. To some extent, such notions of indigenous practices as primitive still exist in current discourse in Ghana, as seen in the tendency to refer to indigenous and faith healing systems as “alternative” or “complementary” to biomedicine. This has been discussed in previous chapters, however, for ease of presentation, the terms traditional/indigenous healers, faith healers, and alternative healers will be used somewhat interchangeably in this chapter.

Various types of alternative healers are recognised in Ghana. Although healers with specific specialisations exist (e.g., traditional birth attendants and traditional surgeons/bonesetters), for this study I focused on four main categories of healers whose work includes (but is not necessarily limited to) mental health care. The four categories are

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traditional herbalists, shrine devotees/diviners (often referred to as "fetish priests" in Ghana), Pentecostal Christian faith healers and Muslim healers. These healers use different methods in their work, based largely on their training and orientation. The herbalists and diviners are widely viewed as cultural experts, and thus have elements of folk knowledge, cultural values and societal expectations of behaviour in their work (Konadu, 2007; Tabi et al., 2006).

The Christian religion is not indigenous to Ghana; however, the churches that undertake faith healing typically belong to the neo-prophetic/charismatic tradition, which espouses a somewhat syncretic doctrine of Christianity. The neo-prophetic movement grew out of the Pentecostal movement of the mid-20th century, with a doctrine which stressed pneumatological manifestations of faith. Much emphasis was thus placed on the work of the Holy Spirit and its gifts of prophecy, miracles (including healing) and speaking in tongues as a sign of good Christian living. Given that traditional African religion also emphasised concepts which manifested similarly (e.g., spirit possession or trances) (Appiah-Kubi, 1981), there was much identification with the concepts that were taught by these churches. This similarity in style may be partly responsible for the fact that the charismatic movement grew in popularity in many African countries such as Ghana, particularly within the past four decades, though there are other reasons for this popularity as well (Zalanga, 2018).

In an examination of the growing phenomenon of charismatism in Ghana, Anderson (2004) observed similarities between the expression of neo-prophetic Christianity and what has been described as traditional African religion. The syncretic nature of many charismatic churches was shown in their emphasis on spiritual agents, confession, and the use of oils and holy water, which are common also in traditional African religious practice. An in-depth discussion of the syncretism of the charismatic movement is beyond the scope of this dissertation, but more detailed discussion can be found in the work of authors such as Asamoah-Gyadu (2013), Gifford (2004), and Omenyo (2006). Similar to Christianity, the

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nature of Islam in Ghana has also been argued to involve elements of indigenous Ghanaian ideas and practices (Read, 2016). The work of healers who identify with these faiths are therefore influenced by both religious and cultural elements (Mullings, 1984).

In the previous chapter, I reviewed literature on indigenous and faith healing practices in Africa, examining the use of alternative health care in mental health, the different types of alternative health care providers, as well as the literature on collaboration between biomedicine and alternative medical practice in different African countries. In this chapter, I focus specifically on alternative mental health care within the Ghanaian pluralistic context.

I will start by examining reported Ghanaian illness beliefs and the treatment methods that are employed by indigenous/faith practitioners, with a focus on mental disorders. Next will be an assessment of the literature on the use of and preference for alternative medicine by patients, and the reasons which have been posited as accounting for this preference. Third, will be a brief history of the formalising process for traditional medical systems in Ghana. The chapter will conclude with an examination of collaborative efforts between biomedical systems and indigenous/faith healing systems in Ghana.

3.1 The mental health beliefs and practices of Ghanaian indigenous healers

The work of indigenous health care practitioners is predicated on their beliefs about the nature and cause of illness. For indigenous healers, the beliefs which inform their work are often rooted in cultural ideas and societal values which are shared by the communities that they serve. According to Omonzejele (2008), in indigenous African systems, stability in an individual’s physical, mental, spiritual and social life is indicative of good health. The experience of instability in any one of these areas of the individual’s life is, therefore, likely to be experienced as an episode of illness. Similar to other African countries, in Ghana, indigenous ideas of illness occurrence are often perceived as an imbalance in two or more components of a person’s life (Opare-Henaku & Utsey, 2017; Pobee, 2001; White, 2015).

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The different components of a well-balanced life include physical and emotional well-being, social and communal harmony, as well as harmony with the gods and the spirits of the ancestors (Fink, 1990; White, 2015). A disruption of this harmony results in physical or spiritual ailments, as well as in mental illness (Akpomuvie, 2014).

Ghana has been described as a highly superstitious and religious country (Arias, Taylor, Ofori-Atta, & Bradley, 2016; Asamoah-Gyadu, 2014; Gifford, 2004). As such, some early reports of Ghanaian beliefs about mental illness placed much emphasis on the belief in witchcraft and curses as explanations of mental illness (see, for instance, Field, 1955, 1960). Within such belief systems, mental illness is construed as resulting from the influence of spiritual entities whose purpose is to cause harm or to punish the individual for some wrongdoing. Such spiritual machinations would typically manifest in unexpected and disruptive behaviours (Richter, Flowers, & Bongmba, 2017).

Despite the reported emphasis on spiritual explanations of mental disorders, there have been some studies which suggest that there exists an awareness of other causal explanations. For instance, Quinn's (2007) findings in a study of two urban and two rural communities in Ghana showed a more predominant acknowledgement of biomedical causes for mental disorders in three of the four communities, with less than 30% of respondents in each group endorsing spiritual elements as causes. Similarly, Kyei, Dueck, Indart, and Nyarko (2014) reported a more predominant endorsement of social factors, such as work stress and marital problems, accounting for mental illness.

However, the belief in spiritual causes for mental disorders cannot be ignored. A cursory look at the billboards and posters in many Ghanaian communities indicate the large number of religious (in particular, neo-prophetic/charismatic Christian) centres which offer healing for various ailments, including mental problems. These "prayer camps" centre around a prophet who serves as a medium through which God heals people (Arias et al., 2016; Read,

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2016). Similarly, the presence of healers of other religious persuasions suggests that spiritual beliefs about mental disorders are a significant part of the lives of many Ghanaians. In a review of mental health literature in Ghana, Read and Doku (2012) argued that Ghanaian beliefs about the nature and cause of mental disorders involved multiple, often fluid elements, unlike the perceived reliance solely on supernatural explanations that had previously been assumed.

There have been few studies which explore the specific treatment methods of indigenous and alternative healers in Ghana. In general, the work of indigenous healers has been described as involving herbal remedies, spiritual engagements, confession, as well as drawing on folk knowledge to restore social balance (Aniah, 2015; Tabi et al., 2006). Although some differentiation may exist in terms of the use of herbal versus spiritual methods, Hampshire and Owusu (2013) argue that this distinction is largely due to regulatory requirements, as many healers possess some knowledge of both systems but make use of specific methods based on the needs of each patient.

However accurate or inaccurate this assertion may be, it appears to be limited to the work of herbalists and diviners. Faith healers have been reported to use more clearly spiritual methods. For instance, Osafo et al. (2015) examined the treatment regimens of Pentecostal pastors in Ghana for managing mental disorders, and reported a strong emphasis on prayer, fasting and the use of oils, candles and holy water, with no specific mention of herbal treatments. These methods were typically employed in a prayer camp where patients stayed while undergoing treatment (Arias et al., 2016; Edwards, 2014). Similarly, Muslim healers in Ghana reportedly use specific prayers and verses from the Qur’an to treat illness (Adu-Gyamfi, 2014).

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Therefore, Ghanaian beliefs and methods with regard to mental illness include physiological, social and spiritual explanations. These explanations are not always fixed but often fluid depending on the illness experience of the individual or their family.

3.2 The use of indigenous and faith healing by patients in Ghana

As was discussed in Chapter Two, various authors have examined why people choose to use medical systems other than biomedical care. The reasons for the choice of care in Ghana reflect similar trends, as has been reported in other African countries. It has been argued that alternative systems of care are often the first point of call for people who view biomedicine as foreign (Ae-Ngibise et al., 2010; Ewusi-Mensah, 2001; Fiasorgbor & Aniah, 2015). The "foreign" nature of biomedicine was perceived as not reflecting indigenous beliefs about the causes of illness.

Beyond similarities in illness beliefs, biomedical care was also argued to be less easily accessible for a significant number of people, thus leading people to opt for care from indigenous healers (Appiah-Kubi, 1981; Biritwum & Jackson, 1997). As was shown in Chapter One, estimates of the human resources for biomedical care suggest that there is approximately one psychiatrist for every one million people in Ghana, with similar ratios of psychologists and social workers being reported, although there were a slightly higher number of mental health nurses working at various levels (Roberts et al., 2014). Furthermore, a large proportion of these professionals work in the relatively few urban sectors of the country, leaving a significant portion of the rural population with limited access to formal biomedical care. Given these estimated human resource limitations, Ofori-Atta, Read, et al. (2010) have estimated that only 2% of Ghanaians requiring mental health care had access to the needed help. Thus, a large proportion of the Ghanaian populace was thought to rely on non-biomedical health care, as this care was simply not available.

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Even for those who had access to biomedical facilities, another factor which has been suggested to account for the choice of using indigenous and faith healing for mental illness is the perceived high cost of biomedical services (Oppong, Kretchy, Imbeah, & Afrane, 2016; Read, Adiibokah, & Nyame, 2009). Some authors have suggested that the flexibility and the modes of payment accepted by indigenous healers were preferable to patients, as these enabled a type of barter system to be used (Konadu, 2007), even when the ultimate cost was higher than the biomedical cost. Patients were able to pay for services by offering to exchange them for poultry or other animals, pieces of fabric, or availing themselves to help with chores and other tasks that the healer may require (Bierlich, 2007; Tabi et al., 2006).

The general perception in early literature has therefore been that people chose to seek help from indigenous healers first because the biomedical services did not align with their beliefs (Aninyam, 1987). However, in a study of patients presenting to four facilities which provided mental health services in Kumasi, Appiah-Poku, Laugharne, Mensah, Osei, and Burns (2004) reported that fewer than 20% of patients had sought help from alternative healers for the first episode of illness. The majority of patients sought help from biomedical facilities despite the assumed supernatural illness beliefs. Likewise, in other studies, Read (2012, 2016) observed that many patients reportedly sought treatment from indigenous or faith healers only when the biomedical methods did not meet their expectations, or due to the perceived limited efficacy of psychotropic medications. Read (2012), therefore, argued that the pathways for mental health care were often driven not so much by illness beliefs about cause, but rather by expected outcomes and the desire for permanent solutions to their health problems.

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3.3 Traditional medicine practice development in Ghana: From informal community practice to formalised care

As has been mentioned above, indigenous healing processes were delegitimised and devalued during colonial times (Barimah, 2016). In fact, under British rule, the *Native Customs Regulation Ordinance* of 1878 banned indigenous healing practices outright (Senah, 2001). In addition to these official rules, the nature of cultural practice meant that indigenous systems evolved as cultures developed, and thus were often context-specific. This made it difficult to create a comprehensive picture of indigenous healing practices in Ghana. Prior to the 1950s, there was limited knowledge on the work of indigenous healers in Ghana generally. The limited knowledge also made recognition and regulation of their work difficult to accomplish.

With the attainment of political independence from colonial rule in the late 1950s, efforts were made to recognise and promote the work of indigenous healers in Ghana. In 1960, the first president of Ghana, Osagyefo Dr. Kwame Nkrumah, initiated the formal establishment of the Ghana Psychic and Traditional Healing Association, whose mandate was to promote the study of "herbalism" and "psychicism" in Ghana for application in the public health sector (Addy, 2005; Warren, Bora, Tregoning, & Kliewer, 1982). A further aim for the establishment of the association was to facilitate the organisation of indigenous healers, as well as to lend some respectability to indigenous medicine practice in Ghana, in contrast to the disregard which had existed during colonisation. Thirdly, the association was expected to eventually facilitate indigenous healers working alongside "orthodox practitioners" to treat illnesses, especially those for which there was no biomedical cure at the time (Senah, Adusei, & Akor, 2001; Warren et al., 1982).

This inaugural group experienced many challenges in achieving its mandate due to differences in beliefs and orientation. As a result of these challenges, several splinter groups

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emerged, such as the Plant Medicine Association, the Ghana Muslim Healers Association, and the Ghana Psychic Healers Association. Individuals whose orientations were considered similar formed these groups, and many of them still exist today. According to Mensah (2011), presently there are six major indigenous healers' association in Ghana, with numerous sub-groups.

By 1999, the fragmented nature of organised traditional medicine practitioners' groups had achieved very little by way of their intended mandate. Thus in November 1999, further efforts were made to unite the different associations through the establishment of a new body called the Ghana Federation of Traditional Medicine Practitioners' Associations (GHAFTRAM). GHAFTRAM was formed to serve as a unifying body for the different categories of indigenous healers. They further served as a liaison between the healers and the Ministry of Health.

In 1991, the Ministry of Health had established a Traditional Medicine Directorate (later renamed the Traditional and Alternative Medicine Directorate, TAMD) as a formal division. A new law of the Food and Drugs Board (PNDC Law 305B) was also introduced in 1992 to regulate the manufacture and sale of herbal medications on the market. These, together with the establishment of GHAFTRAM and the development of the Ministry of Health's National Strategic Plan for Traditional Medicine development in 1999, facilitated the enactment of the *Traditional Medicine Practice Act (Act 575)* in 2000. This Act mandated the formation of the Traditional Medical Practice Council (which was officially established in 2010) to license, regulate and oversee the work of traditional and alternative medicine practitioners in Ghana (Mensah, 2011; Senah et al., 2001).

The official recognition of alternative medicine in Ghana has therefore undergone some transformation over the years. Currently, the work of indigenous healers is governed by the Traditional and Alternative Medicine Division of the Ministry of Health, GHAFTRAM,

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the Food and Drugs Authority, and the Traditional Medical Practice Council (Addy, 2005). Specific to mental health, the recently passed *Mental Health Act (Act 846 of 2012)* refers to working with organised bodies such as GHAFTRAM to promote access to mental health care in Ghana.

Much of the effort at formal organisation of indigenous medicine has focused on the work of diviners and herbalists, and to some extent, the Muslim healers. However, there is less official organisation for the work of Christian faith healers. As discussed above, Christian faith healers are predominantly Pentecostal/charismatic in orientation. As such, healing is considered an integral part of their religious expression. Although such churches are required to be registered with the Ghana Pentecostal and Charismatic Council (GPCC), the prayer camps are not registered separately as health care facilities, primarily because their work may also include prayers for non-health problems. This presents difficulties for regulating and monitoring their work.

Although the efforts at organising alternative healers in Ghana have continued for some years, there are a significant number of healers who are not officially registered under any body. Some reasons that have been suggested for this include the need for secrecy in the work of some categories of healers, as well as the intertwining of religious activities with health outcomes in some forms of practice (Abukari, 2016; Mokgobi, 2013).

3.4 Collaboration between biomedical institutions and indigenous healers in Ghana

There have been many calls for the integration of the different forms of health care in Ghana, as in other countries (WHO, 2013). As we have discussed above, various factors account for the widespread use of alternative medicine in Ghana, including biomedical human resource constraints, as well as availability and perceived accessibility of indigenous and faith healers (Ae-Ngibise et al., 2010). As a result, there have been calls for and attempts at collaboration between the biomedical system and various alternative systems.

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One of the early-recorded collaborations between biomedicine and herbal medicine in Ghana was in the Mampong-Akwapim district in the 1940s. This was an initiative of a medical doctor, Dr. Oku Ampofo, who left government practice to set up a private practice with the aim of providing a recognised space for herbalists to practice alongside doctors (Evans-Anfom, 1986). This partnership was considered quite successful, and through this collaboration, Dr. Ampofo compiled lists of medicinal plants and herbal remedies that were commonly used by herbalists in the region. This initiative is credited as being foundational for the establishment of the Centre for Scientific Research into Plant Medicine (CSRPM) in 1975 (Evans-Anfom, 1986).

Following the successful partnership in the Mampong-Akwapim area, the Ministry of Health, together with the CSRPM and other local stakeholders, developed the Primary Health Training for Indigenous Healers programme (PRIHETIH) (Warren et al., 1982) in Techiman in the early 1980s. This programme aimed to provide biomedical primary health care training for indigenous healers to improve their methods. It sought to widen the collaboration between biomedicine and other healers, and therefore included herbalists, priests, traditional birth attendants, and traditional surgeons. Although the programme was met with much enthusiasm, an evaluation done ten years later showed that the healers' methods had not changed (Ventevogel, 1996). Aries, Joosten, Wegdam, and van der Geest (2007) speculated that the PRIHETIH programme failed to achieve its intended purpose because of the different pathophysiological orientations that existed between the different classes of healers, a difference which had not been taken into account when the PRIHETIH programme was developed. Konadu (2007) appeared to agree with this assertion, referring to the calls for integration as "an illusion". According to him, the unequal political and cultural power relations would result in the forceful assimilation of one system into the other, leading to the

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eventual disappearance of the weaker group – most likely, the indigenous healers (Konadu, 2007; van der Geest & Krause, 2014).

Despite the perceived failure of the PRIHETIH programme, other attempts at establishing collaborations have been reported (e.g., Amoah, Sandjob, Bazzoc, Leitea, & Biavattia, 2014; deGraft-Aikins, 2002; Krah, Kruijf, & Ragno, 2018; O'Brien et al., 2012). In 2011, the Ministry of Health, in a bid to begin integration of herbal and biomedical facilities, undertook a pilot study which introduced herbal units at hospitals. Small herbal medicine units were established in 17 hospitals across the country to provide patients with the option of purchasing certified herbal remedies (Boateng, Danso-Appiah, Turkson, & Tersbol, 2016). In reviewing this programme in one hospital in Kumasi five years later, Boateng et al. (2016) reported that the herbal and biomedical sectors at that hospital were running parallel to each other, rather than integrated with each other. Further, only few patients were aware of the presence of the herbal unit. The authors speculated that this was likely because of the absence of clear policies and guidelines on referral (Boateng et al., 2016). Thus, the different units existed separately, without working together as had been desired.

These reports are examples of collaborative programmes which were developed largely for primary health partnerships with traditional healers. With regard to mental health collaborations, attempts at integration have also been generally unsuccessful. Exploring the factors which hinder or promote partnerships between indigenous medicine practitioners and biomedical practitioners, Ae-Ngibise et al. (2010) observed that mutual distrust and scepticism, limited knowledge about practices, and concerns about human rights abuses were cited by different stakeholders as important barriers that have prevented successful collaborations between mental health professionals and indigenous/faith healers. The stakeholders in this study included indigenous healers, biomedical practitioners, and policymakers. Stakeholders in other studies (e.g., van der Watt et al., 2017) expressed similar

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sentiments. Doku et al. (2011) reported comparable stakeholders' views, but also included inadequate policy implementation as a factor which affected integration of mental health services in Ghana. Awenva et al. (2010) identified barriers to policy implementation, including a lack of political interest in mental health, inadequate policy dissemination, and an absence of research-based evidence for reform. The participants further advocated for collaborative efforts to be more inter-sectoral by including the educational, legal and development sectors of the country in order to achieve success.

Osafo (2016) similarly examined the possibility of a collaborative network between mental health professionals and religious leaders in Accra. In addition to the cited reasons above, religious healers also decried biomedicine's aversion to creating space for spiritual conditions, resulting in help-seeking stigma and territoriality. In order to achieve the desired integration of mental health service in Ghana, Osafo (2016) proposed a task-sharing model which incorporates a mutual appreciation for the work of the other.

This desire for mutual appreciation has been reported by indigenous/faith healers in other studies. There was a general perception among healers that biomedical professionals regarded them with some level of disdain, often dismissing their beliefs and methods (Ae-Ngibise et al., 2010; Asamoah et al., 2014; Osafo et al., 2015). In one study, staff at prayer camps indicated a keen interest in working with the biomedical field to provide technical and infrastructural support (such as medication), but desired to do so only if they were treated with respect (Arias et al., 2016). In a related study, Ofori-Atta et al. (2018) worked with one prayer camp to provide biomedical care in addition to the standard spiritual care to a randomised sample of patients at the camp. According to the authors, the goal was to show staff at the camp the effectiveness of biomedical methods, and to encourage collaboration between the two systems of care. Although the patients who were given medical treatment had better outcomes in the short-term than their control counterparts, the authors found no

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significant change in the methods and attitudes of the staff at the camp. This lends support to the arguments of authors such as Read (2012, 2016), that indigenous/faith healers are aware of the usefulness of biomedical medications for short-term relief of symptoms, but do not perceive biomedicine to provide better long-term outcomes.

In addition, the methods employed by Ofori-Atta and colleagues (2018) did not appear to seek an understanding of the prayer camp methods; instead, they appeared to simply demonstrate biomedicine's prowess to the religious healers. While this was a unique initiative in the drive for collaboration, it echoes Konadu's (2007) sentiments about the unequal power relations which make integration difficult. In this study too, the prayer camp staff appeared to recognise the benefits of medication, but felt that it did not provide the expected outcomes in the long run. Other studies with biomedical workers have shown similar attitudes towards the work of faith healers. The health care staff often recognised the usefulness of the spiritual engagement that religious healers employed, but were concerned about what they perceived as subjective and unstandardised methods, some of which were considered abusive (Ae-Ngibise et al., 2010; Arias et al., 2016).

Examining the role of indigenous/faith healers' perceived power in the treatment of mental illness in Ghana, Read (2017) argued that a critical element to be considered in the dialogue on integrating mental health services, was the practitioners' beliefs surrounding the power of each system of care to heal the patient. Collaboration between the different systems would need to take into consideration the contested notions of healing power held by different practitioners, in order to be successful. Read (2017) reasoned that indigenous/faith healers often positioned themselves as possessing healing power which could provide longer-lasting solutions to patients' problems than biomedicine. On the other hand, biomedicine was perceived by the healers to possess recognition and legitimacy in the national health

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framework. Such competing ideas about power and place in the healing hierarchy would influence the willingness to collaborate.

3.5 Chapter summary

In this chapter, I outlined the different facets which make up the field of indigenous medicine in Ghana. With this, and the previous chapters, as a backdrop, I now turn to the views and beliefs of the participants that I interviewed, to provide further information about alternative care for mental disorders in Ghana.

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PART 2: EXPLANATORY MODELS OF INDIGENOUS/FAITH HEALERS

In Part 1, I presented the background, rationale and previous literature for this study. Part 2 begins the results sections of this dissertation. In this part, I discuss how the healers conceptualised different disorders. The analysis of the healers' beliefs included their notions of the nature, course, and perceived impact of the different disorders.

Part 2 therefore comprises three published articles in the following chapters:

i. Chapter Four (Article 1): The healers' explanatory models for mental disorders

ii. Chapter Five (Article 2): The healers' explanatory models for epilepsy

iii. Chapter Six (Article 3): The healers' explanatory models for intellectual disability

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CHAPTER FOUR: ARTICLE 1

Explanatory models of mental disorders among traditional and faith healers in Ghana

4.0 Introducing Article 1

This chapter contains the first of the eight articles which form part of this dissertation. In this paper, I used the explanatory models of illness framework to examine the beliefs of the different categories of indigenous and faith healers about mental disorders. I explored their beliefs about causation, onset, prognosis and impact of three disorders; namely, schizophrenia, major depression and posttraumatic stress disorder (PTSD). Through this paper, I sought to investigate how the healers conceptualised different types of mental disorders as classified by biomedical understanding, examining whether there were differences between the different categories of healers.

The findings suggest that there were some differences in the conceptualisation of mental disorders with regard to biomedical classifications, and (for some disorders) between the various types of healers.

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Explanatory models of mental disorders among traditional and faith healers in Ghana

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ABSTRACT

Traditional and alternative medicine is an integral part of the mental healthcare system of many African countries. The treatments and practices of these traditional and alternative healers will be influenced by their ideas about the causes and effects of mental disorders. With the concept of explanatory models of illness as a framework, we examined the notions of different categories of traditional and faith healers about mental disorders. Using case vignettes, we conducted interviews with 36 participants to explore their beliefs about the causes, course and effects of a serious mental disorder, a common mental disorder and a disorder driven by social circumstances. From our data, there was consensus about what constituted a serious mental disorder. However, the other disorders were not seen as mental disorders. Although there was an acknowledgement of biological and social causes of serious mental illness, the dominant view was that of supernatural causes. The most significant effect of mental illness reported was a loss of social connectedness and productivity. These models are discussed with reference to their implications for collaboration, mental health literacy efforts, as well as biomedical practice.

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Introduction

In recent years, the efforts to scale up mental healthcare in low and middle income countries (LMICs) have placed much emphasis on acknowledging and understanding traditional/alternative medical (TAM) systems of care (Gureje et al., 2015; Gureje & Lasebikan, 2006). These systems are widely used in African countries (Saxena, Thornicroft, Knapp, & Whiteford, 2007). TAM refers to systems of knowledge, skills and practices which are used to diagnose and treat illness. They are based on indigenous ideas, beliefs and values of specific people, regarding illness and health (WHO, 2013). TAM incorporates the cultural and ideological framework of the people who utilize it, and as such is a popular avenue of care for many people experiencing mental distress in settings where formalized biomedical care is limited (Chowdhury, 2016; Crawford & Lipsedge, 2004; Nortje, Oladeji, Gureje, & Seedat, 2016).

The TAM system is also rooted in African traditional religious beliefs and concepts. These concepts include a notion of health and wellness as a state of cosmological balance in the individual's physical, mental/emotional and social life (Asamoah-Gyadu, 2013; Opoku, 2002; White, 2015). TAM healing therefore involves contextual knowledge about folklore, accepted behaviours for good health, in addition to herbal remedies (Tabi, Powell, & Hodnicki, 2006).

Thus, TAM plays a significant role in modern healthcare in African countries such as Ghana, due to its perceived affordability, easier access to TAM services by people in rural areas, and the

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contextual knowledge that the healers possess, given their presence within their patients' communities (Ae-Ngibise et al., 2010; Musyimi, Mutiso, Nandoya, & Ndetei, 2016; Ofori-Atta et al., 2010). In addition to these, in more modern times, the upsurge of Pentecostal/charismatic churches in Africa has resulted in a marked increase in Christian faith healing establishments (called 'prayer camps') where alternatives to biomedical care are provided (Arias, Taylor, Ofori-Atta, & Bradley, 2016; Edwards, 2014; Gifford, 2004).

TAM practitioners therefore constitute a major portion of the healthcare workforce, particularly for mental health. The WHO (2013) estimated that up to 80% of mental disorders are treated by traditional healers. Given their positioning, these healers' practice will be influenced by their understanding of mental disorders, and are therefore worth examining.

The concept of explanatory models of illness (EMs; Kleinman, 1980) is a useful way of examining the healers' beliefs and ideas about mental disorders. According to Kleinman, explanatory models are 'the notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process' (p. 105). These explanatory models influence help-seeking behaviours, treatment compliance and satisfaction for patients (Callan & Littlewood, 1998), and may also influence choice of therapy for both patients and practitioners (Kleinman, 1980). Thus, the explanations given to the type of illness, the reasons for onset, and the recommended treatments are important to explore from the perspective of the patients, their support networks as well as the healers (Dinos, Ascoli, Owiti, & Bhui, 2017).

Some previous studies have been carried out to explore EMs of non-western people in different contexts (eg Bhui & Bhugra, 2002; McCabe & Priebe, 2004a). These studies reported explanatory models which emphasized either biological, psychosocial or supernatural factors. The models differed based on ethnicity, education, as well as socio-economic status (McCabe & Priebe, 2004b; Shankar, Saravanan, & Jacob, 2006).

Similar studies have been conducted to examine the EMs of people in different African countries (eg Abbo, 2011; Aidoo & Harpham, 2001; Alem, Jacobsson, Araya, Kebede, & Kullgren, 1999; Okello & Neema, 2007; Ventevogel, Jordans, Reis, & de Jong, 2013). For instance, Patel (1995) reviewed studies from 11 sub-Saharan African countries which reported on explanatory models of mental illness. Despite the diversity of illness beliefs found, and the strong emphasis on spiritual causation, he determined that there was an awareness of the distinction between mind and body, thus sharing some similarity with western illness beliefs.

Focusing specifically on healers' EMs, Teuton, Bental, and Dowrick (2007) reported an emphasis on both spiritual and physical models for psychotic conditions among Ugandan healers, although the spiritual explanations were more dominant. Similarly, Sorsdahl, Flisher, Wilson, and Stein (2010) examined South African healers' EMs, and asserted that they held multiple simultaneous EMs, suggesting complex and fluid notions of mental illness. Comparable research has been reported with traditional healers in other countries including Ethiopia (eg Alem et al., 1999; Monteiro & Balogun, 2014), Nigeria (eg James, Igbinomwanhia, & Omoaregba, 2014), Kenya (eg Muga & Jenkins, 2008), Zambia (eg Aidoo & Harpham, 2001), Uganda (eg Abbo, Okello, Ekblad, Waako, & Musisi, 2008; Okello & Neema, 2007), Zimbabwe (eg Patel, Musara, Butau, Maramba, & Fuyane, 1995), Sudan (eg Haugum, 2011) and Tanzania (eg Gessler et al., 1995).

Thus, there has been some focus on how TAM practitioners conceptualize mental disorders in some African countries. However, relatively little has been written about the EMs for mental disorders of TAM practitioners in Ghana. Some research has explored Ghanaian pastors' notions about mental health (eg Asamoah, Osafo, & Agyapong, 2014; Osafo, Agyapong, & Asamoah, 2015); others have looked at the use of TAM services by Ghanaians (eg Ae-Ngibise et al., 2010; Ofori-Atta et al., 2010; Quinn, 2007); others have looked at the types of conditions that traditional healers typically treated (eg Osei, 2001), as well as some reports of traditional medicine policy in Ghana (eg Doku et al., 2008; Tsey, 1997). However, to our knowledge, there are no documented studies which have examined the explanatory models of different categories of TAM practitioners in Ghana.

In this paper, we contribute to the discourse on traditional medicine in Ghana by looking at the differences and similarities which may exist among different categories of Ghanaian TAM practitioners regarding mental disorders. We examine how they conceptualize different mental disorders and the perceived effects on the patient, as well as their perceptions of the course of the different disorders. Although perceptions of appropriate treatment also form part of EMs, we do not report on the different treatment regimes in this paper. Analyses of TAM treatment methods for mental disorders have been reported elsewhere (for herbalists' methods, see Kpobi, Swartz, & Omenyo, in press); for traditional medicine men's methods, see Kpobi & Swartz, 2018; manuscripts for Muslim healers and Pentecostal/charismatic healers are currently under consideration.

Methods

Setting and participants

The study was set in the Greater Accra Region of Ghana. Initial recruitment of participants was done through the Ghana Federation of Traditional Medicine Practitioners' Associations (GHAFTRAM). Most categories of TAM practitioners have associations which serve as a way to organize them in terms of their work, roles and, periodically, training. GHAFTRAM is a body which brings together all the various organized groups of traditional healers, and works with the Ghana Traditional Medicine Practitioners' Council to monitor, regulate and promote TAM in Ghana. Through GHAFTRAM, we purposively recruited healers who treated mental disorders from different categories.[1] Other participants were recruited through the Ghana Pentecostal and Charismatic Council (GPCC), which oversees the work of Pentecostal/charismatic churches. Through snowballing, as well as personal networks, we engaged additional participants to make up the final sample for this study.

A total of 36 participants took part in this study, comprising eight traditional herbalists, ten Muslim healers (called *mallams*), ten Pentecostal/charismatic ministers and eight shrine devotees/medicine men.

Procedure

This study received institutional ethics approval from Stellenbosch University. Additional ethics approval was obtained from the Ghana Health Service Ethics Review Committee, as well as the Ghana Traditional Medicine Practitioners' Council. Further permission was obtained from GHAFTRAM and the GPCC. Once all permissions were obtained, suitable participants were recruited. The participants were informed of the objectives of the study and their rights as participants.

With verbal and written consent, individual semi-structured interviews were conducted. The interviews were conducted in English, Ga or Twi (the languages most commonly spoken in the Greater Accra Region), depending on the language that the participant was most fluent in. All interviews were audio-recorded with the consent of the participants.

Most of the interviews were conducted by the first author, who is female and is fluent in English, Ga and Twi. However for some of the participants, a male research assistant was recruited to conduct the interviews. This was because cultural and/or religious rules prevented some male participants from speaking directly to a female. The research assistant was a psychology graduate who was fluent in all three languages, was trained for the purposes of this study, and was closely supervised by the first author.

In order to explore the healers' perceptions of different disorders, three case vignettes were presented to facilitate the discussion. One vignette each of a serious mental disorder (schizophrenia), a common mental disorder (depression) and one which reflected common social situations (post-traumatic stress disorder, PTSD) were used. The interviewer read each case to the participant, and asked them questions to explore their views on the nature of the problem, what caused such problems, what effects the problem could have for the patients, as well as how they would

treat the problem. The interview schedule was developed based on the eight core EM questions (see Kleinman, 1980).

For this paper, we examine the TAM practitioners' explanatory models of the nature, causes, effects and course of the disorders. As indicated above, we have analysed the healers' treatment methods in more detail in other manuscripts.

Data analyses

All interviews were transcribed verbatim by the first author. The data were analysed at two levels. The first level involved coding and making interpretations of the healers' descriptions of the nature, cause and course of the different disorders. At the second level, the analysis focused on the participants' own interpretations of the causal factors, effects and course of the disorders. The ideas and opinions that each participant provided were analysed in themselves, but also in comparison with those related by other participants. Data were analysed using ATLAS.ti qualitative data analysis software (v.8). The main ideas that emerged are presented as results below.

Results

Traditional healers' explanatory models for different disorders were elicited through case vignettes which were read to them to facilitate the discussions. Each vignette, and the participants' formulations of each case, are outlined below.

Schizophrenia

Case vignette on which participants were asked to comment: 17-year-old Kwame has, over the past three months, behaved in an unusual manner. His parents report that he can often be found whispering to himself and seemingly having a conversation with someone he calls 'Sir', whom he says is 'in the heavens'. He insists that the voices he hears run a commentary on his behaviour. Whenever his parents try to speak to him during these conversations, Kwame becomes aggressive and threatens to kill them because he believes they 'want his downfall'. On other occasions, he is extremely terrified and believes his teacher is out to get him because he has been ordained by God to redeem his country. As a result of his fears, Kwame has become withdrawn, no longer bathes or changes his clothes, and his school performance has seen a marked decline.

Participants' formulations: All the participants agreed that Kwame had a mental disorder. Depending on what language the interview was conducted in, they called Kwame's condition 'madness' or *sɛkɛ* (in Ga) or *abɔdam*/*ɛdam*/*adambɔ* (in Twi). These names are commonly used to describe a condition where the person's behaviour is considered unusual, disruptive and/or unpredictable. The descriptions bear much similarity to biomedical notions of psychotic behaviour.

> That is what we call *abɔdam* … it is something that changes a person completely … the person's whole behaviour is very strange, and he starts acting like he is not even a human being … walking about naked, eating food from the gutter and so many things … they can get angry very easily … and they cause trouble everywhere … . (F2, shrine priest)

All the participants believed that supernatural factors such as curses, witchcraft, malign spirits, punishment for wrongdoing, etc. could cause this type of illness. However, all but three participants acknowledged that there could be other causes. When asked to indicate the other causes, 31 of the 36 participants (corresponding to 86%) suggested that drug or alcohol abuse was the most likely other cause. Further, 28 participants (corresponding to 78%) stated that traumatic brain injuries resulting from car accidents could also cause such behaviour. Others believed that such conditions could be genetic and run through families.

Despite these admissions, most of the participants explained that there were instances when spiritual means could be used to orchestrate road traffic accidents which would then result in brain injury. Similarly, a curse could be placed on an individual which would make him/her become addicted to drugs, and consequently to become 'mad'. In addition to these, curses or karmic punishment could result in mental illness for individuals whose behaviour was judged as immoral. Thus, the healers held multiple causal explanations for mental disorders. These were dominated by supernatural and behavioural explanations.

When asked about the severity of the condition, again all the participants indicated that it was a very serious problem which required immediate intervention. Many of them believed it would negatively impact the patient's life. Beyond the physiological problems which may arise from actions such as eating contaminated food, the disruptive behaviour also tended to push people away from them, thus resulting in social isolation. Some believed it could result in death if left untreated.

> It is a very serious thing! Because it changes you and if you're not careful the person can even die … they won't be able to live a normal life because of how the sickness makes them behave … and also the things they do … so as soon as you realize that this person is becoming mad, you have to quickly rush and get help so that he doesn't become worse. (H7, Herbalist)

Post-traumatic stress disorder (PTSD)

Case vignette on which participants were asked to comment: Esi was with her sister when they were involved in an accident six months ago on the Kumasi road. Her sister was crushed to death right beside Esi. After this accident, Esi has not been herself; she feels guilty about the loss of her sister because they were travelling to an event that she had arranged. She is unable to concentrate on any tasks, and sometimes she feels like she is not present in her body. Over the past six months, Esi has flashbacks of the accident and sometimes has bad dreams about it. She then becomes agitated and is unable to sleep. Since the accident, Esi has not been able to travel on that road, and sometimes feels afraid when she sees a car which resembles the one that they were in. She startles very easily when she hears a car screeching, and has become quite irritable.

Participants' formulations: All the participants agreed that Esi had a problem, but only three of the 36 participants thought this was a mental disorder. The other 33 believed she was simply having a hard time adjusting to the loss of her sister. They stated that it was a normal reaction to have, considering the gravity of the traumatic experience. Those who thought Esi had a mental disorder said her symptoms were due to 'thinking too much' or 'feeling bad' because of the circumstances of her loss. Some of the Pentecostal pastors in our sample indicated that she had allowed 'a spirit of fear' to take over her life.

When asked about the causes of her symptoms, the participants stated that Esi was behaving in that manner due to the traumatic experience she had gone through. None of the participants believed the symptoms by themselves were spiritual in nature. However 28 of them (about 80%) indicated that the accident which resulted in the trauma could have been orchestrated through spiritual means. The three participants who believed Esi suffered from a mental disorder (all of whom were herbalists), also believed that if she did not get help, the problem could develop into full-blown madness.

All the participants agreed that she required some kind of intervention to be able to overcome her problem. They all advocated counselling as a key intervention, but depending on the orientation of the healer, they recommended different activities to supplement the counselling. Most of the herbalists, for instance, recommended that the patient be given a herbal sedative to help her to sleep better. They stated that once she was able to sleep, she would not be able to 'think too much', hence the fear, guilt and irritability would gradually fade. Similar sentiments were expressed by the shrine priests, with some of them prescribing an additional process of protection from further accidents. These protections came in the form of amulets or charms. Perhaps unsurprisingly, the pastors and *mallams* included prayer as an additional intervention.

> With this kind of case, she needs to get some serious counselling … because she is struggling to understand why her sister died just like that … Yes, so she has to go for counselling, so that we can help her.

Thus, the participants' explanatory models for PTSD were predominantly psychosocial in nature. The recommended treatments included both psychosocial and herbal methods.

Depression

Case vignette on which participants were asked to comment: Elsie complains that she just can't get out of her sad mood. She can't seem to find the energy to do anything these days, and gets tired easily with very little exertion. Her work as a journalist, which used to excite her, has suffered because she can't concentrate, she has lost interest in all aspects of the work, and she feels incompetent at her job. Although she feels tired all the time, she can barely sleep through the night anymore and constantly finds herself waking up after only a few hours of sleep. This has been going on for about a month.

Participants' formulations: in conceptualizing this case, some of the herbalists (ie five of the eight herbalists in our sample) suggested that the symptoms were indicative of a physiological problem and not a mental disorder. When pressed for details, they gave examples of problems such as underlying stomach ulcers, other dietary problems, menopause and stress reactions, as factors which could result in such symptoms.

However, several of the pastors in our sample used the word depression to describe this case and agreed that it was a mental disorder. They believed that it resulted due to the patient's inability to cope with some stressor in her life, and had developed from 'thinking too much'.

> Yes, that is also a mental problem, but it is not like the madness … I think you people call it depression … it often happens with ladies. I'm sure the lady has many problems in her life and she can't cope. So she will be thinking about it all the time … and then it makes her sad. (P3, Prophet)

Other healers indicated that this was a milder form of madness, using terms like *bɔdam anitie* (in Twi), and *sɛkɛ jwɛn* or *omanfo sɛkɛ* (in Ga). These names translate as 'clever madness' or 'a mad person who is clever/smart'. In other words, they believed it was a precursor to madness, and had not yet deteriorated into full-blown madness, since the person was lucid and somewhat aware of their behaviour. They believed this could be caused by stressors, but could also result when someone envied the patient's success and 'bought' the curse through witchcraft to afflict the patient. Some of the Muslim healers believed that the patient could behave this way when they were possessed by *Jinn*, which tormented them.

All the participants cautioned that, at this stage, the person could easily be helped to prevent the condition from developing further. For the herbalists, the avenue of help was an exploration of the physiological problem and providing treatment for it. The pastors advocated counselling, prayers and fasting, with or without the use of prayer aids like holy water or anointing oil. Similarly, the *mallams* and medicine men used various prayers and incantations to treat such a condition.

Discussion

The data obtained in this study confirm that there are multiple explanatory models about mental disorders held by traditional and faith healers in Ghana. These models are fluid and complex, sometimes held simultaneously, but may also vary depending on the nature of the condition. Severe conditions such as schizophrenia which result in overt disorganized or disruptive behaviour are clearly seen as mental disorders. Further, there was much agreement among the healers about the potential course of such illness and its effect on the life of the patient.

For the vignette of a common mental disorder (ie depression), there was much less agreement that it was a mental disorder. The participants who considered the case to be a mental disorder were typically pastors who were comparably more formally educated, suggesting perhaps an exposure to more

western ideas about mental illness. The herbalists' emphasis on physiological problems may similarly be a reflection of their training and experiences.

There was consensus among the participants that someone presenting with symptoms suggestive of PTSD was not mentally ill. Such symptoms were considered socially appropriate reactions given their exposure to some traumatic experience, signifying that they had an appreciation for the potential psychological effects of stressors and other social factors.

Therefore, a person was seen as having a mental illness when their behaviour was bizarre, aggressive or disruptive. This is also seen in the description of depression as a precursor to actual madness. The use of descriptions such as 'clever madness' also suggests a belief that persons living with a mental disorder possessed some intellectual deficit. For those healers who saw depression as a mild form of madness, they appear to believe that depression could be a deteriorating condition resulting in serious mental disorder, as indicated through their advice to seek immediate help for the patient.

Generally, the causal explanations for the different disorders involved some element of spiritual influence, despite the differing views on whether or not the symptoms constituted a mental disorder. There was a prevailing belief that what may appear as a physiological condition, may have been brought about (or could be exacerbated) through spiritual means. Thus, even when the participants acknowledged a behavioural or genetic factor as the cause of the disorder, there were usually attempts to ascertain whether it had been triggered due to supernatural means such as ancestral curses or bewitchment.

Another prevailing supernatural notion was that mental disorders could be caused by immoral or socially unacceptable behaviour. As Opare-Henaku and Utsey (2017) put it, mental illness was seen as a retributive condition. This was particularly prevalent among those who spoke about drug and alcohol abuse as possible causes of severe mental disorder. Similar sentiments were expressed when the person was seen as having been cursed on account of marital infidelity, crime or a disregard for cultural values, emphasizing the idea that living with a mental disorder may be a consequence of moral failing. This view stresses the idea of social justice as a factor in the aetiology of mental illness (Teuton et al., 2007); that is, people who did not behave in a manner which was socially acceptable in some way deserved their fate. It also highlights the stigma attached to some mental illness. On the other hand, for those who saw severe mental disorders as a spiritual attack from an adversary, the prevailing notion was one of sympathy.

The perceived effects of all three conditions were largely serious, with the most prominent effect being the loss of social connectedness. The participants often stressed the fact that the psychotic behaviour of the mentally ill caused social isolation, given people's fear that they would be harmed by the patient. They also emphasized the inability of such people to hold meaningful work, and to properly perform activities of daily living. Given the interdependent and communal nature of many communities in Ghana, the loss of productivity constituted a major effect, and may require greater input from the patients' social circles in terms of health-seeking avenues as well as treatment compliance (Olafsdottir & Pescosolido, 2011).

Finally, it appears that the mental health literacy of the practitioners was relatively low. This presents some concern about misdiagnosis and treatment. Although many of the participants indicated that depression and PTSD were normal reactions to stressors, these conditions present risks of harmful behaviour such as suicide, if left untreated. Thus, the mental health knowledge of TAM practitioners is important to assess, in order to avoid potential negative outcomes for patients, arising from misdiagnoses or delayed interventions.

The findings reported above are similar to what has been reported in other studies on explanatory models in Africa. In particular, the emphasis on spiritual causes is not unknown among traditional healers in other African countries (eg Abbo, 2011; Mzimkulu & Simbayi, 2006; Patel, 1995; Sorsdahl et al., 2010). However, there was an acknowledgement of psychosocial factors as causative agents for mental disorders, and this bears some similarity to the biomedical model (Shankar et al., 2006). The perception of mental illness as synonymous with psychotic behaviour has also been reported in studies in other African countries such as Nigeria (eg James et al., 2014), Uganda (eg Teuton

et al., 2007), Zimbabwe (eg Patel et al., 1995) and Zambia (eg Aidoo & Harpham, 2001). Unlike the similarities found in these countries, in some South African studies (eg Sodi et al., 2011; Sorsdahl et al., 2010), there was a further differentiation within psychotic behaviours which were pathological and that which was a reflection of ancestral calling. However, this distinction was not found in our study.

Finally, the idea of mental illness and social isolation has also been discussed in other studies (eg Adewuya & Makanjuola, 2008). This isolation does not affect just the individual, but may be reflected in the attitudes towards other family members. As some of our respondents suggested, marriage and childbirth are important components of communal relations, and an association with mental illness may hinder such relations. Additionally, the belief in adversaries or enemies causing mental illness may put a strain on familial and other associations, imposing further social distance for the individual. However, the healers' valuing of social connectedness may be reflected in the treatment programmes that are developed for the patient, and could be a useful resource for psychosocial rehabilitation and re-integration of patients.

Conclusions

The use of explanatory models of mental disorders provides a useful means of understanding lay concepts of mental illness. In this study, we explored traditional and faith healers' perceptions of serious mental disorder (schizophrenia), common mental disorder (depression) and a disorder resulting from social conditions (PTSD). Their views on what constituted a serious mental disorder were similar to biomedical definitions. However they had differing views of depression and PTSD.

Given the traditional healers' positions within the communities of their patients, and given the pluralistic nature of health-seeking of patients in Ghana (Ae-Ngibise et al., 2010; Ofori-Atta et al., 2010; Read, 2017), knowledge of their explanatory models can form an important component of clinical training and practice. With an understanding of the fluid nature of explanatory models, clinical training can advocate for better attention and appreciation of the positioning of the patients by clinicians. Those in practice can harness the patients' existing beliefs and utilize them in the development of treatment programmes.

In addition, understanding their views on mental disorders is important in light of efforts to develop a more integrative healthcare system for mental health. Referrals and community re-integration can be facilitated better with such insights. Their placement within the community can be a useful resource for fostering behaviour change for patients who require it, and also for ensuring compliance with treatment.

Although specific treatment methods were not examined in this paper, of note is the fact that the participants advocated counselling as an important means of helping people with non-psychotic mental disorders. The pastors in particular shared the view that biomedical counselling could also be used to help the patient if the cause was not a spiritual one. Such sentiments are encouraging and may serve as facilitators for collaboration between healthcare systems.

Finally, since the more-educated pastors were better able to identify with biomedical models of depression, education appears to be an important factor in mental health literacy. Given the pastors' positions, they are very well placed to partner with other health systems to engage in public mental health education and promotion efforts.

Our study does have some limitations which are important to note in interpreting these findings. The first limitation is the fact that this was a relatively small group of participants. Certainly, our conclusions cannot be said to be representative of the views of all traditional healers in Ghana. Related to this limitation is the fact that our participants were all located in the Greater Accra Region of Ghana. Although the Greater Accra Region has a high level of migration of people from other parts of the country, its largely urban composition may present different outcomes when compared to a typical rural setting. A further limitation was the use of languages other than English to elicit labels and concepts of mental disorders. Although the first author is a native speaker of Ga and

Twi, the translation of key terms and concepts into the local languages and back translating into English presents some risk of error. Finally, the participants' descriptions were in response to specific vignettes. Hence, it is possible that their responses to actual cases may vary.

Despite these limitations, we have reported some important insights into the conceptualization of mental disorders by different categories of healers in a pluralistic healthcare setting. These explanatory models contribute to the knowledge of TAM practice in Ghana, and can inform plans towards achieving more integrated mental healthcare in the country.

Note

1. The different groups of healers classify themselves based on orientation, creed, methods and/or beliefs. We thus used these pre-established categories of healers as a guide.

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CHAPTER FIVE: ARTICLE 2

Ghanaian traditional and faith healers' explanatory models for epilepsy

5.0 Introducing Article 2

Similar to the previous article, Article 2 describes the explanatory models of the healers. In this article, I examine the beliefs and ideas of indigenous and faith healers about epilepsy. As one of the mental, neurological and substance use disorders (MNS), epilepsy figures in low- and middle-income countries (LMICs) suggest that it is one of the most common neurological disorders. Although epilepsy is not a mental disorder, it is commonly treated through alternative means, as is the case for psychiatry. This is likely due (in part) to the limited number of biomedical professionals available in LMICs. In addition to these factors, epilepsy is often associated with psychiatric co-morbidity.

The participants who formed part of this study all indicated that epilepsy care was part of their work. I therefore examined their beliefs about epilepsy, assessing their views on the nature of epilepsy, its causes, and perceived impact. The healers' views about the nature and causes of epilepsy included social, biological and supernatural factors. These were sometimes held simultaneously.

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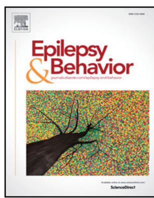
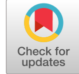


Ghanaian traditional and faith healers' explanatory models for epilepsy



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ABSTRACT

Epilepsy is the most common neurological condition in sub-Saharan Africa. A significant number of people with epilepsy in low- and middle-income countries do not receive formal biomedical care. They utilize the services of various traditional and alternative medicine practitioners. However, there is relatively little information about the beliefs and methods of alternative healthcare providers about epilepsy in many African countries. Using explanatory models of illness framework, we interviewed thirty-six traditional and faith healers in Ghana on their beliefs and perceptions about epilepsy, as well as how they would treat epilepsy. The healers' beliefs about the nature of epilepsy were reflected in the labels they assigned to the condition. These indicated a belief in the influence of the moon in epilepsy. Furthermore, the participants held multiple, simultaneous explanatory models of causes for epilepsy, including biological, social, and supernatural causes. Epilepsy was also considered to have serious social implications for patients, especially for women. Finally, their treatment methods involved a range of herbal and spiritual practices. These varied based on the identified cause of the condition, as well as the orientation of the healer. We discuss these findings with reference to their implications for potential collaboration between biomedical and alternative healthcare systems.

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1. Introduction

In sub-Saharan Africa, epilepsy is the most common neurological condition, with approximately 80% of people with epilepsy (PWE) originating from countries in this region [1–3]. Despite the high prevalence of epilepsy in less developed countries [4], it is estimated that about 75% of PWE in low- and middle-income countries (LMICs) do not receive formal biomedical care [2,5]. Some of the reasons accounting for this wide treatment gap include the limited availability and access to primary care facilities or neurologists, as well as cultural explanations for epilepsy and the stigma associated with such a condition [6].

These reasons, among others, may explain the preference of some PWE to seek treatment from traditional/faith healers [7], as is the case for other conditions and disorders. Traditional and faith healing systems are built on the beliefs, values, and customs of specific communities [8]. Thus, traditional and alternative health practitioners' explanations about epilepsy are typically based on the cultural understandings and experiences of epilepsy. Given their positioning within communities, such explanations may influence how PWE are treated [9,10].

In light of the wide biomedical treatment gap for epilepsy in many African countries, the use of traditional and alternative medicine (TAM) is common [9]. Given this widespread use, it is important to understand the perceptions and beliefs of traditional and alternative healers about epilepsy. One way of achieving this understanding of their beliefs about epilepsy is by examining their explanatory models (EMs) [11].

The concept of EMs of illness allows a deeper exploration of people's beliefs about a condition. It enables the assessment of their perceptions of the cause of the illness, its course, and what effects the condition is perceived to have on the individual [11,12]. The models also explore preferred treatments for the condition. Despite the high patronage of TAM by PWE in African countries, there is limited documented information about the explanatory frameworks that the healers possess, and which inadvertently influence their treatment for epilepsy. By exploring EMs of traditional healers for a condition such as epilepsy, we can achieve a clearer understanding of how they explain and treat the illness, and the outcomes they expect. Furthermore, because of TAM healers' positions within the community, their beliefs about epilepsy are likely to be congruent with those of their patients. Such knowledge provides further avenues for facilitating collaboration dialogs between biomedical and TAM systems of healthcare.

Previous research has been conducted on the beliefs and attitudes of laypeople in different African countries about epilepsy. In these generally small-scale studies, epilepsy was typically reported to be believed to be caused by curses or witchcraft, and a punishment for sin [13–16], although there was also some recognition of biomedical factors such as brain injury and perinatal conditions [9,17]. The attitudes of communities towards epilepsy were also generally negative. Epilepsy was viewed as a contagious disease in some studies, with PWE experiencing stigma and discrimination [1,13,18,19]. Some exploration of gender differences has also been studied, with Ae-Ngibise et al. [20]

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reporting a high prevalence of active convulsive epilepsy (ACE) among males in the Kintampo district of Ghana.

These studies have generally been conducted among community members. However, there have been other studies which examined the perceptions of traditional healers about epilepsy and the methods that they used to treat it (e.g., in Zambia [21]; in South Africa [9,10]; in Kenya [22]; in Burkina Faso [23]; and in Tanzania [24]). Some of the treatments that have been reported include cleansings, scarification, and various herbal methods. According to Adjei et al. [1], traditional healing often involved restoring social balance following some wrongdoing. Thus, the methods were thought to work at righting a wrong.

Although some studies have been conducted on epilepsy in Ghana (exploring lay beliefs [25,26], biomedical care for epilepsy [27], and examining attitudes towards PWE [1,19]), to our knowledge, there is no documented study which has reported on the beliefs of Ghanaian traditional and faith healers about epilepsy. In this study, we examined the EMs of epilepsy as held by TAM practitioners in Ghana.

2. Methods

2.1. Research design

This study used an exploratory qualitative design to examine the EMs of epilepsy that were held by different categories of traditional and faith healers in Ghana. We made use of the explanatory models of illness framework through a case vignette to elicit participants' views and explanations of epilepsy.

2.2. Research setting and participants

This paper reports findings which form part of a larger study on traditional and faith healing in Ghana. It was set in the Greater Accra Region of Ghana. In order to gain access to different categories of TAM practitioners, we liaised with the Ghana Federation of Traditional Medicine Practitioners' Associations (GHAFTRAM), which is a body that organizes and oversees the practice of different categories of traditional healers in the country. Their membership includes herbalists, Muslim healers, as well as traditional medicine men/shrine priests.[1] In addition to the GHAFTRAM members, we also contacted the Ghana Pentecostal/Charismatic Council (GPCC) to identify potential Christian faith healers. Additional participants were recruited through snowballing. The inclusion criteria that was used to select participants included the healer living or working in the Greater Accra Region, having practiced for at least five years, and being able to speak English, Twi, and/or Ga (these are the predominant languages spoken in Accra).

Thus, our participants were organized into four different categories of healers: we spoke with traditional herbalists, traditional medicine men (also called shrine/fetish priests or devotees), Muslim clerics/healers, and Pentecostal/charismatic Christian pastors/healers. In total, thirty-six healers were interviewed for this study, comprising ten pastors, eight traditional medicine men, ten Muslim healers (locally called *mallams*), and eight traditional herbalists. In Table 1 below, a summary of the demographic characteristics of the respondents is provided.

Table 1
Summary of demographic characteristics of participants.

Characteristic	Number (%)
Gender	
Female	5 (13.9%)
Male	31 (86.1%)
Type of healer	
Herbalist (H)	8 (22.2%)
Shrine priest (F)	8 (22.2%)
Mallam (M)	10 (27.8%)
Pastor (P)	10 (27.8%)
Mean age	54.6 years
Mean years of practice	28.1 years

2.3. Procedure

Ethics approval for this study was provided by Stellenbosch University Humanities Research Ethics Committee, as well as from the Ghana Health Service Ethics Review Committee. We also obtained permission from the Ghana Traditional Medicine Practitioners' Council, GHAFTRAM, and the GPCC before any data were collected. Once potential participants were identified, the purpose of the study was explained to them. They were also informed about their rights as participants and about what to expect from the interview process. Verbal and/or written consent was obtained from all participants before any data were collected.

Given the stigma that is culturally associated with epilepsy, in order to begin the conversation on epilepsy, we elected to use the vignette method to conduct the interviews. The vignette method is useful for facilitating discussions on sensitive topics because of its use of the third-person approach; thus enabling the participants to speak more comfortably on the subject [28]. The following case vignette was presented to the participants:

> Etornam is an 18-year-old boy with a history of convulsions since he was six months of age. Although these were infrequent in his early childhood, they increased to three to four seizures per day when he reached puberty. When describing the onset of an episode, he said that the initial feeling was usually a tightness in his head and chest, followed by sweaty palms, and then he would briefly lose consciousness. His family reported that sometimes when Etornam had an episode, he would smack his lips, and was generally unresponsive to those around him. During the seizure, he is unable to talk but he says he can hear, although he cannot fully process information.

Once this vignette was read aloud to each participant, semistructured interview questions were used to examine individual healers' beliefs about epilepsy. The interview questions were based on the eight EM questions as developed by Kleinman [11] and the methods used by Keikelame and Swartz [9]. The interview included questions such as 'What do you think caused the illness?', 'What do you think the illness does to the patient? How does it work?', and 'How severe do you think this illness is?' The questions were asked to assess the healers' explanations of the nature and cause of epilepsy, as well as their views on treatment and prognosis.

The interviews were conducted in English, or in one of the local languages, Ga or Twi. In most cases, however, a combination of English and local languages was used, depending on which the participant was most comfortable with. The first author is a native Ghanaian, fluent in all three languages, and familiar with code-switching linguistic practices in the area. All the interviews were audio-recorded with the consent of the participants and lasted an average of 43 min.

2.4. Data analysis

All interviews were transcribed verbatim and, where necessary, translated into English then back translated into the local language by a linguist to ensure accuracy and consistency. The data were analyzed through thematic analyses using ATLAS.ti qualitative data analysis software (v.8). We utilized Braun and Clarke's [29] recommended six-step process of thematic analysis. The data were classified to highlight the participants' beliefs about the nature, causes, effects, and treatment of epilepsy as broad thematic areas. These broad thematic areas were drawn from the categories outlined by the EM framework.

[1] These categories reflect the organized groups within GHAFTRAM. For ease of access, we made use of these preestablished categories.

3. Results

We asked the participants questions to examine their views about epilepsy in five broad areas. First, we examined the labels that they had for epilepsy, together with their views of its nature. Second, we explored their knowledge on the symptoms of epilepsy. Third, we looked at their notions of etiology for epilepsy. Fourth, we explored their views on the implications or effects of epilepsy on the individual. Finally, we assessed the methods that they used to treat the condition. Below, we present each of these sections by looking at the similarities that we found across the different categories of healers, as well as highlighting any differences that were observed.

3.1. Identifying and naming the condition

When asked what they thought was ailing the person in the vignette, all the participants immediately recognized it as epilepsy. They indicated that he was suffering from some brain disorder. They emphasized that it was not a mental disorder but also cautioned that it could very quickly result in 'madness' if left untreated or if it was mistreated. This was because they believed the fits could cause the patient's head to repeatedly hit against the floor which could result in brain damage. The resultant brain damage could then lead to madness.

The names that were used to describe this condition were *ɛtware* or *ɛsoro* (in Twi), and *ŋwɛi* or *gbili-gbili* (in Ga). The words *ɛsoro* and *ŋwɛi* literally mean 'the sky' or 'above', and are derived from cultural beliefs that epilepsy was connected to the moon which 'pulled' at the individual. These words are more commonly used to describe the convulsions that occur during an epileptic episode. The words *ɛtware* and *gbili-gbili* are typically used to refer to the illness itself:

> *This kind of illness…we call it* ɛtware. *It is always connected to the moon…whenever there is a new moon, that is when…the seizures become more intense but when the new moon wanes, then it seems to get better.* (H4).

3.2. Healers' explanations of symptoms of epilepsy

In answer to the question 'how does it work?', the most common descriptions given included jerking, stiffened limbs, eyes rolling back, foaming from the mouth, urinary or bowel incontinence, as well as loss of consciousness. All the participants generally described such symptoms. Eight of the thirty-six participants showed knowledge of epileptic auras, but the majority of the participants did not recognize the auras, despite indicating that they had experience in treating PWE. Of the eight who recognized the auras, six were herbalists and two were pastors. The *mallams* and the shrine priests as well as majority of the pastors did not recognize the described epileptic auras. One of the participants described the after-effects of the episode to us:

> *Any normal human being doesn't just…start shaking and foaming at the mouth like that…he has an illness… After the seizure passes, he will be like someone who is drunk because they can talk but they are a bit slow and confused, so they may answer questions correctly, and some will be wrong. So after some hours, then they will have relaxed better and then you can ask them what was happening to them or whatever.* (M5).

3.3. Healers' beliefs about causes of epilepsy

When asked about causes, the participants held multiple views on causation, including biological, social, and supernatural causes. The predominant belief among the participants was that epilepsy usually started in childhood as a result of overly high body temperature:

> *Yes, when the baby is born, the mother has to be very careful…[she must] make sure that the baby does not get high fever…if you don't make the fever come down, the child will start getting convulsions, and by the time they get to five or six years old it will become the full epilepsy.* (H1).

This belief in high fever causing epilepsy was reported by all the participants. However, some participants suggested that epilepsy could also develop as a result of 'dirty blood':

> *Usually it is because their blood has become dirty…it has been building up for some time so the body can't stand it anymore…because of their diet and maybe even taking in plenty alcohol. That can make the body to become toxic and then they start having these fits…it is the body's way of telling them that something is not right.* (P7).

This belief was most common among the herbalists, who indicated that diet and lifestyle choices could result in contamination of the blood, which would subsequently manifest as epilepsy. Some participants further believed that this 'dirty blood' could be a hereditary factor, and hence cause epilepsy to run in families.

Finally, some participants also held the belief that evil spirits, *Jinn*, and curses could be used to inflict such a condition on a person. These views were common among the pastors, *mallams,* and shrine priests. However, some of the herbalists also believed in the possibility of spiritual causes of epilepsy. Some participants (mostly the medicine men and the *mallams*) also believed that the moon had a role to play in the onset of epilepsy, although the specific mechanism was unclear. When 'spiritual' factors were seen as a cause of the illness, it was reported commonly to start unexpectedly and was mostly seen as very severe or sometimes unresponsive to the regular biomedical treatments.

3.4. Healers beliefs about the implications of epilepsy

All the participants saw the effects of epilepsy as potentially very harmful. As has been mentioned above, the repeated banging of the head on hard surfaces were believed to be triggers for brain injury, which would manifest as mental illness:

> *You see, for most of the mentally ill people…about 90% of them are as a result of epilepsy. Epilepsy has serious implications – for some people, during an episode, they hit the floor and everyone can see that he has this illness…the illness will suddenly start shaking them, and they will drool for some time and then it stops. Such conditions retard the brain…the brain is unable to develop past a certain level.* (H2).

Furthermore, given the perceived unpredictable nature of the seizures, they could occur at any time, and this posed a threat to the individual's safety. Several of the participants gave examples of instances where epilepsy could pose a danger to the patient:

> *Sometimes, the fit can come suddenly, and they will fall down near a coal pot or somewhere where there is fire… Or he can even fall into hot oil…and some of them can even get [an episode] when they are crossing the road! So it can be a very dangerous thing.* (M8).

Other effects that were discussed revolved around stigma. Some participants held the belief that epilepsy was contagious, and therefore, they believed that people would not want to go near the person experiencing an episode. Others also talked about the fact that the potential brain damage that could result from having epilepsy meant that the individual would be unable to find life partners or would perhaps be unable to bear children normally. Again, these were common

to all the participants, suggesting a possible cultural influence in their perceptions.

3.5. Treatments

When asked how they would treat epilepsy, the methods varied based on the orientation of the healer. All the participants indicated that they would need to identify the cause of the epilepsy before deciding the appropriate treatment methods. That is, physical means would be used to treat 'physical epilepsy' and spiritual means could be used to treat 'spiritual epilepsy'. The physical remedies tended to involve herbal mixtures, inhalants, and tablets, as well as dietary restrictions. Such methods were commonly prescribed by herbalists as well as some shrine priests. However, they also indicated that, in some cases, they referred patients to hospitals for care. The decision to refer the patient was generally made based on the healers' assessment of the nature and cause of the condition, as well as of their own ability to treat the particular case.

The spiritual remedies differed based on the specific faith of the healer. Christian healers used prayer, exorcism, fasting, holy water, and anointed oils in their treatments; the Muslim healers used verses in the Qur'an in addition to herbs; and the shrine priests used chants, incantations, confession, and other rituals to banish or repel the spiritual forces which were identified as responsible for the illness.

Despite acknowledging that epilepsy was a serious condition, most of the participants did not accept that it was a chronic condition, and believed that it could be cured. Furthermore, the participants who believed that seizures were caused by lunar activity offered treatments which coincided with the different phases of the moon.

4. Discussion

We examined the perceptions of Ghanaian traditional and faith healers about epilepsy. All the participants in our study agreed that epilepsy was in itself not a mental disorder, but could result in mental disorders if poorly managed. They reported local names for epilepsy, some of which suggested a belief in the activity of the moon playing a role in the onset and presentation of epilepsy. This belief in the role of lunar activity in illness manifestation is not unknown in biomedical history, particularly for epilepsy [30,31], where it was long believed that the appearance of a full moon could trigger seizures. Others also believed that different phases of the moon could trigger different types of seizures [32]. Similar to our findings, treatments were often tailored to coincide with specific phases of the moon.

Many of our participants also held the view that the bodily fluids of PWE could infect other people with the condition. This concept is also similar to what has been reported in other studies. Previous researchers have documented the belief in the contagious nature of the bodily fluids of PWE (e.g., in Zambia [21]; in Nigeria [33]; and in Ethiopia [34]). Such contagion beliefs are thought to account for a large aspect of stigma towards PWE.

The herbalists' emphasis on epilepsy as a feature of 'dirty blood' is a further dimension of the cultural connotations of bodily fluids and illness. As Helman [12] suggests, issues of blood constitute more than simple physiological states in some cultures. In addition, Helman is of the view that these lay cultural beliefs about blood should not be ignored because they may be indicative of some hidden bodily symptoms. Therefore, these lay explanations may be a reflection of wider social and/or spiritual beliefs. Similarly, our participants' belief in dirty blood and the contagion of the bodily fluids of PWE may influence the help-seeking avenues which are sought.

In addition to the perceptions of the nature of epilepsy, we also explored their explanations for the causes of epilepsy. They held multiple views about causation including hereditary, social, and spiritual causes. Many of them further indicated that hereditary conditions may have started as spiritual illnesses, and developed into physiological conditions through the generations. Thus, spiritual agents may cause conditions which appear physiological in nature. Similarly, witches could capitalize on physiological conditions to wreak havoc in the life of an individual whom they wished to harm. The EMs of causation of epilepsy were, therefore, both biomedical and supernatural.

All the participants saw epilepsy as a serious condition which could adversely affect the life of the individual. The foremost effect that most participants spoke about was the potential threat to the individual's safety. Many gave examples of people experiencing an episode while near an open fire (i.e., for those whose cooking was primarily done outdoors), or water body. Others spoke about the dangers of PWE driving or crossing the road unaided.

Apart from the perceived danger associated with having epilepsy, others also discussed the embarrassment that could result from having a convulsion in public, considering the attendant incontinence or resulting injury that were perceived to be common outcomes. These were almost exclusively associated with women. Also predominantly associated with women was their assertion that most families would not want their sons to marry women with epilepsy, although the opposite was not considered as serious a problem. Others also believed that PWE would have difficulty in childbirth. This was a further source of embarrassment for women with a diagnosis of epilepsy.

The EMs reported by our participants are not unlike those reported in other African countries. Nonbiomedical explanations for epilepsy are not a new notion in healthcare. Epilepsy has been viewed as a curse, as a form of demonic possession, or as a punishment for sin in different cultures at different times [18,32,35–37]. It has also been viewed as a contagious condition in various cultures and, hence, required specific treatments. However, our participants appeared to hold concurrent EMs regarding the origin of epilepsy where both biomedical and supernatural reasons were able to exist side-by-side. This is similar to what has been reported elsewhere [9,18].

The treatments that were recommended for epilepsy were dependent on the identified cause of the illness. Thus, the healers also held multiple treatment models, which they employed based on the cause. Furthermore, the healers were open to referring cases, which they had identified as physiological in nature, to biomedical facilities. Such sentiments are encouraging for potential collaboration dialogs between biomedical and TAM practitioners.

All the participants viewed epilepsy as a serious, and sometimes dangerous, condition. Given the communal style of living that exists in many Ghanaian communities, the presence of an illness which carries such stigma may have an adverse effect not only on the patient but on their family as well. Furthermore, the perceived inability of PWE to undertake some activities of daily living, given the possibility of triggering an episode, may constitute a meaningful loss of productivity and income for the family.

The impact on communal relations is also reflected in the participants' belief in the difficulty of PWE to find partners. In particular, much emphasis seems to be placed on the effects of epilepsy on women, concerning marriage and childbirth [38]. This embarrassment and stigma that is associated with epilepsy has also been reported in other cultures across the continent [33].

5. Conclusions

The findings from this study indicate that traditional and faith healers in Ghana hold multiple, and sometimes simultaneous, EMs about epilepsy. The causal models showed little variation across the different categories of healers; however, the type of treatment that was recommended varied, depending on the orientation of the healer. The perceptions of the effect of epilepsy on the lives of PWE were predominantly serious and negative. These views have implications for how PWE are treated and can inform public education and awareness-raising efforts.

There were a few limitations which are important to highlight. Considering the population of TAM practitioners thought to practice in the country, this was a relatively small sample of healers. Thus, we do not consider their views to be representative of the views of TAM practitioners in Ghana. Secondly, our use of a case vignette may have resulted in the participants' relating views which were specific to that case. These views may differ when they are confronted with an actual case. Despite these limitations, we believe our findings can make an important contribution to the dialog on healthcare for chronic conditions such as epilepsy in Ghana.

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Competing interests

The authors declare that they have no competing interests.

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CHAPTER SIX: ARTICLE 3

Ghanaian traditional and faith healers' explanatory models of intellectual disability

6.0 Introducing Article 3

Article 3 is similar to the previous two articles in that it examines the explanatory models of the indigenous/faith healers, this time about intellectual disability. Intellectual disability is also often associated with psychiatric conditions. The healers in our study all had experience treating intellectual disability, and thus were able to provide rich perspectives on this condition.

Unlike other conditions, the healers viewed intellectual disability as a congenital condition which was brought about by factors such as maternal negligence. They also admitted that it was not curable but needed to be managed. They discussed various ways that living with intellectual disability could impact on the life of the individual and their social network. The findings are discussed with reference to potential collaboration with other sectors in the field of intellectual disability studies.

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ORIGINAL ARTICLE

Ghanaian traditional and faith healers' explanatory models of intellectual disability

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Abstract

Background: The use of traditional/alternative medicine for health care in Africa has been examined for various conditions. However, there is limited research about traditional/alternative health care for intellectual disability. The present authors explored the explanatory models (EMs) of intellectual disability held by traditional/faith healers in Ghana.

Methods: Using a case vignette, the present authors conducted semi-structured interviews with 36 traditional/faith healers in Accra, Ghana. Using the EMs of illness framework as a guide, participants were asked questions to examine their beliefs about the nature, causes, course and recommended treatment of intellectual disability.

Results: The healers' causal explanations included maternal negligence during pregnancy and spiritual factors. They also believed that intellectual disability was a congenital, lifelong condition which could not be cured.

Conclusions: Unlike other conditions which traditional healers claimed to cure, participants admitted that intellectual disability was not curable. The present authors suggest that the findings highlight opportunities that exist for collaboration between biomedicine and traditional medicine.

KEYWORDS
explanatory models, Ghana, intellectual disability, traditional medicine

1 | INTRODUCTION

The rates of intellectual disability vary from country to country, but are probably higher in low- and middle-income countries (LMICs) than in wealthier countries, due to social and economic factors such as poverty, nutrition and poor or limited formal healthcare services (Kromberg et al., 2008). There is limited access to biomedical healthcare services in these countries, and the use of traditional and alternative medicine (TAM) is common (Abera, Robbins, & Tesfaye, 2015; Christianson et al., 2002; Gureje et al., 2015). TAM is often the first point of call for many people in LMICs, and TAM practitioners form a large part of the healthcare labour force in these countries (WHO, 2013).

Traditional medicine is built on the beliefs, values and norms which are traditional or peculiar to specific communities (WHO, 2013). Faith-based healing, through, for example, Christian or Muslim religions, also plays an important part in the alternative healing sector (Chowdhury, 2016; Crawford & Lipsedge, 2004). TAM methods are therefore influenced by their understanding of illness or disability and their effects.

Various categories of TAM practitioners are recognized in different contexts (Tabi et al., 2006; Twumasi, 1975). Some practitioners are strictly herbalists, utilizing their knowledge of plant, herb and animal properties to treat people. Other practitioners use "spiritual" or faith methods for healing, such as the Islamic clerics/diviners, who use Qur'anic verses and prayers in their healing. Another example of the spiritualists is the traditional medicine men or religious shrine priests (sometimes called shrine devotees), who serve as conduits for specific deities or ancestors through various ritualistic processes such as possession and divination. Other faith healers are the Christian faith healers, who treat illness through prophecies, exorcism, sprinkling of holy water, prayers and fasts, as well as other prayer aids such as anointed oils and salts (Gessler et al., 1995; Stekelenburg et al.,

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2005; Tabi et al., 2006). These faith healers may or may not use herbs as part of their craft.

Given the reported use of TAM for conditions such as intellectual disability (Brolan et al., 2014; Kromberg et al., 2008; Njenga, 2009), the practitioners' beliefs about intellectual disability are worth examining. A useful way of examining illness and disorder beliefs is through the use of explanatory models (EMs) (Kleinman, 1980). EMs reflect the beliefs of individuals about an episode of illness or life condition (i.e., its aetiology, course and effects). EMs may also determine the choice of treatment, as well as patients' adherence to and satisfaction with the treatment programme (Callan & Littlewood, 1998). Given that traditional healers are typically positioned within the communities of their patients, their EMs may be congruent with those of their patients and may reflect cultural concepts and ideas around the condition.

Despite the popularity of TAM usage, there is surprisingly little research on EMs for intellectual disability in non-western countries, particularly from Africa. Previous studies on developmental disorders have generally focused on parents or caregivers with a developmentally delayed child (e.g., Altiere & von Kluge, 2009; Brown, Ouellette-Kuntz, Hunter, Kelley, & Cobigo, 2012; DePape & Lindsay, 2015; Divan, Vajaratkar, Desai, Strik-Lievers, & Patel, 2012), examining their views on intellectual disability and the challenges that they may have experienced (John & Montgomery, 2016). Given that many people living with intellectual disability experience difficulties with communication, some studies have also examined issues of communication and the implications of these for social and family life (e.g., Wylie et al., 2017).

Other studies have explored the felt and/or enacted stigma of living with developmental disorders or caring for a child with developmental disorders (e.g., Gray, 2002, 2006; Tilahun et al., 2016), while some other studies have looked at the perceptions of biomedical health workers about developmental disorders and their treatment (e.g., Gona et al., 2015; Kromberg et al., 2008). However, very little research has examined the beliefs of traditional and alternative healers about intellectual disability.

A few studies have reported on the use of TAM services by parents of children with intellectual disability (e.g., Aldersey, 2012; Kromberg et al., 2008). These have typically been reported among parents in non-western countries, or among immigrants from non-western countries (e.g., Brolan et al., 2014; Mirza et al., 2009; Scior, Addai-Davis, Kenyon, & Sheridan, 2014). In these studies, most of the parents reportedly sought "cures" for intellectual disability from TAM practitioners. Although there are some reported claims by traditional healers about their ability to cure such disorders, Kromberg et al. (2008) argue that the evidence is mostly anecdotal. Due to these (and other) limitations, there is little research on the perspectives of the TAM healers themselves about their abilities and methods with regard to intellectual disability, particularly in African countries such as Ghana.

In Ghana, research on intellectual disability has focussed on special education and the experiences of parents (Avoke, 2002; Kassah, Kassah, & Phillips, 2018; Oti-Boadi, 2017). Services are also limited, with no specific mention of intellectual disability in most disability policy documents (Anthony, 2011; Sackey, 2015). Although people with intellectual disability can enrol onto the National Health Insurance Scheme for free, the shortcomings of the scheme mean that the services which are accessible are likewise limited. There is also no formalized or established government disability welfare system; thus, most families rely on non-governmental organizations, churches and other social networks for support. These social support structures include TAM as a healthcare option.

This study therefore examines the beliefs and explanations held by traditional and faith healers in Ghana about intellectual disability. Previous research suggests that one of the reasons for the popularity of TAM in Ghana is the larger number of TAM practitioners over biomedical practitioners (it has been estimated that there is one traditional healer for every 200 people in Ghana); thus making them more easily accessible (Ae-Ngibise et al., 2010). The present authors thus sought to investigate the healers' notions about the causes of intellectual disability, what effects they perceived it could have for the individual and/or their family, as well as their recommended treatment options for intellectual disability or their ability to cure it. The present authors were concerned to establish whether healers believed that they could "cure" intellectual disability, as has been reported in the literature on Ghanaian healers in relation to mental health conditions (Ae-Ngibise et al., 2010). With this in mind, the present authors analyse their beliefs as factors to consider in collaboration between TAM and biomedical health systems in Ghana.

2 | METHODS

2.1 | Research setting and participants

This study was an exploratory qualitative study. It was conducted in the Greater Accra Region of Ghana and is part of a larger study of traditional and alternative healing in Ghana. Through liaising with the Ghana Federation of Traditional Medicine Practitioners' Associations (GHAFTRAM), which oversees the practice of various categories of traditional/faith healers in the country, the present authors identified potential research participants. Additional participants were identified through the Ghana Pentecostal/Charismatic Council (GPCC). GHAFTRAM is organized into groups which are classified based on orientation, creed or methods. Thus, the present authors utilized the pre-established categories within the Federation, viz. the herbalists' association, the Muslim healers' association and the psychic healers' association to access the herbalists, Muslim clerics and shrine priests, respectively. The Christian healers were drawn from the GPCC given that faith healers who operate healing prayer camps, self-identified as charismatic churches. The present authors thus sought healers from charismatic churches which operated prayer camps where individuals sought healing. Subsequent snowballing was used to recruit further participants.

To be eligible for participation, the healers needed to live/work in the Greater Accra Region, must have practised for at least five years and be able to speak English, Twi and/or Ga (the dominant languages

in the region). There were therefore four different categories of traditional/faith healers who took part in the study: traditional herbalists, traditional medicine men (also called shrine/fetish priests or devotees), Muslim clerics/healers and Pentecostal/charismatic Christian pastors/healers. A total of 36 healers were interviewed for this study, comprising ten Muslim healers (called *mallams*), ten pastors, eight traditional medicine men and eight traditional herbalists. Table 1 provides a summary of the demographic characteristics of the participants.

2.2 | Procedure

Before data collection, ethics approval was obtained from the Stellenbosch University Humanities Research Ethics Committee, as well as from the Ghana Health Service Ethics Review Committee and the Ghana Traditional Medicine Practitioners' Council. Additional permission was also obtained from GHAFTRAM and the GPCC. Once approval was granted, potential participants were approached and the objectives of the study were explained to them, as well as their rights as research participants. Individual informed consent was obtained from each participant before any data were collected.

Individual semi-structured interviews were conducted in English, Ga or Twi (or a combination of English and one of the local languages), depending on which the participant was most comfortable with. All interviews were conducted by the first author, who is Ghanaian, a clinical psychologist and a native speaker of both Ga and Twi. She was thus familiar with linguistic code-switching practices within that context. However, some interviews were conducted with the assistance of a male research assistant. This was necessary in instances where cultural or religious expectations frowned on direct interaction with a female. For instance, one shrine priest indicated that his position as a representative of the deity did not allow him to speak directly to a woman. The research assistant was a psychology graduate, was trained before any data were collected, and closely supervised by the first author during the interview. All the interviews were audio-recorded with the consent of the participants. The interviews took place in the participants' homes or work places (often these were the same).

TABLE 1 Summary of demographic characteristics of participants

Characteristic	Number (%)
Gender	
Female	5 (13.9)
Male	31 (86.1)
Type of healer	
Herbalist	8 (22.2)
Shrine priest	8 (22.2)
Mallam	10 (27.8)
Pastor	10 (27.8)
Mean age	54.6 years
Mean years of practice	28.1 years

The present authors elected to use a case vignette to facilitate the interview process, given the stigma that is culturally associated with intellectual disability. The vignette method is useful for undertaking discussions on sensitive topics due to its use of the third-person approach (Gourlay et al., 2014). The present authors believed this would enable the participants to speak more comfortably on the subject. The following vignette was read to the participants:

> *Effie was slower in reaching her developmental milestones such as sitting, crawling and walking, and learned to speak later than her peers. Her mother reports that at eight years old, Effie is unable to bathe and dress herself, and often requires assistance in eating and using the toilet. Effie also struggles in school with reading and writing, and has been held back twice due to her difficulties at school.*

After reading the vignette aloud, the interviewer asked participants questions to determine how they conceptualised the case. The questions that were asked were based on the eight core EM questions (see Kleinman, 1980), and sought their explanations of the nature of intellectual disability, the causes of the condition, what possible effects it could have for the individual or their family, as well as how they would treat such a condition, and whether they had experience in treating it.

The interviews were transcribed by the first author in the languages that they were conducted in and, where necessary, translated into English, then back translated into the local language by an independent linguist, to check for consistency and accuracy.

2.3 | Data analysis

All interviews were transcribed verbatim and analysed using ATLAS.ti qualitative data analysis software (v.8). The data were initially analysed by the first author, and subsequently checked and corroborated by the second author. Areas of disagreement were discussed and resolved by both authors. The data were analysed thematically using Braun and Clarke's (2006) recommended six-step process. First, the present authors generated initial codes to highlight the participants' beliefs about the nature, causes, effects and treatment of intellectual disability as broad thematic areas. Subsequently, the present authors tentatively classified similar trends and patterns which had emerged from the data. These initial classifications were revised as the patterns were properly defined. The present authors based our interpretations on the participants' individual accounts, but also in comparison with those expressed by other participants.

3 | RESULTS

3.1 | Identifying and naming intellectual disability

All the participants indicated that the vignette did not describe a case of mental disorder, despite popular representations of intellectual disability as a mental illness (Avoke, 2002). They suggested that

the child in the story was most likely born with some structural brain deficit. They used words such as *gyimi-gyimi* (in Twi) or *buulu-buulu* (in Ga). These words translate to "stupid, stupid," and all the participants were quite uncomfortable using the terms. When the present authors asked for a name for the described condition, they all prefaced their answers with phrases like, "excuse me to say." Many of them stated that they did not think it was an appropriate way to describe a child whose condition had occurred through no fault of their own. For instance, one female pastor stated the following:

> *Sometimes some people call them gyimi-gyimi, because of the way they behave … they can't do anything normally. Yes, some of them … will be [drooling]. But that is how they were born, it is not something that they can control.* *(P5, female pastor)*

Such descriptions of deviating from "normal" were common, with participants relating the behaviours of people with intellectual disability as falling outside of expected behaviours. These names and sentiments were held by all the participants and did not vary based on the healing orientation of the healers. The participants' discomfort with the derogatory terms suggests that they had an appreciation for the stigma and discrimination attached to the use of certain names and labels.

3.2 | Participants' notions of severity of intellectual disability

The participants also indicated that there were different developmental disabilities with varying levels of severity. Many of them suggested that the severity determined the extent to which the child could function optimally and achieve some level of personal independence, which served as a measure of "normality":

> *Yes, some of them can be okay, they only need [a little] guidance and so if you train them in a way that they can understand the training … oh, he can do everything that you and I can do! But just that he doesn't learn the same way that we will learn, so you have to find out how to talk to them and teach them so that they can also learn how to live … it is not all of them that are so serious, some of them … unless you talk to them for a long time, you won't know that there is something wrong with them.* *(F3, shrine priest)*

Thus, the healers believed that intellectual disability was a serious, lifelong condition. Here again, they emphasized the fact that intellectual disability was not an illness which needed a cure. Instead, their accounts suggested a belief in the severity of intellectual disability being constructed based on the extent of the individual's ability to behave in a manner considered socially appropriate. These notions of normality were held by all the participants and did not show much variation across the different categories of healers.

3.3 | Participants' explanations of aetiology

With regard to causes, each of the participants held multiple views. These views were mostly regarding circumstances or physiological problems which could have occurred in the womb. Many of the herbalists believed that intellectual disability could result from something the mother ate while pregnant. Other healers suggested that the mother had likely not attended antenatal clinics regularly, and hence had not followed the directions of doctors or midwives. Still others suggested that it could result from some strenuous activity the pregnant mother had undertaken such as lifting heavy things, as well as perhaps a road traffic accident that the pregnant mother could have been involved in:

> *Mostly, these things happen during pregnancy…yes, maybe the mother did not go to antenatal clinic … so that the doctor can check how the baby is lying, or even they can see if there is something wrong with the baby before it is born. Then they can give her medicine … to make sure that the baby will be healthy. Some of them also don't watch their diet when they are pregnant … there are some things that a pregnant woman should not be eating, like oily foods and too much salt.* *(H3, male herbalist)*

Apart from pregnancy-related causes, some suggested that another possible cause could be spiritual machinations. Some of the medicine men and pastors suggested that curses which ran through families could affect the child and he/she would develop an intellectual disability from birth. Further, jealousy or envy could cause a malevolent person to seek to kill the child; when these attempts to kill the child did not succeed, the resultant condition could be intellectual disability. A few participants also indicated that some unscrupulous parents may choose to trade their child's intellectual capacity for wealth and/or status. Such spiritual machinations were intensely frowned upon by the participants.

Some of the shrine priests in particular, also indicated that some people with intellectual disability were sent to earth as a message from the gods. They were thus seen as "para-human," and care had to be taken in dealings with them. They indicated that it was the parents' and/or communities' responsibility to identify the message that the gods wished to give to them through the birth of such a child. This could be performed through various means such as divination or spirit possession.

Thus, the healers' beliefs about the aetiology of intellectual disability were both spiritual and teratogenic in nature.

3.4 | Participants' views on the implications of intellectual disability

As has been described above, all the participants agreed that intellectual disability was a serious condition and they believed it was mostly permanent. At most, they recommended that the child be

taken to a "special school" in order to be able to learn some personal care and social skills. Some of them believed that if the training was targeted and consistent, the child could live a fairly normal life (in the sense of a life similar to that lived by others), even though they did not expect the child to be able to achieve much success in life:

> *Children like that, they are born like that, so you – the mother – you just have to manage it little by little … If you observe the mothers of such children, they know what makes their child comfortable and even how to speak to [the child] so that he will understand. And so if they get the additional support of the Special School, it helps.*
> *(P9, pastor/prophet)*

All believed that intellectual disability was a congenital condition and not an illness. None of them claimed to be able to "cure" intellectual disability. All the participants indicated that they had been referred cases of intellectual disability for treatment from time to time. Some herbalists indicated that their treatment would generally consist of prescribing herbal tonics which could make the child calm, in order to allow him/her to participate in school and other social activities. The pastors and *mallams*, although also regarding intellectual disability to be a permanent condition, indicated that God could intervene and cure the child, if He so wished. These participants believed that they themselves did not have a role in curing intellectual disability.

None of the participants spoke at any length about treatment methods for intellectual disability; however, they emphasized the need to give parents the knowledge and means to care for their children with intellectual disability. Some participants believed that they had a role in management of intellectual disability. For instance, the pastors and shrine priests were strong advocates of their being involved in psychosocial support for people with intellectual disability and their families. They suggested that they could be instrumental in facilitating supportive care structures such as community spaces where children with intellectual disability could be taught skills which would enable them to earn a living. Some of them also believed in providing social support for parents of children with intellectual disability through counselling and financial assistance (from the churches), among others. In general, the participants had an appreciation of the fact that people with intellectual disability and their families required specific support. They were aware of the potential implications of intellectual disability on family life and believed that their positions within the community could be harnessed to provide support.

4 | DISCUSSION

In summary, from the data, the healers held multiple explanatory views about intellectual disability. Despite differences in healing orientation and methods which existed between the different categories of healers, there was much similarity in their beliefs and perceptions about intellectual disability. The nature of the condition was largely considered to be congenital and thus not curable. There was, however, an appreciation for varying levels of severity of intellectual disability, and its attendant impact on adaptive ability. The causes were believed to be biological (i.e., prenatal) but also possibly spiritual. The pregnancy-related causes were mostly considered to be the result of negligence on the mother's part. The healers further acknowledged the usefulness of special education for training, but did not expect children with intellectual disability to be able to live a functional life. They did not discuss the importance and value of social inclusion.

The healers hesitated to use the names that are commonly used to refer to children with intellectual disability, suggesting an appreciation for the perceived stigma and discrimination that is attached to the condition. The pastors in our sample were comparably better educated, and their empathy may be a reflection of this. Similarly, the herbalists' sensitivity to the stigma may be a reflection of their experience in helping parents.

The names used to refer to children with intellectual disability have been reported in previous studies in Ghana. Avoke (2002) reported similar names among the Ewe of south-eastern Ghana, as well as the Lobi in the North-western parts of Ghana. All these different groups used labels which indicate the belief in persons with intellectual disability being stupid or fools. Similarly, Opare-Henaku and Utsey's (2017) analysis of Akan concepts of mental illness also reported the use of this label. This is perhaps a reflection of the emphasis on education which has dominated disability policies and discourse in many African countries, including Ghana (Kassah et al., 2018). For many people, it appears that the ability to do well (or otherwise) in school is a reflection of an individual's intellect. Unlike the reported attitudes of participants in the other studies, our participants were very uncomfortable using derogatory terms to refer to people with intellectual disability. Despite this, the participants' emphasis on education was directed towards separate special education, and not inclusive educational opportunities. Although the present authors did not ask this of the participants specifically, it is worth noting as a potential direction for future research.

With regard to causes, the emphasis that is placed on the mother's behaviour during pregnancy further reiterates the view of disorders as a consequence of negligence or a punishment for wrongdoing (including, interestingly enough, according to our participants, not attending biomedical antenatal care) (Segrave, Spivakovsky, & Eriksson, 2017). This also speaks to the expected behaviours of pregnant women in the Ghanaian context. Some previous studies have discussed the taboos and behaviours associated with pregnancy in Ghana, which seek to prevent congenital conditions such as intellectual disability. These behaviours include the avoidance of certain foods (e.g., fish, snails and eggs), and the use of herbal teas and enemas (Arzoaquoi et al., 2015; Otoo, Habib, & Ankomah, 2015). Based on the narrations of our participants, there is also the expectation of regular visits to healthcare providers, whether biomedical or traditional.

However, the participants also indicated the possibility of supernatural circumstances leading to intellectual disability. This finding

is also similar to what has been reported in other African cultures (e.g., Bunning, Gona, Newton, & Hartley, 2017 in Kenya; Etieyibo & Omiegbe, 2016 in Nigeria; Kromberg et al., 2008 in South Africa, and Stone-MacDonald & Butera, 2014 in Tanzania). These African studies also reported beliefs in mercenary spirits, jealousy and envy, as well as ancestral displeasure or curses as supernatural factors which could result in intellectual disability.

Thus, the need to apportion blame was very dominant. The blaming of mothers for congenital problems in their babies is not unknown in the literature. Studies in both western and non-western countries have reported similar beliefs and attitudes towards parents of children with developmental disorders, including self-blame by parents (McConkey, Truesdale-Kennedy, Chang, Jarrah, & Shukric, 2008; Read, 2000; Ryan & Runswick-Cole, 2008). Some studies reported participants believed that intellectual disability occurred as a consequence of perceived wrongdoing (Ha, Whittaker, Whittaker, & Rodger, 2014), or negligence on the mothers' part (Blum, 2007; Gammeltoft, 2008). Blaming has also been reported to originate from health professionals and other professionals involved in the child's care (Aston, Breau, & McLeod, 2014; Pelleboer-Gunnink, van Oorsouw, van Weeghel, & Embregts, 2017). Similarly, the traditional healers in our study believed that a child's developmental disorder may be the result of the mother's actions or inactions.

All the healers stated that they had been asked to treat children with intellectual disability in the past. However, the general consensus was that intellectual disability was congenital, and hence, a lifelong condition and could not be cured but rather should be carefully managed to afford the individual the chance of a relatively stable life. This is quite different from the notions that have been reported in other African studies (Haihambo & Lightfoot, 2010; Omonzejele, 2008). Consequently, this may suggest the belief that intellectual disability is not an illness which requires a "cure," but rather a lifelong condition, or disorder which reflects the consequences of certain circumstances. The participants' view of intellectual disability as a disability rather than an illness is in keeping with contemporary biomedical views and may augur well for collaboration.

In general, the healers in our study held largely positive views about people with intellectual disability. They were keen to emphasize the importance of avoiding derogatory labels. They also appeared to have an appreciation for the importance of prenatal medical care. Further, they were also realistic about their inability to cure such conditions. Most of them (but particularly the pastors and *mallams*) believed that parents could learn important life lessons from caring for a child with intellectual disability, and advocated for an acceptance of their needs. These views are quite different from the frequently reported negative attitudes towards intellectual disability which have dominated literature from African countries, including Ghana; where children born with intellectual disability have been reportedly killed or ostracized by communities in the belief that they were a sign of bad luck (Avoke, 2002; Haihambo & Lightfoot, 2010). Several previous studies have indicated that people with intellectual disability in various African countries face derogatory labels, discrimination, stigma and negative stereotypes (e.g., Adnams, 2010; Aldersey, 2012; Baffoe, 2013; Haihambo & Lightfoot, 2010). Although our participants were aware of these negative views, they did not agree with them, and advocated for transformation in Ghanaian intellectual disability discourse. These may be a reflection of their educational backgrounds and/or experience with intellectual disability, but may also be a sign of changing times and a potential window of opportunity to drive change.

The views of the participants have potential implications. In particular, based on their admission that they saw patients with intellectual disability, they are well placed to facilitate appropriate early interventions. Given more education about intellectual disability and additional targeted training, they could be valuable for collaborative efforts in medical care and social interventions, particularly given their stated appreciation for the benefits of biomedical antenatal care. Unlike what has been suggested in the literature, our participants did not claim any personal power to cure intellectual disability. This notion presents further opportunity for collaboration with biomedicine in the care and management of a condition which they admit is lifelong. It also bodes well for collaboration with other sectors such as the education, health, learning support and social care sectors.

Further, the healers' roles as community or spiritual leaders also affords them the opportunity to spearhead transformative dialogues which address stigma and social exclusion for persons living with intellectual disability (Badu, 2016). This is a role which the healers in our study indicated they were willing to play. Their discomfort with the derogatory labels may be a reflection of changing attitudes towards intellectual disability, and these can be harnessed to drive awareness and education about the condition within their spheres of influence. Such awareness and education collaboration can also potentially transform the erroneous practice of mother-blaming.

Thus, traditional and faith healers in Ghana have multiple beliefs about intellectual disability. These beliefs influence their attitudes towards patients and parents, as well as the treatment recommendations of the healers. These views have implications for collaboration, public education as well as the development of social interventions and policies.

5 | CONCLUSIONS

Our study had a few limitations which are noteworthy. The first limitation was the relatively small sample. Although this number is adequate for a qualitative study, the present authors wish to caution that the views expressed should not be interpreted as necessarily representative of the larger population of traditional and faith healers. Further, due to the cultural underpinnings of TAM systems of care, there is the need for larger-scale studies to be undertaken in order to obtain a clearer understanding of the beliefs of TAM practitioners in Ghana. Secondly, the views expressed by our participants were based on the case vignette which was presented to them. This method may limit what is discussed and may not be a reflection of their behaviour when confronted with actual cases. Thirdly, given the widespread understanding of intellectual disability as a gestational

occurrence, the views of traditional birth attendants (TBAs) would likely have provided additional nuanced conceptualisations. The present authors did not interview TBAs at this time, but recognize that their views and methods may differ, considering the fact that they have more contact with pregnant women in the community.

The current study focused on examining intellectual disability in the area of traditional and alternative health care, but the present authors do recognize that important interactions also exist between children with intellectual disability, and other people in their social circles (such as teachers and social workers). These interactions are also necessary to gain a more complete understanding of local concepts and available support for intellectual disability. Further, an exploration of traditional and alternative healers' perceptions of activity limitations associated with intellectual disability and their perceived roles in this area is also important to obtain a fuller understanding of TAM care for intellectual disability. The present authors did not examine this aspect of their care at this time, but these interactions may be of interest for future research. Our findings are, however, important in the intellectual disability conversation. They can serve as foundational data on which a more in-depth understanding of intellectual disability in Ghana can be built, particularly given the dearth of documented research.

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CONFLICT OF INTEREST

The authors declare that they have no conflicting interests.

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PART 3: TREATMENT METHODS OF DIFFERENT TYPES OF HEALERS

The first three articles (which made up Part 2) discussed the explanatory models of the participants with regard to their perceptions of the nature of the illness, its causes, course and potential impact that living with the specific disorders could have on the life of the individual. In the articles to follow, I examine the treatment methods of each category of healers. Therefore, Part 3 comprises the following chapters/articles:

i. Chapter Seven (Article 4): Traditional herbalists' treatment methods
ii. Chapter Eight (Article 5): Muslim healers' treatment methods
iii. Chapter Nine (Article 6): Traditional medicine men (shrine priests') treatment methods
iv. Chapter Ten (Article 7): Pentecostal Christian healers' treatment methods

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CHAPTER SEVEN: ARTICLE 4

Traditional herbalists' methods of treating mental disorders in Ghana

7.0 Introducing Article 4

In this paper, I scrutinise the work of the traditional herbalists. These healers considered their methods to be based on pseudo-scientific ideas. They employed systematic approaches to treating their patients, and described the steps involved as necessary for particular outcomes. The herbalists' methods involved specific diagnostic processes, as well as specific modes of administering the medication. These all had a targeted outcome and purpose. The paper discusses these processes in light of what they could potentially mean for patient care.

Aspects of this paper have been presented at the 1st Pan-African Psychology Congress (PAPU2017), held in Durban, South Africa (September 2017). One participant requested that photographs of her products be included in the dissertation. Figure 3 below is a picture of herbal soap that was used to perform herbal baths. Similarly, Figure 4 is a picture of a herbal ointment which is to be used by the patients.

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Figure 3: Sample of herbal soap (Photo provided by participant)

Figure 4: Sample of herbal ointment (Photo provided by participant)

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Article

Traditional herbalists' methods of treating mental disorders in Ghana

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Abstract
The use of traditional medicine for the treatment of various disorders is not a new practice. Indeed, various categories of traditional healers form a large part of the healthcare workforce in many low- and middle-income countries, and given the paucity of mental health professionals in these countries, traditional and complementary medicine practitioners are utilised even more so for mental disorders. In Ghana, efforts have been made to formalise and standardise the work of traditional medicine practitioners. This goal is still mostly unmet, partly due to the lack of scientific knowledge of their beliefs, methods, and practices in mental healthcare. Very few studies have documented this knowledge. In this article, we report on some of the methods that are used by traditional Ghanaian herbalists in treating mental disorders. Eight herbalists working within the Greater Accra Region, who specialised in mental health, were interviewed through individual semi-structured interviews. Thematic analysis showed that traditional herbalists' work in treating mental disorders revolved around four key themes: the method of diagnosis; the treatment methods used; the mode of administering the treatment; and the purpose of the specific treatment. These themes are discussed with reference to their potential implications for patients' care and outcomes.

Keywords
Ghana, herbalists, mental disorders, traditional medicine

Introduction

The use of traditional medicine for the treatment of various disorders is not a new practice. Throughout the world, biomedicine exists and operates alongside a host of other healing practices. Indeed, various categories of alternative healers form a large part of the healthcare workforce in many low- and middle-income countries (Kajawu, Chingarande, Jack, Ward, & Taylor, 2016). Given the paucity of

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mental health professionals in these countries, traditional and complementary medicine practitioners are utilised even more frequently for mental disorders (Nortje, Oladeji, Gureje, & Seedat, 2016; Sodi et al., 2011). The popularity of traditional healing systems for mental healthcare is arguably due to the cultural beliefs and values shared by the healer and their patients, especially in Africa (Ae-Ngibise et al., 2010; Quinn, 2007). These shared beliefs about illness and wellness determine – to a large extent – the help-seeking behaviours of many mentally ill people in Africa (Ovuga, Boardman, & Oluka, 1999; Quinn, 2007). For some people, these beliefs also include questions about the effectiveness of biomedicine for treating certain illnesses. In addition to these belief systems, the widespread use of traditional medicine practitioners (TMPs) has also been attributed to the ready availability of, and easy access to, their services (Ae-Ngibise et al., 2010; Sodi et al., 2011).

In Ghana, it has been estimated that there is one psychiatrist for every 1.4 million people (Kpobi, Osei, & Sefa-Dedeh, 2014), and these psychiatrists are located predominantly in urban/peri-urban areas; the figures are similar, though slightly better, for other formal mental health professionals. On the other hand, the estimate of traditional healers is one for every 200 people (Ae-Ngibise et al., 2010). This suggests that a TMP would be likely to see approximately 70% of people requiring mental health attention as a first point of contact (Ofori-Atta, Read & Lund, 2010).

Given these (and other) factors, efforts have been made to formalise and standardise the work of TMPs. With the Ghana Traditional Medicine Practice Act of 2000 (Act 575) (WIPO, 2017), efforts are being made to integrate traditional practices into the healthcare profile of Ghana. This Act also provides for the establishment of the Ghana Traditional Medical Practitioners' Council to regulate and streamline the work of TMPs. This goal is still mostly unmet, partly due to the lack of scientific knowledge of their beliefs, methods, and practices. Very few studies have been conducted to document this knowledge and even less is known about the methods of traditional healers in a mental healthcare setting.

The concept of traditional healing in Ghana

According to the Traditional Medicine Practice Act 2000 (Act 575) of Ghana (WIPO, 2017), traditional medicine is "the beliefs, ideas and practices recognized by the community to provide healthcare" (p. 14). A traditional healer is therefore a person who engages in community-recognised methods for the purposes of treating medical conditions (Xaba, 2002). Such methods are indigenous to specific communities and, for many African countries, involve various ideas about the achievement of cosmological balance as a measure of wellness (Asamoah-Gyadu, 2013; Opoku, 2002; White, 2015). The Ghanaian traditional health system is therefore not limited to herbal remedies for illness, but it also includes knowledge of folklore, community traditions and values, and rules and behaviour deemed necessary for good health, as well as people and structures necessary for healthcare delivery (Tabi, Powell, & Hodnicki, 2006).

Various categories of TMPs who provide mental health services are recognised in the Ghanaian context (Acquah, 1958; Tabi et al., 2006; Twumasi, 1975). First are the herbalists, who use their knowledge and understanding of plant, herb, and animal properties in their work. Second, there are the Islamic diviners/soothsayers, who use Qur'anic verses and prayers in their healing (with or without the use of herbs). Third, the traditional religious shrine priests (or shrine devotees), who serve as conduits for specific deities or ancestors, are recognised by their distinct mode of dress and work through possession, divination, and communication with the deities through "spiritual" means. The fourth category comprises the Christian faith healers, who treat illness through methods of prophesying, exorcism, sprinkling of holy water, prayers, and fasts, as well as other prayer aids such as anointed oils and salts (Gessler et al., 1995; Hevi, 1989; Mensah, 2011; Stekelenburg et al., 2005; Tabi et al., 2006).

Some literature has discussed methods used by traditional healers for treating patients with mental disorders, such as the preparation of herbal formulas that are administered in various forms for curative, prophylactic, cultural, and/or symbolic purposes (e.g., Kajawu et al., 2016; Mulaudzi & Matsheta, 2008; Sodi et al., 2011). Other studies have discussed the use of bones and other animal parts as methods (e.g., Makgopa & Koma, 2009), the use of spirit possession and divination (e.g., Konadu, 2006; Truter, 2007) as well as the use of ritual songs and dances (e.g., Nattrass, 2005; Sodi, 2009) for therapeutic and healing purposes. These studies argue that the traditional healer is believed to provide holistic care, which focusses not only on physiological symptoms, but incorporates social, cultural, and emotional variables into the treatment regimen. As a result, they cater to the African need to understand the origin of illness.

However, apart from data on herbalists' use of selected plants, roots, and stems for the production of herbal remedies (Tabi et al., 2006), there is limited literature on the specific methods employed by the various categories of healers in treating mental disorders, especially within the Ghanaian context. As far as we are aware, this article presents the first published report on the methods that are used by traditional Ghanaian herbalists in treating mental disorders. Although the beliefs about mental disorders are also important to understanding the work of the herbalists, in this paper, we focus on the specific methods that are used in treating mental illness.

Methods

Research setting and participants

The present study was conducted in the Greater Accra Region of Ghana. Greater Accra is the smallest coastal region in Ghana. It is a peri-urban region that has large sections of urban neighbourhoods (including the nation's capital, Accra), but also contains small rural villages and communities on the outskirts. The region therefore has biomedical health facilities, but also has a number of traditional health practitioners operating mostly from the outskirts and the smaller rural communities of Greater Accra.

The data reported here form part of a broader study of four categories of healers, but we focus here on the methods used by herbalists. The Traditional Medical Practitioners' Council (which is the regulatory body for the practice of traditional medicine in Ghana) maintains a registry of a range of traditional practitioners, but it does not list herbalists by practice specialisation. As a result, the Council referred us to the Ghana Federation of Traditional Medicine Associations (GHAFTRAM), an association to which most traditional practitioners belong, and through which the Council seeks to monitor the work of TMPs. Through GHAFTRAM, access was obtained to some herbalists who treated mental disorders within the Greater Accra Region; further snowballing was used to recruit others. Individual semi-structured interviews were conducted with eight herbalists.

Participants were included in the study if they were registered members of GHAFTRAM and the Traditional Council, could speak English, Ga or Twi (the most commonly used languages in the region), and if they had practised as herbalists for at least five years. Due to its cosmopolitan nature, the Greater Accra Region has a mixed ethnic population. As a result, the cultures and practices are typically diverse. Our participants were therefore not limited to people who were indigenes of the Greater Accra Region, but included those who had migrated there from other regions of the country.

Despite this diversity, this sample is not assumed to be representative of the population. Further, given that not all herbalists in Ghana belong to GHAFTRAM, we recognize the potential bias that may exist in our findings. However, the data obtained from these participants does provide insights into their work in mental health.

Participants' ages ranged from 47 to 62 years, with a mean age of 54.5 years. Interviews were conducted with six male and two female herbalists. The number of years of practice ranged from 23 years to 45 years.

Procedure

Ethical approval was obtained from the Stellenbosch University Humanities Research Ethics Committee, as well as the Ghana Health Service Ethics Review Committee. Further permission was obtained from the Ghana Traditional Medical Practitioners' Council and GHAFTRAM. Once approval was granted, potential participants were identified from the GHAFTRAM registry. These were approached and the objectives of the study were explained to them. Individual informed consent was obtained from each participant, as well as consent to record.

All interviews were audio-recorded. Interviews took place at participants' homes and places of work. Interviews were conducted in the language that the participant was most comfortable with; in most cases, this involved a mix of English and Ga or Twi. Participants were asked a range of questions on different aspects of their work as healers; those relating to their work with mental disorders included questions such as "How are you able to identify what the patient's illness is?", "How would

you treat [this] illness?", and "What are the most important results you hope to achieve from this treatment?", among others. Interviews were transcribed verbatim and, where necessary, translated into English, then back translated into the local language by a linguist, to ensure accuracy and consistency. In addition, basic demographic information was collected from the participants.

Data analysis

The data were analysed through thematic analyses in an inductive manner. Following Braun and Clarke's (2006) recommended six-step process of thematic analysis, initial codes were identified from the herbalists' descriptions of their work processes. These codes were assessed to identify significant patterns and trends. Themes were thus generated from the emerging information that the participants provided. These were subsequently revised and properly defined, and are presented as results below.

Results and discussion

The analysis showed that traditional herbalists' work in treating mental disorders revolved around four key themes: a) the method of diagnosis, b) the treatment method, c) the mode of administering the treatment, and d) the purpose of the specific treatment.

Diagnostic methods used

In order to identify a patient's problem, the herbalists used various informal diagnostic methods. All our participants reported that they undertook physical examination of the patient as a means of diagnosing the problem. They spoke about visually examining the patient's appearance in order to determine the problem. For example, one 49-year-old man said:

> …when the patient comes, you have to first look at him carefully…they stop bathing, they don't cut their nails and they smell very bad…when you see all these signs, then you know it is madness…

For this participant, obvious changes in hygiene and appearance served as confirmation of the patient's condition. However, some indicated that they would interview the patient or his relatives before concluding on the specific nature of the illness:

> I will usually ask all these questions about what they eat and the kinds of activities that they participate in…and so they don't even need to go and do any lab test with any machine for me to see what is wrong…we don't always need the machines and the tests before we can see that this is the problem or even what the solution should be…

This 59-year-old man described his use of in-depth interviews to diagnose the condition and to determine the course of treatment. There is also an underlying scorn for biomedical diagnostic methods in his narrative. Other participants spoke about relying on the information of family members to aid in their diagnosis. For example, this 62-year-old man observed:

> By asking the family members who brought him to describe the symptoms, and by asking them questions to rule things out, I can determine what is worrying the person. Mostly, there will be one or two key symptoms that tell me exactly what the illness is...

Apart from speaking to the patient and their relatives about the symptoms, a few of our participants described divine revelation as a means of diagnosing illnesses. This was either through visions or in dreams, but periodically, it was through other people. One 50-year-old man stated:

> God also reveals some to me directly, sometimes I will get it as a vision, or sometimes I can immediately fall asleep and then I will dream about the patient's problem...or through other people whom he sends to me. He could use other people to show me what specific treatments to use to treat specific diseases...

Therefore, the herbalists used observation, patient interviews, third-party informants, and, to a less common extent, divine revelation to make their diagnoses. These findings are similar to those described by other researchers (e.g., Agara, Makanjuola, & Morakinyo, 2008; Oliver, 2013; Swartz, 1999). Kajawu et al. (2016) for instance found similar methods in their study of various categories of traditional healers in Zimbabwe. Notably different, though, is the fact that divine revelation was not typically reported by the Zimbabwean herbalists, but was more common among the diviners and spirit mediums in their sample. Similarly, Sodi et al. (2011) reported that herbalists in their Tsonga sample in South Africa used interviews and observation, but not dreams and visions, for their diagnostic purposes.

Contrary to our findings, Hampshire and Owusu (2013) found that herbalists in their Ghanaian sample emphasised their reliance on what they termed "scientific" methods of diagnosing illness, which did not rely on any spiritual interventions. Our participants expressed similar sentiments, with the difference being that some reported having received a "special gift of healing" from God.

Treatment methods

Another theme that emerged was the different treatment methods used by the herbalists to treat mental disorders. These can be classified under four categories: a) the use of herbal remedies, b) the use of ritual objects, c) the use of prayer as a method, and d) prescribed behaviours for preventive purposes.

All of our participants spoke about the various herbal remedies that they used to treat their patients, although none was willing to divulge the specifics of the herbs they used. In this regard, the herbalists may be protecting their intellectual property, similarly to how drug companies protect theirs. Many of them described a stepwise process for recovery. The first step was usually giving the patient a herbal bath. The second step was then for the patient to inhale herbs that had been brewed or burned; sometimes an herbal emetic was given to induce vomiting. The third step involved taking herbal decoctions or infusions that needed to be taken based on the healer's specific instructions; in a few instances, a herbal suppository or enema was also prescribed. The final step was to prescribe an ointment or poultice for daily or periodic use by the patient. The following narrative from a 56-year-old woman describes the various steps:

> ...when they come to me...the first thing that I do is to give him something to take a bath with... So, after I have given him this bath, then I have to give him some herbs that I have boiled to inhale, and also, I give him a mixture that he has to take (orally)...and following those processes, I give him some special creams to rub all over his body as well...

A 47-year-old man put it this way:

> ...sometimes, we give them herbal mixtures which they will drink and others that they will use to bathe before they drink the medicine...sometimes there is a special kind of herbs that we can burn and the person will have to breathe the smoke...

All the participants described these methods in different variations, with the purpose of counteracting the symptoms of the illness, but also as a means of undoing the perceived cause of the illness (these are discussed further below). For the most part, our participants did not prevent their patients from using biomedical methods, but their scorn for its efficacy was not hidden either. They therefore passively allowed patients to combine their methods with biomedical treatments if the patients wanted to. However, whenever any problems or complications arose, the blame was often cast on the interference of biomedicine. The 62-year-old man put it quite succinctly:

> ...some of the patients continue to use the medicine that the doctors give them, but those ones don't work well compared to our own...because our forefathers knew that the herbs can do both the physical and the spiritual... But sometimes when you say it, they don't listen to you... then when they go and something happens...then they come running back to you...

Another treatment method that was described by participants was the use of ritual objects. These objects provided a means of both diagnosis and treatment of the condition. For instance, the participant below is a 50-year-old man who believed

that mental illness was caused by the activity of the moon. He believed that the moon had bound the spirit of the patient and needed to be appeased with specific objects in a specific manner in order for the patient to be released:

> ...when it comes to madness, it is always connected to the moon... whenever there is a new moon that is when they become violent... So, I go to the refuse dump during the new moon, and take red oil and salt along. [Then] I make three holes in the ground, then I put the red oil in the middle hole, and the salt will be divided into two and put in the left hole and the right hole... I then command the moon that this madness that has been used to afflict the patient...the moon [should] release him from that madness. ...It should take the oil and the salt as offerings to replace the man's sickness...

Others spoke about mixing the herbal remedies with bones, stones, and/or beads to increase their efficacy. This 47-year-old man described it as follows:

> ...sometimes we use stones or count beads while we make the herbs so that it becomes very powerful...and then it works very fast for the patient...

The third method that was described by some of our participants was the use of prayer as a method of treatment. Due to the pervasive belief that illness is caused by evil spirits, many of the participants stated that the effectiveness of their other methods to the healing process depends on their inclusion of some spiritual element. One participant, a 54-year-old woman, believed that the spiritual nature of mental illness means that prayer is the best way to ensure that the herbal methods work:

> ...personally, I think those kinds of things are more about spirits so it would be better if you add serious prayers [to the healing process]...so that the spirit is removed. So, maybe the herbal bath will be able to do something, but then you pray on top of that to make sure that it really works and that the spirit doesn't come back...

The fourth method that emerged was the prescription of specific behaviours and processes that the patient needs to go through to complete the healing, or to prevent a relapse. These behaviours include restraint, isolation, and dietary restrictions.

> ...in those cases, I usually capture them and tie them up until the new moon rises...then I can go and perform the necessary things...whilst they are tied up, the relatives will have to shave his head...if you don't do it during the new moon, it will never work... (50-year-old male herbalist)

> ...if you observe, most of our places are not in the midst of town, they are in a very isolated place where there is solitude, why do you think it is so? The quiet, echoing spaces for healing are very important...the healing spaces also matter. So, you can push a sick person there and lock him up, and then you can grow the herbs around there... (53-year-old male herbalist)

> I always tell them not to eat certain things because it will trigger another episode...They have to be careful about eating okra. They also have to stop eating eggs, and... meat of any kind should be avoided as much as possible... it will be better if they eat fish. (47-year-old male herbalist)

The herbalists described these restrictions as necessary for the healing process to be effective and holistic. Unlike biomedically-based prescriptions around diet and health, the prescriptions made by these healers seem to be based on spiritual implications surrounding illness. As shown above, they believed that as soon as someone disobeys these rules, opportunity is provided for the illness to return. Other than these instances of disobedience, they believed that their methods of treatment cure mental illness completely. This is primarily because of their belief in the influence of spiritual dimensions in illness causation. These beliefs, in addition to the belief that the moon is a determinant in the manifestations of mental illness, are not unknown in history of biomedical psychiatry in other parts of the world. The use of dietary restrictions, isolation, and prescribed behaviour is perhaps similar to that which is used in biomedicine for other chronic conditions such as diabetes (de-Graft-Aikins, 2005). However, for our healers, the reasons for prescribing these processes is deeply linked to their spiritual conceptualization of the illness.

The methods of treating mental illness described above are similar to what has been found in other studies in other African countries (e.g., Konadu, 2006; Mzimkulu & Simbayi, 2006). Kajawu et al. (2016) reported similar uses of herbs by herbalists in Zimbabwe, such as using infusions, tonics, poultices, and ointments. Gari, Yarlagadda, and Wolde-Mariam (2015) also reported these methods in an Ethiopian population. Similarly, Makgopa and Koma (2009) described the use of ritual objects by healers in addition to the herbal remedies. Some studies (e.g., Nattrass, 2005) reported the use of herbal laxatives or purging as a common practice of healing, with the belief being that mental illness is located in the stomach. This previous work shows the common trends of traditional methods found in Africa, arising mostly out of common beliefs about the origins and causes of illness. The key difference in our present sample was the systematic process described.

Mode of administering treatments

Another theme which emerged revolved around the person responsible for administering the treatment. As we discussed above, the herbalists described various methods of treating their patients. These methods were either carried out by the healers themselves, or by the patient and their family. The treatments are administered in specific ways and need to be followed carefully to be effective. The healers themselves more often administer the herbal baths and inhalants:

> I have to give them the bath myself...because I have to make sure that they use the herbs correctly...then after I make a paste from the herbs...which I rub in their nostrils, on their eyes and in their ears. So, when I put it in their ears, I wait for

> about five minutes, then I put it in their eyes, then I wait another five minutes or so, and then put it in their ears. I normally wait for about five minutes or so to observe how they are reacting to the medicine, to know if I have to stop or increase it, or whatever... (49-year-old male herbalist)

The patients are usually given the topical medications to apply themselves (or with the aid of a family member). In addition, they are given instructions on how to take the oral medications or infusions:

> So, that herb which he has to inhale, I give it to him every three days, and the one he drinks, he has to take it every day. Whilst he is taking those medicines I will also...-give him some special creams to rub all over his body as well... (56-year-old female herbalist)

These methods are believed to ensure that the herbal remedies are efficacious. It also suggests a belief in the healer's own specific power, which forms an integral part of the process.

Purpose of specific treatments

The final emergent theme was the purpose ascribed to the various treatment methods that the healers prescribed. These have been categorised as follows: a) banishing evil spirits, b) protection from relapse/further attacks, and c) awakening the mind.

A common theme that ran through the narratives of many of our participants was the belief that illnesses are caused by evil spirits that need to be removed or banished. Therefore, the methods that are prescribed and undertaken have the primary purpose of banishing the evil spirits that had caused the illness or which had bound the patient in a disoriented state. One 62-year-old man said:

> I usually bathe them to make the spirit go away from the person...because I can see that the thing that has come upon him is not something that is naturally there. It is something unusual that has come upon him...because the way I see it, if I don't unravel that influence, and put something on his physical body to begin to unravel that influence, even if I give him medication it will not work for him... So, I have to give him something in order to remove that spirit which has him bound – the spirit that gave him that illness...

One of the female herbalists described her reasons as follows:

> ...depending on the problem I have to add some particular type of herb to the water for the bath to be effective...so with those herbs, when you use it to bathe, it expels every evil spirit from the person's body...

Such descriptions were common in our sample and formed the basis of most of their treatments. This also explained the systematic nature of the prescribed treatments, given that they believed that illnesses were caused by evil spirits, which needed to be removed before other methods are used to undo the physical damage that had been caused by the spirits.

In addition to banishing spirits, others cited prevention of relapse or protection from further spiritual attacks as their reason for prescribing specific treatments. For instance, many of our participants reported giving their patients herb-based creams and ointments to use after they had been healed. The reason cited for this was that it protects them from the potential attack of spirits in the future. A 59-year-old male herbalist recounted a treatment that he had given to a young boy who was plagued by evil spirits:

> I also gave them some ointment to rub over his head. The ointment is because, as the Bible says, when the evil spirit leaves a person's body it will roam around looking for another body to inhabit, but if it cannot find another body, it will return to the previous host with seven others like it. So, this ointment will prevent the spirit from returning to the body because now God has been brought to inhabit the person's body...

The 56-year-old female herbalist put it this way:

> The creams I give them to rub, we use it to banish the devil... if you're able to stop him, he will not dare return again. So, for some of our patients, they would like to buy the soaps or ointments that I make and use it from time to time so that there is no chance that the evil spirit will ever come back again... it is made from the same herbs that I use to perform the baths ...

The third purpose that the participants cited had to do with their belief that mental illness causes the mind to slumber. Many of them used phrases like "awakening the mind" to describe the outcome of their treatments. For instance, one man remarked:

> ...the medicine that I make him inhale, will wake his mind up...and his knowledge will come back...

Others also spoke about how the inhalants have the ability to penetrate the brain in order to awaken the mind of the patient:

> But the one that is inhaled...it goes straight to the brain...and then when...his former aggressive and violent behaviour have reduced, it shows us that the mind has become clear again... (54-year-old female herbalist)

> ...you give the patient some medicine that will make him sleep for a long time, then while he is asleep, you burn those herbs and place it next to him so that he will inhale it and then it will go into his brain while he is sleeping...and then his mind wakes up and he comes back to his state of mind... (62-year-old male herbalist)

Again, these purposes are similar to those described by other researchers in other studies (e.g., Simmons, 2012; Sodi et al., 2011; Sorsdahl, Flisher, Wilson, & Stein, 2010). The primary motivation appears to be to free the patient from the influence of the evil spirits that cause illness, and secondarily to prevent a recurrence of the condition. The underlying belief is, therefore, that any illness is treatable if the healer has the power and the knowledge to get rid of the spiritual component. Following this unbinding of the spirit, the physiological factors can then easily be treated.

Summary and implications

The present study explored the different treatment methods that one category of traditional healers – herbalists in the Greater Accra Region, Ghana – use for mental disorders. The herbalists reported some informal and spiritual diagnostic methods for identifying the specific conditions. They also described various herbal and ritual methods for treating mental illness, and had specific purposes for using such methods. There were also specific instructions for how the prescribed treatment was to be carried out.

All of these descriptions of the methods and purposes for specific treatments correspond with what has been described as an African notion of illness (see Mbiti, 1986; Opoku, 2002; White, 2015). However, there seems to be an intricate overlay of physiological factors in the narratives of these herbalists. That is, the belief that specific herbs have been created for spiritual healing, or that specific people have been given the ability to harness healing power from these herbs, is underscored by the fact that ultimately, some physiological processes need to occur for the illness to be treated properly.

These methods and practices have implications for the well-being of the participants, not only in the Ghanaian context, but potentially in other countries where traditional medicine is similarly used in a widespread manner. In particular, the informal nature of diagnostic processes suggests that diagnoses and treatment regimens are given on a case-by-case basis. Considering that patients are ingesting these remedies, these could potentially exacerbate their conditions, or result in other problems. Some previous studies have been conducted on the potential nephrotoxicity of some African and Chinese herbal medications (e.g., Akpan & Ekrikpo, 2015; Singh & Prakash, 2011). This is arguably due to the inconsistent methods that are used in preparing the medications. As such, these remedies present risks for the patients who use them.

Apart from the diagnostic implications, the methods may present a danger of toxicity, based on the informal or intuitive methods through which the herbal remedies are prepared. These methods are often not standardised, nor are they based on accepted empirical analyses (Singh & Prakash, 2011). Issues of hygiene and contamination could therefore result in patients developing complications and/or other conditions. Despite the attempt by the Traditional Medical Practitioners' Council and the Food and Drugs Authority of Ghana to regulate the practices of these healers, there is a large aspect of their work that is rooted in mysticism and remains unseen, so hence is difficult to monitor.

Further, many of our participants placed much emphasis on "spiritual" factors, such as curses and witchcraft, as causes of illness (this is similar to other studies, e.g., Field, 1961; Omenyo, 2006; Twumasi, 1975). Although we did not discuss specific causal belief systems in this paper, this emphasis on evil spirits as the cause of all illness may result in suspicion and hyper-vigilance in patients who might have benefitted from biomedical interventions. Such suspicions may affect family and social relations, or may lead to other disorders such as depression and anxiety disorders. These may inadvertently be attributed to evil spirits or to a failure to adhere to treatment on the part of the patient. Thus, a vicious cycle of blame and impairment may result.

Finally, the prevailing assumption for many traditional healers is that patients need to use either traditional medicine or biomedicine; indeed, some studies (e.g., Kajawu et al., 2016; Sandlana & Mtetwa, 2008) reported that traditional healers ask their patients to stop taking any medication prescribed by a hospital, as this was believed to interfere with the spiritual healing process. In our sample, the herbalists did not forbid patients from using other treatment options (including biomedicine) outright, but periodically hinted at the fact that such medications may interfere with the treatment process. This passive attitude toward alternative treatments can be risky for patients who could benefit from biomedical methods. It also speaks to the distrust that the herbalists have for biomedical methods and their practitioners, and may reflect their attitudes towards collaboration with biomedical systems.

These implications are drawn directly from our own data about the Ghanaian context, but may be equally applicable in other countries that similarly rely on the use of traditional medicine. Indeed, studies such as Akpan and Ekrikpo (2015) on the use of herbal medicines in Nigeria suggests that the use of alternative medical treatments has also grown in popularity in Nigeria. Similarly, studies in Zimbabwe, Kenya, and South Africa suggest that biomedical treatment is not the only option for much of the population. These are all countries with similar socio-economic conditions to Ghana, and where indigenous practices are still widely used. As a result, knowledge of their methods in mental healthcare may be an important step in understanding this system of care. In addition, concerns over the regulation and standardization of treatment may apply in other African countries with similar resources. Further, attitudes towards collaboration with biomedicine in these countries may also be similar.

Conclusion

The use of traditional herbal practices within the healthcare system in Ghana is a valuable but little-understood area. These practices are best understood from the perspective of the healers themselves. Once an insider understanding of the practices of TMPs is obtained, then the potential implications can be anticipated.

It is important, however, to mention that understanding their methods as important, and even potentially useful, cultural practices is one thing, but recommending herbal treatments over, or in addition to, biomedical treatments for patients is another. From our data, it is clear that the herbalists believe that they play an important role in their communities. Any person interested in community

well-being needs to take cognisance of this. But this is not the same as arguing that the herbal and other treatments are effective in treating mental disorders.

Our data did not explore the quality of practices, their efficacy, or the possible negative effects of herbal remedies for mental disorders. However, the absence of complete evidence for the efficacy of traditional treatments or for toxicity does not, of course, imply that we know that these treatments are not helpful or that they are toxic. In order to properly address this question, more work needs to be done with this group of healers.

Given this fact, and given that the work that herbalists do is largely unregulated and not standardised, nor open to easy large-scale empirical enquiry, it is understandable why biomedical practitioners may hesitate to refer patients with mental disorders to herbalists. This reluctance may extend to other forms of traditional healing, but may be particularly strong in the absence of knowledge of what herbal remedies are ingested, and with what possible effects. Until the methods and practices are streamlined and better regulated, biomedical practitioners may continue to avoid referrals. Further, until we gain an understanding of the differences and similarities between causal models in the different healing systems in Ghana, collaboration may continue to be difficult.

However, it does appear from the data that herbalists' understandings of mental disorders may be congruent with those of the people they treat, and it has been suggested that this congruence, as well as their emphasis on spiritual care, may be helpful in terms of treatment outcomes and adherence to treatment regimens (Sorsdahl et al., 2010).

Despite the insightful information that was obtained, there were a few limitations to our study, which are important to highlight. Considering the fluidity of traditional healing systems, an analysis of the methods of the other categories of TMPs in Ghana with regards to mental health would have been useful. The herbalists interviewed in this study also described methods that are typically ascribed to diviners and/or faith healers. Therefore, a comparison of the methods of these other categories would be insightful, and may well suggest the need for different categorizations. Secondly, an exploration of patients' views of treatment methods is also necessary. Their perspectives and experiences would provide important insights into the efficacy of these methods.

Despite these limitations, this study constitutes an important first step in understanding traditional herbalist treatment methods in Ghana surrounding mental disorders. Considering the widespread use of these methods, such knowledge would be useful in improving regulation and monitoring. It is also important, if there is to be any collaboration between biomedical and traditional healers in mental healthcare in Ghana, that any planned collaboration be based on an informed understanding of the healers' practices.

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CHAPTER EIGHT: ARTICLE 5

Muslim traditional healers in Accra, Ghana: Beliefs about and treatments of mental disorders

8.0 Introducing Article 5

The next group of healers whose work I examined was the Muslim clerics/healers. In the previous chapter, I discussed the work of traditional herbalists in the treatment of mental disorders. The herbalists viewed themselves as providing alternative, but systematic care for patients. In this sense, they attributed positive outcomes to their own abilities. In contrast, the *mallams* attributed their work to the power of Allah. They emphasized their own inability to treat illness. They also strongly emphasized their role as servants of a higher power, whose choice it was to heal or otherwise. Although they largely used the words of the Qur'an in their healing, some cases necessitated the inclusion of herbal or other elements in the treatment regimen.

One participant requested that photographs of himself and his healing implements be included in the dissertation. These photographs are presented below as Figures 5 and 6. In the first set of pictures (Figure 5), on the left is the board on which Qur'anic verses were written with ink (contained in the small white container). These verses were then washed with water into pots containing herbs and roots (shown on the right) and subsequently soaked for a few days. In Figure 6, the participant is shown wearing his official robes and holding a copy of the Qur'an.

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Figure 5: Photographs of writing board and soaked herbs (Photos taken by Lily Kpobi at the request of the participant)

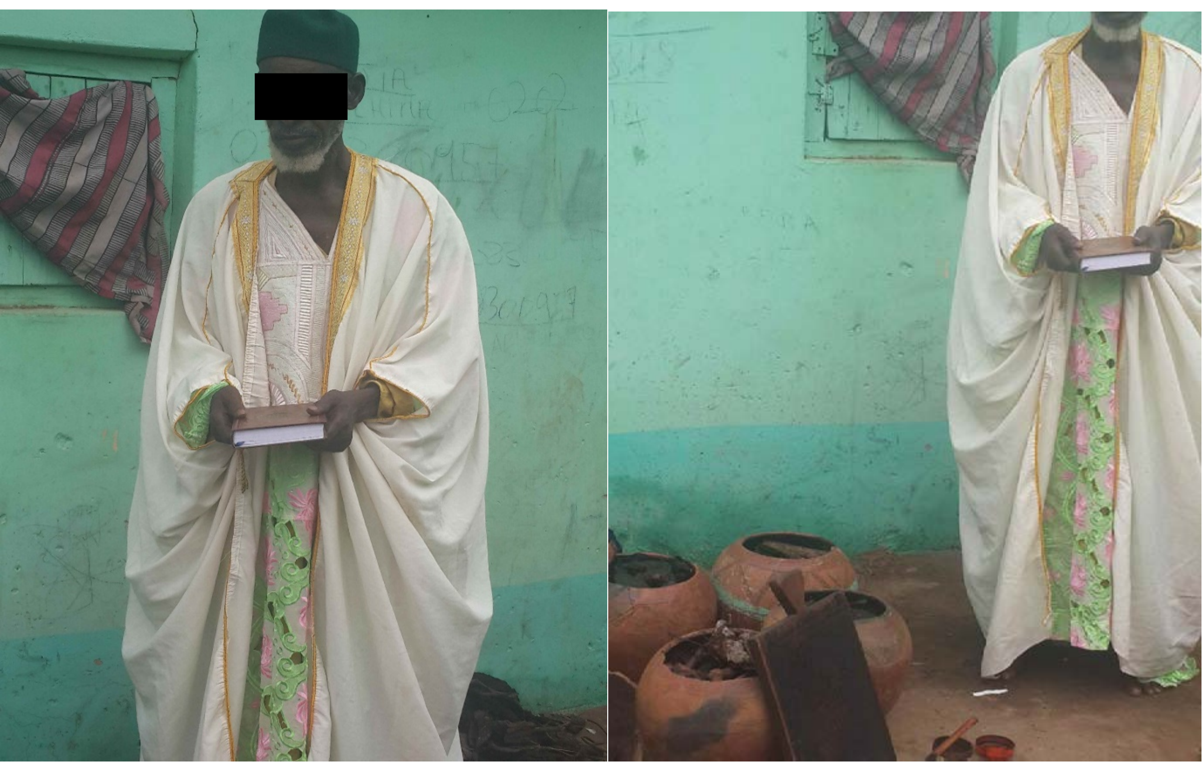

Figure 6: Photograph of a mallam wearing his official robe and holding a Qur'an (Photos taken by Lily Kpobi at request of participant)

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ORIGINAL PAPER

Muslim Traditional Healers in Accra, Ghana: Beliefs About and Treatment of Mental Disorders

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Abstract
Traditional and faith healing is a common practice in many low- and middle-income countries due to resource limitations and belief systems, particularly for disorders such as mental disorders. We report on the beliefs about mental illness from the perspective of one category of alternative healers in Ghana—the Muslim faith healers. We also report on their methods of diagnoses and treatment for mental disorders. Results show that the healers' beliefs about mental illness revolved around the notion of *Jinn* as causing most mental illness. Emerging themes are discussed with reference to their potential implications for patients' care and health-seeking behaviour.

Keywords Ghana · Islam · Jinn · Mental disorders · Faith healing

Introduction

Untreated mental illness presents a significant burden for both the individual and their wider environment and, consequently, may result in a loss in national productivity levels (Sipsma et al. 2013). Indeed, the WHO (2011) estimates that mental disorders account for nearly 12% of the total global burden of diseases. In addition to this, the mental health burden in many low- and middle-income countries is further complicated by the shortage of trained mental health professionals, weak policies that do not address the needs of the ill, the limited resources allocated to mental health within these countries and/or the difficulties in accessing these limited resources (Rathod et al. 2017). This is also the case for Ghana, where it has been estimated that there is one mental health professional per every one million people (Ae-Ngibise et al. 2010; Jack 2011). Further, the new mental health law which allows for improved resources and services remains largely unimplemented, 5 years after it was passed. As a result, many cases of mental illness in Ghana arguably remain undiagnosed or untreated (Ofori-Atta et al. 2010).

In addition to these broader factors, concepts of mental illness causation and treatment are deeply rooted in social and cultural notions of illness and misfortune (Musyimi et al. 2016). As a result, traditional and faith healing systems are often the preferred choice for

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patients and their relatives (Chowdhury 2016; Crawford and Lipsedge 2004). In Ghana, as in many other African countries, it has been argued that this is not only because of the similarities in beliefs and values, but also due to the perceived accessibility of these healers, as well as the often-flexible nature of remuneration (Ae-Ngibise et al. 2010; Gureje et al. 2015).

Various studies have also described how notions of health and healing are influenced by religious beliefs (e.g. Adewuya and Makanjuola 2008; Ally and Laher 2008; Nortje et al. 2016; Tabi et al. 2006), and this includes religions that are not considered indigenous to the people. However, despite global similarities in core facets of any transported religion, the local expression of religion in terms of beliefs and practices is shaped by factors which differ based on geographic location, as well as indigenous influences. Consequently, approaches to healing will be directed by a combination of cultural, religious and personal beliefs of the patient as well as the healer (Keikelame and Swartz 2015; Kleinman 1980).

In recent years, there have been increased calls for collaboration between traditional medicine systems and biomedicine (Gureje et al. 2015; Nortje et al. 2016). In Ghana, however, efforts at collaboration have been largely unsuccessful (Ae-Ngibise et al. 2010). This is likely due in part to the fact that, although there is some knowledge of the indigenous beliefs about mental illness, there is little documented on the specific methods used in treating these disorders. In addition, traditional medicine practitioners are often viewed as one broad category with similar practices. The differences which exist among different groups of healers based on their belief systems are also poorly documented. Therefore, in order to understand mental health in Ghana, there is the need to understand the context within which these systems operate. Such knowledge can then drive collaborative efforts which may be more likely to be sustained.

In Ghana, 18% of the population, according to recent census data, describe themselves as Muslim (Ghana Statistical Services 2012). There is a well-developed set of healing practices aligned to Islam in Ghana (Adu-Gyamfi 2014; Edwards 2011), but to our knowledge, there are no published studies on the mental healthcare methods of Muslim religious healers in Ghana. It is on this group of Ghanaian healers that we focus in this article.

Islam and Mental Illness

Belief in the supernatural and its influence on human behaviour and experiences is a common concept in many world religions. Islam in particular emphasises the existence of specific unseen spirits or entities, and the role they play in the lives of people. These spirits—called *Jinn*—are believed to possess traits similar to humans but, in addition, have the ability to take on various forms (Laughlin 2015). They are also believed to be either good or evil. The evil *Jinn* are considered to be the cause of much of the havoc that exists in the world (Dein et al. 2008; Islam and Campbell 2014).

The *Jinn* are also believed to have the ability to possess people, which may result in the possessed falling ill, behaving in ways that are considered unusual or sometimes malevolent, or in some cases leading to extraordinary prowess or abilities (Hussain and Cochrane 2002; Kapferer 1991; Laughlin 2015). In addition to possessing people, the *Jinn* are also able to give people the ability to perform black magic or witchcraft (called *Jaadoo*) to harm others, or to cause them to behave in disruptive ways (Hussain and Cochrane 2002; Laher and Kahn 2011). Descriptions of unusual behaviours are often similar to biomedical notions of mental illness, but are believed to be caused by the *Jinn*. As a result of these prevailing beliefs, some Muslims resort to religious and faith healing practices rather than,

or in addition to, biomedical methods (Al-Ashqar 2003; Ally and Laher 2008; Dein and Sembhi 2001).

There is also the belief in the evil eye (or *Nazr*). Unlike the *Jinn,* the evil eye is believed to originate from humans themselves as a result of envy or jealousy (Ally and Laher 2008). Such jealousy or envy can cause a person's spirit to wish ill upon another's. This ill will is believed to manifest in abnormal behaviours. When an individual is inflicted with the evil eye, they are believed to exhibit symptoms such as lethargy, insomnia, and listlessness, all of which are similar to what is classified as clinical depression in biomedical understanding (Ally and Laher 2008; Sayed 2003; Syed 2003).

Islam teaches that God allows illness to afflict a person for his own reasons. However, some suggest that the patient is allowed (even expected) to seek solutions to their problems through natural remedies, spiritual remedies, or a combination of the two methods (e.g. Littlewood 2004; Parkin 2007; Roy 1982). As a result, healing practices may involve the use of herbal and alternative methods in addition to methods considered "spiritual" (Adu-Gyamfi 2014). Other writers argue that such methods reflect a more syncretic approach to Islam and that Islam in its "pure" sense advocates reliance on God and his words for healing or deliverance. Based on these two viewpoints, patients could either receive strict regimens which are considered spiritual or divine in nature, or they would receive a combination of spiritual and natural remedies for illness.

Previous studies have discussed the Islamic notion of *Jinn* possession (e.g. Islam and Campbell 2014; Littlewood 2004; Wilce 2004) and the prevalence of this belief among minority populations. Other studies have discussed Islamic methods used in exorcism of these *Jinn* (a process called *Ruqyah*; e.g. Adu-Gyamfi 2014; Al-Ashqar 2003; Younis 2000). Many of these studies have highlighted the use of such methods in matters of illness and misfortune among Muslims, including mental disorders, for different categories of patients. Seemingly, mental illness is considered by many Muslim healers as a state of *Jinn* possession. Hence, healing involves exorcism of the spirit which has afflicted the patient.

Despite this knowledge, and considering the tendency of faith healing methods to involve a blending of indigenous cultural and religious beliefs/practices, the methods are likely to differ from one setting to another. Inasmuch as the core beliefs may be similar, the specific approaches to obtaining such healing would likely differ from country to country. The aim of this article is therefore to describe the methods for treating mental disorders from the perspectives of Ghanaian Islamic healers.

Although some research has been done on the use of traditional and faith healing by patients in Ghana, these have been predominantly about biomedical conditions such as tuberculosis, HIV/AIDS and cancer (e.g. Addo 2008; Amoah et al. 2014; Dodor 2012; Opoku et al. 2012). Further, much of the focus has been on the use of such methods by patients but not on the actual methods themselves. Finally, these studies generally examine traditional and faith healers together, without separating them into categories based on their creeds or their training. The data reported in this article form part of a larger study of different categories of healers, but in this article we focus on the work of Muslim traditional healers in mental healthcare in Ghana.

Methods

Research Design

In this study, a qualitative approach was employed to answer the question: "How do Muslim healers in Accra understand and treat mental disorders?" Specifically, we employed an experiential qualitative design (Braun and Clarke 2013) to examine the lived experiences of the healers with regard to the treatment of mental disorders. We found the use of an experiential qualitative approach to be appropriate for exploring the participants' views on mental disorders based on their own experiences. This study therefore used an interpretative phenomenological lens in order to understand the mental health views and perceptions of Muslim traditional healers in Accra. This design also allowed us to interact with participants within their natural setting, thereby allowing a somewhat "insider" perspective of their contexts, and ensuring a greater level of openness (Babbie and Mouton 2001; Gray 2009). This was particularly useful given the stigma associated with mental disorders in Ghana.

Research Setting and Participants

The study was conducted among Muslim faith healers in the Greater Accra Region of Ghana. The Greater Accra Region is located on the southern coast of Ghana. It is a peri-urban region populated with both rural and urban settlements, including Ghana's capital city, Accra. There is a high level of rural–urban migration from other parts of the country to the region. As such, the population of Greater Accra comprises people from various ethnic, religious and faith groups.

There are different categories of healers recognised in the Ghanaian context. These include herbalists, shrine priests, pastors (or Christian faith healers), and Islamic or Muslim religious healers. The Muslim healers are called *mallams* in local parlance. For this study, we interviewed mallams in the Greater Accra Region. Many of these mallams had migrated from one of the northern regions of Ghana (where Islam is more dominant) and were located in neighbourhoods which were predominantly Muslim settlements.

For this study, ten mallams were recruited through the Ghana Federation of Traditional Medicine Practitioners Associations (GHAFTRAM), which is an umbrella body of the various groups of traditional and alternative healers. Specifically, GHAFTRAM put us in touch with the leadership of the Ghana Muslim Traditional Healers Association, a sub-group of the Federation, through whom potential participants were purposively and conveniently recruited. In addition, snowballing was used to identify further participants. Individual, semi-structured interviews were conducted with the ten healers.

Mallams were included in the study if they could speak English, Ga or Twi (the most commonly used languages in the region) and if they had practised as mallams for at least 5 years. All ten mallams were male, and their ages ranged from 51 to 76 years. The number of years they had practised ranged from 16 to 47 years.

Procedure

Before any data were collected, ethics approval was obtained from Stellenbosch University Research Ethics Committee. Further, local ethics clearance was obtained from the Ghana Health Service Ethics Review Committee. In addition to these, institutional permission was

obtained from the Ghana Traditional Medical Practitioners' Council and from GHAFTRAM.

Through GHAFTRAM, potential participants from the Muslim healers' subgroup were identified. Due to cultural and religious rules, these participants were approached through a trained male research assistant, given that it was frowned upon for females to interact directly or unaccompanied with mallams. Individual informed consent was obtained from each participant after the objectives of the study were explained. Basic demographic information was also collected from participants.

The participants were asked a number of questions on a variety of topics using a semi-structured interview schedule. The items in the semi-structured interview schedule were developed based on concepts from previous studies of traditional and faith healing (see Keikelame and Swartz 2015; Kleinman 1980; Sorsdahl et al. 2010). With regard to their work with mental disorders, questions such as "how are you able to identify what the patient's illness is?", "how would you treat [this] illness?", and "how do you think this illness will affect the patient?" among others, were asked. The broader schedule was developed for the larger study on different categories of healers.

All interviews were audio-recorded with consent and took place in the homes and/or workplaces of the healers. The interviews were conducted in English, Ga and/or Twi, depending on which the participant was most comfortable in using; in most cases, this involved a combination of English and one of the local languages. Interviews lasted an average of 41.2 min.

Data Analyses

All interviews were transcribed verbatim depending on the language of the interview. Where necessary, the transcripts were translated into English, then back translated by a linguist to check for accuracy and consistency.

Data were analysed thematically using the six-step model described by Braun and Clarke (2006). Initial codes were generated inductively based on the participants' accounts of their beliefs and methods. Following this, emerging patterns and trends were identified and classified as tentative themes. These were reviewed and defined to produce the broad thematic areas described below. All data were analysed using the ATLAS.ti qualitative data analysis software (v.8).

Results and Discussion

Based on the data collected in this study, the work of mallams surrounding mental healthcare can be organised into two main themes. First, the diagnostic methods used by the mallams to identify the problem. Second, the specific treatment methods and regimens that are used. Each of these is discussed below. However, these methods were dominated by the mallams' explanations about the origin of mental illness. Therefore, we begin this section by discussing their beliefs on the causes of mental illness.

Beliefs about Mental Illness

All the mallams that were interviewed described their ideas about how mental illness came about. These descriptions were dominated by the idea of *Jinn* as causing most illnesses, but

especially those which affect the mind. For example, one participant, a 76-year-old mallam stated,

> *…there are some [people] who get mad through the* Jinn*… They can be like we the normal human beings* [sic]*, the way we appear. And they can behave just like us, some of them are very good and they can bring blessing on your path, but some of them are evil and they work with the demons and satan to cause trouble. So sometimes the trouble that they cause is leading people to madness.*

From this participant's description, the *Jinn* can have a positive influence on people as well as causing trouble. Such descriptions were common from our participants. However, many of them explained that the *Jinn* possess people in various ways or for various reasons. One way that they could inhabit a person is through the individual's own behaviour or mistakes. This is described by another participant as follows:

> *…these* Jinn *…they are usually in bathrooms, toilets, anywhere that is dirty … So when you enter places like that you can meet the bad* Jinn*… they can enter you… especially if you talk while they are around; they will enter you through your mouth… then they start to… give you mental illness and other things.*

This participant describes the process of *Jinn* possession as happening through the mouth as an entrance into the body. Such explanations were common from our participants. For them, the *Jinn* can enter the person when they neglect to do things that would protect them from this possession. Some of our participants spoke of things that could be done to protect the individual from *Jinn* possession, such as reciting a short incantation before entering bathrooms or toilets, or places that were seen as dirty. Others also spoke about behaviours and traditions which were meant to be followed for protection from the *Jinn* and consequently mental illness. One such description is given below, by a 59-year-old mallam:

> *…you see, that is why… every woman has to cover her hair whenever she is going outside…they are usually weak and more vulnerable to the spirits…the* Jinn *are just like us, so when they see the woman's hair or they see some other part of her body …they can fall in love with her, and enter her …if she doesn't cover herself, she allows them to come into her very fast!*

However, apart from the things that people do which cause them to be possessed, there were also descriptions of instances where the person was afflicted by *Jinn* as a result of witchcraft or the machinations of an "enemy". Such cases were also common explanations for unusual behaviour. Our participants believed that when someone was jealous of another, they could cause the *Jinn* to possess the other person in a bid to destroy them. This was done by offering the spirits something of value to them. There were therefore many descriptions of people "buying" *Jinn* influences to use to harm others. An example is described as follows:

> *…in the spiritual aspect, when you give birth to a person or when you are growing up, they know what you are and what you will become, so they can also buy those evil* Jinn *and they will be following you and disturbing you by giving you that type of illness called madness. That one, someone went to the spiritual world and bought it for you.*

This description appears to be similar to what other studies have described as the effects of the evil eye (*Nazr*). Although our participants acknowledged the presence of the evil

eye, their descriptions appeared to circle back to the *Jinn* as causing this evil eye. This is quite different from what others have reported as the evil eye being a result of human behaviour (e.g. Ally and Laher 2008).

Despite the dominance of spiritual explanations for mental disorders in all our participants' accounts, some of them did admit that there was the possibility of other causes for mental illness. These alternative explanations primarily involved mistakes made by other people, such as road traffic accidents leading to brain injury, or drug misuse, subsequently leading to abnormal behaviour.

The beliefs of our participants regarding the causes of mental illness were therefore dominated by spiritual explanations. This is not unlike what has been found in other studies in different populations (e.g. Dein and Illaiee 2013; Khalifa and Hardie 2005). For the most part, these explanations are derived from descriptions in the Qur'an and the Hadith about how *Jinn* and *Nazr* influence human behaviour (Islam and Campbell 2014). This is particularly so with regard to possession through the individuals' own neglect. However, explanations of *Nazr* attacks by enemies appear to have been influenced by indigenous African notions of illness and misfortune. Such notions include the belief in jealousy, envy and/or greed as motivating factors for one person to seek the harm of another. As a result, the jealous individual may cause their target harm through spiritual means. Considering the stigma attached to mental disorders, one of the common ways that this is done is through afflicting the person with mental illness.

Diagnostic Methods Used

As part of their treatment process, the mallams had specific means of diagnosing their patients' conditions. The predominant mode of diagnosis was through interviewing the patient and/or their relatives. Many of them described this process as "*the same way that the doctors do it*". For instance, one participant, a 52-year-old mallam stated,

> *…the complaint that the person makes… will help us to see that it is because of this illness or that illness that is why the person is complaining of this or that behaviour…just like how they will do it when you go to the hospital; the doctor will ask you questions, to understand what has brought you there.*

Despite this similarity to biomedical methods, a key part of this interviewing process involved questioning the patient about their dreams. Many of our participants described dreams as a vital clue to identifying the underlying illness that plagued their patients. One such narrative is described below:

> …when they bring the people to me… I have to see whether he had a dream that he is in a river, or maybe he had a dream that he was seeing some dead person… somebody who died a long time ago; you might have a dream and you can see the person. So when I ask all these questions …that will show me what kind of illness it is.

According to this participant, the nature of the patient's dreams would reveal the kind of illness plaguing him. He reported that different themes in the dreams would manifest in different behavioural symptoms. And these in turn inform the treatment approach.

In addition to the healers' interviews and observations, almost all participants reported that despite their personal efforts, the true diagnosis will often be revealed once certain verses of the Qur'an were recited or read for the patient.

> So when [they] come, we recite the Qur'an to their hearing, then the spirits that are in the person will start to confess and will tell us why they have inhabited that person's body… [it] depends on the way the person will be reacting to us…when we are reading the verses [from the Qur'an]…it will help me to know that what is worrying him is a mental problem or a spiritual problem or whatever.

By reciting the verses of the Qur'an for diagnostic purposes, the healers' belief in spirits causing mental illness is evident. Their use of the verses was due to their belief in the power contained within those words, which could banish or repel the spirit that was causing the disturbance in the individual.

The use of Qur'anic verses for medical diagnoses is not a new practice. Previous studies have reported this in different Muslim populations (e.g. Al-Habeeb 2003; Ally and Laher 2008; Gadit and Callanan 2006). Significantly different in our sample of mallams was the explanation of different elements of patients' dreams as indicating specific disorders. Again, this is likely influenced by indigenous cultural explanations of illness which have been fused with Islamic methods. This syncretic approach to healing is therefore dependent on both healer and patient perceptions within the cultural contexts that influence illness manifestation and outcomes (Stephenson 2013).

Treatment Methods Employed

Another aspect of the mallams' work involved the different treatment methods that they employed for patients with perceived mental disorders. To a large extent, these methods were similar for all our participants, although some differences did exist based on their individual backgrounds and beliefs.

The predominant method that was described by the mallams was the recitation of verses from the Qur'an. All ten participants reported that even if they prescribed additional treatments for their patients, the primary mode of healing was through the words of the Qur'an. Ultimately, they believed that all healing was done by God through them. Verses, or sometimes whole chapters, were therefore recited to the hearing of the patient. If the patient was able to, they would be required to read the verses themselves. They believed the Qur'an contained the very voice of God which had the power to cure any illness. This is illustrated in the quotation below, by a 54-year-old mallam:

> …the al-Qur'an has many verses that can be recited and used to treat problems for any individual. So when we start saying those words from Allah over and over again many times, then the spirit of sickness will start to feel uncomfortable and then it will leave the person… sometimes we will write it down for them to also read for themselves, or maybe their family members can read it [for them] when they go home.

However, simply reciting or reading the verses from the Qur'an was sometimes inadequate when dealing with a difficult case. Some of the participants explained that sometimes the verses were written down with specific herbal extracts and washed with water. The water that was used to wash these verses was believed to imbibe the power of the verses and hence contained healing power as well. Patients were sometimes made to bathe with this water and/or drink it to complete the healing. The quotation below illustrates this process:

> I usually… give them some holy water or spiritual water…they use it to bathe, they drink it, and also use it to mix the herbs that we will give them… At midnight then they bathe with the water. He doesn't have to take plenty [of the water], just a small bowl of the spiritual water; he will pour it… on his head, usually he will start at the head and bathe with it.

In some cases, the water that was used to wash the verses is used to soak plants or roots which the patient will bathe or drink. For instance, one of our oldest participants, a 76-year-old mallam who reported that he had been healing people for over 40 years, described his method to us in detail:

> *…we treat the people who come to us, with the verses from the Qur'an and sometimes with herbs… Sometimes we have to soak the herbs and the roots in the pots for some days. Then we use the* "tawada"*, that one is some ink that we make from a particular tree, to write the verses of the Qur'an on this board* (a wooden plank)*, which we call "*allo*". Then… we write the healing names of God on it and then we wash it into the pot that has the herbs in it, for the person to drink it, or even to bathe with it and then it can remove all the things that will be causing the problems from their lives… so that nobody else will get that madness.*

In other instances, the verses were written on talismans like rings and given to the patient to wear during and after treatment:

> *Sometimes you can [make] a talisman with the verses, so that the person can even wear it on him… So we can give them [a] ring, it is very powerful. It has the Qur'an on it. So… if you recite [the verses] and the* Jinn *didn't respond, if you give him or her the ring, immediately it is like fire that will burn [the* Jinn*], and so he will respond…then we can use it to remove the spirit from the person.*

In addition, the herbal remedies that patients were given were not limited to herbal infusions or decoctions; sometimes, patients were given herbal ointments or perfumes to use as a means of protection from further attacks; other times, herbs were lit on fire and the patient made to inhale the smoke. All these were done to banish the evil spirits and, subsequently, to protect the patient from further attacks:

> *…when we finish with all that, there is some pomade, I make it from some of these herbs that we have here…he will just have to rub it and put it on himself, especially the head… that place where the problem is, then it will go.* (71-year-old mallam)

> *…then you can take some of these other ones…some herb that he will put on the fire directly, for it to burn, so that the smoke, he will be inhaling it.* (66-year-old mallam)

All of these processes were done to banish or repel the evil spirit, which is believed to cause the mental illness, from the patient. The methods, however, appeared to be based on a trial-and-error approach, and none of our participants were able to prescribe specific durations for the treatments they provided. Many of them simply repeated their treatments a number of times until they could observe a change in the behaviour of the patient. At most, they reported the number of times that verses or chapters needed to be written in order to be effective:

> *… we will pick a particular* Sura *from the Qur'an, we call it* "Yaseen"*, and we will write it 41 times, so that you will be drinking it and bathing in it for one week or one*

month, depending on what it is…some of them even do it for one year! But after that, nothing will happen again.

Other participants also prescribed different durations for the treatment, but they all reported that it was stopped only when there were no further indications of the presence of the spirits or of symptoms of possession.

Some of the methods described above are similar to those described in other Muslim populations (e.g. Ally and Laher 2008; Cinnirella and Loewenthal 1999; Dein et al. 2008; Islam and Campbell 2014). Our participants, however, also described additional practices which appear quite syncretic in nature. The writing and washing of Qur'anic verses, coupled with the specific preparations of herbal remedies, is certainly influenced by traditional Ghanaian herbal practices (Tabi et al. 2006). Similarly, the use of protective talismans appears to draw from traditional animist religions. However, the belief in the power of the words of the Qur'an and its use in repelling evil spirits was described by all of our participants as expected of a good Muslim. Based on their teachings and traditions, these verses are believed to be able to overcome any difficulty or misfortune. As a result, many of them believed that it was the only thing needed for healing or wellness. For some, any suggestion of alternative or additional treatments was considered inappropriate.

Discussion

In this article, we have described beliefs and explanations given by Islamic healers in Ghana (called mallams) regarding the origin and cause of mental disorders. We also described the methods they used to diagnose and treat mental disorders. The mallams all believed that mental disorders are caused by evil spirits called *Jinn* who possess people for various reasons and cause them to behave in unusual or inappropriate manners. Their descriptions of such abnormal behaviour (and what they considered mental disorders) were primarily about severe psychotic behaviour. This predominance of belief about *Jinn* as the cause for mental disorders was somewhat surprising. From previous studies (e.g. Ally and Laher 2008; Cinnirella and Loewenthal 1999; Dein et al. 2008; Islam and Campbell 2014), we expected a wider range of causes to be identified. All our participants did acknowledge that other factors such as the evil eye, road traffic accidents and drug misuse could result in brain malfunctioning which would manifest in abnormal behaviour. However, despite admitting that these other factors could arise through human error, they also believed that the *Jinn* could orchestrate such incidents. Particularly in the case of drug misuse, they saw such behaviour as a moral failure on the part of the individual which allowed the *Jinn* to possess them.

The mallams used various informal spiritual methods for diagnosing disorders. The primary mode of treatment involved using the Qur'an and its chapters or verses. In addition to the Qur'an, they also used various herbal remedies and talismans to complete the healing or to protect the patient from future episodes.

These methods are based on religious and indigenous notions of mental illness causation (Mpofu et al. 2011) and involve a mixture of Islamic and indigenous practices. The Islamic aspects involve not only the specific verses of the Qur'an, but also ideas which were drawn from other Islamic texts like the *Sunnah* and the *Hadith*. These are read or recited with the belief that they have the power to expel evil spirits which are thought to possess people, resulting in abnormal behaviour.

People's preference for such methods was also reported by our participants. This was not only due to congruent belief systems, but also due to the flexibility of this health

system. For instance, some of our participants reported that patients did not need to make monetary payments if they could not afford it. The healers were willing to receive whatever means of thanks that the patients were able to provide; in some cases, they reported that they did not receive any form of payment at all. This was primarily due to their conviction that they merely served as conduits for the healing process which ultimately came from God. They saw themselves as providing a more humanitarian service than biomedical systems provide.

This certainly has implications for patient health-seeking. As has been reported in other studies in Ghana, people were reported as preferring to go to traditional healers because of factors such as accessibility and affordability (Ae-Ngibise et al. 2010; Ofori-Atta et al. 2010). The mallams' benevolence would therefore be appreciated and may be sought by the people in a context where mental health resources are limited.

Though treatment by mallams may be more accessible to the public than other treatments for reasons of cost, this does not address the question of how effective treatments may be. The processes and treatments that the mallams undertake are largely unstandardised. Much of their work appears to be trial-and-error, and it is possible that treatments may be ineffective or even, in some cases, present risks for patients. One of the major risk areas was the use of herbs and inks which patients needed to drink or bathe in. None of our participants were able to explain the specific content of these inks. This may present a risk of toxicity for the patients who imbibe the mixtures.

In this study, we have described some of the methods used by Islamic healers for mental disorders. Despite the uniformity of their use of the Qur'an in healing, there is a level of ambiguity present in their outcomes. Their reliance on the confession of the so-called *Jinn* to diagnose, and also to determine the direction of the treatment process, is highly unreliable considering the potential for patients with psychotic disorders or patients who are disoriented, to utter things which are not accurate. As such, what the healer would suppose is a *Jinn* confession of possession, may well be the result of a confused patient.

Further, the treatment regimens did not have fixed timelines. The healers relied on observed changes in behaviour to determine recovery. Given the self-limiting nature of many common mental disorders, this may also be a false outcome of passing time.

Paradoxically, there was a deep commitment on the part of our participants to doing the patient no harm. The mallams frequently spoke of the repercussions that they would encounter if their methods led to any adverse effects for the patient. This was one of the reasons for their reliance on the Qur'an, which they said would never lead to harm for the patients. However, their use of herbs and other materials is not specifically guided by the Islamic holy books or by other protocols and is therefore difficult to regulate or standardise.

Regardless of this ambiguity, the value of the spiritual engagement of the healers with the patients cannot be denied. The patients' belief in what the healer was doing has been suggested to serve as a positive coping mechanism for them, which influences recovery and relapse rates (Hanely and Brown 2014).

Conclusions

The use of faith healing for mental disorders is not likely to stop in the foreseeable future. The healers' congruence with patients' beliefs about the causes of illness and misfortune is one of the major reasons for its widespread use and popularity. Therefore, calls for collaboration between traditional and faith healers, and biomedical systems are a move in the right direction. However, the limited knowledge about the work of traditional medicine

practitioners is a big drawback to successful collaboration. This lack of knowledge may also explain some of the mistrust and suspicion that often exists between these two systems of healthcare (Gureje et al. 2015).

However, understanding their methods and recommending their use for patients are two different situations. From our data, the mallams believe that their work is more humanitarian than that offered by biomedical systems, and as a result, more effective. However, most of them also believed that biomedical methods were a waste of time since they did not tackle the root cause of the disorders. This speaks to their perceptions of potential collaboration with biomedicine. Indeed, many of them stated outright that they did not think it was necessary to work with doctors because the doctors' methods would not result in complete healing. Such statements are worrisome, in the light of the widespread call for collaboration between the different systems.

This study has found insightful descriptions about the methods of Islamic healers in the Ghanaian context with regard to diagnosis and treatment for mental disorders. Regardless of this information, there were a few limitations which are important to note. Given the cultural influences on notions of illness, the descriptions and views of mental illness may also be held by other healers. The data must therefore be viewed within the larger context of traditional or alternative healthcare in Ghana. That is, a comparison of the different categories of healers would be insightful. Secondly, an exploration of the patients' experiences and views would also provide a broader picture, particularly into the efficacy of these methods. Despite these limitations, we believe the results can provide an important first step in understanding mental healthcare and practices in a Ghanaian context.

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Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Declaration of Helsinki and its later amendments or comparable ethical standards.

Informed Consent Informed consent was obtained from all individual participants included in the study.

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CHAPTER NINE: ARTICLE 6

"That is how the real mad people behave"*: Beliefs about and treatment of mental disorders by traditional medicine men in Accra, Ghana*

9.0 Introducing Article 6

In this article, I present the methods of the traditional shrine priests. These priests are also sometimes referred to as diviners or traditional medicine men. The shrine priests represented specific deities/gods, and purported to work only when directed by these gods to do so. Their diagnostic and treatment methods therefore included various ways of divination, prayer and incantations. The healers' reliance on the directives of the gods for guidance in their work further entailed a strong work ethic to ensure they did no harm. They believed that any misuse or misrepresentation of the deity would result in negative consequences for them.

Although this paper was intended to discuss the priests' treatment methods, these methods were highly influenced by their beliefs about illness and mental disorders in particular. Thus, this article includes a section on their beliefs. Their causal beliefs were dominated by spiritual and inter-personal explanations for mental disorders.

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'That is how the real mad people behave': Beliefs about and treatment of mental disorders by traditional medicine-men in Accra, Ghana

Lily Kpobi **and Leslie Swartz**

Abstract

Background: Traditional healing methods are considered central to mental health care in low-income countries such as Ghana, because they are perceived to be more easily accessible, more affordable and generally ascribe similar causal beliefs to those of the patients. However, not much is known about the work of traditional healers largely because their methods are shrouded in mysticism and secrecy. There is a need to understand the ideology and beliefs of traditional healers surrounding mental disorders, including knowledge about their practices in mental health care.

Aims: In this article, we discuss the causal beliefs and treatment methods of traditional medicine-men from Accra, Ghana. We also describe their diagnostic and treatment methods for mental disorders.

Methods: Eight medicine-men, indigenous to the Greater Accra Region, were interviewed through individual semi-structured interviews. The data were analysed through thematic analysis.

Results: The medicine-men's beliefs about mental illness were dominated by supernatural ideas. Mental illness was also seen as a form of punishment or resulting from envy, and there was a strong reliance on spiritual direction from the gods for diagnosis and treatment.

Conclusion: These themes are discussed with emphasis on their potential implications for patients, as well as for collaborative efforts.

Keywords

Ghana, traditional healers, gods, mental disorders

Introduction

The treatment of mental disorders by formal biomedical institutions in low- and middle-income countries (LMICs) has been limited. This biomedical model views mental disorders as a biological malfunction of the brain and places much emphasis on the use of pharmacological approaches in treating the malfunction (Deacon, 2013). Various reasons have been suggested for the limited availability of biomedical treatments for mental disorders in LMICs, including the expensive nature of the biomedical model, limited number of trained personnel and divergent beliefs about causal factors (Cocks & Moller, 2002; Devenish, 2005; Liddell, Barrett, & Bydawell, 2005; Sodi et al., 2011). As a result, alternative healing systems are estimated to be used by up to 70% of people (Ofori-Atta, Read, Lund, & the MHaPP Research Programme Consortium, 2010), arguably because they are perceived as filling in the gaps in the biomedical system, by incorporating socio-cultural beliefs and practices in their treatment (Ae-Ngibise et al., 2010).

Traditional healing is considered central to mental health care in many countries because it is perceived to be more easily accessible, more affordable and generally ascribes similar causal beliefs to those of the patients (Ae-Ngibise et al., 2010; Read, 2012). However, not much is known about the work of traditional healers, largely because their methods are often shrouded in mysticism and secrecy (Mokgobi, 2014).

Given the limited knowledge of the methods of traditional healers, and the high patronage of traditional healing systems, it is important to negotiate between the benefits

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of traditional medicine use on one hand and the potential harm and/or toxicity that may exist on the other hand. To achieve that balance, an understanding of the ideology and beliefs of the traditional healers surrounding mental disorders is needed, including more knowledge about their methods in mental health diagnosis and treatment.

Indigenous beliefs and the use of traditional methods for mental health care have been documented in several African countries. Variously, mental illness in African cultures is conceptualised as caused by physical and spiritual imbalance within the individual (Sodi, 2009), ancestral displeasure, evil spirits and jealousy (Mashamba, 2007; Xaba, 2002), as well as malevolent spells or curses (Monteiro & Balogun, 2014). Such supernatural causal beliefs have been reported in different countries including South Africa (e.g. Mashamba, 2007), Zimbabwe (e.g. Kajawu, Chingarande, Jack, Ward, & Taylor, 2016), Nigeria (e.g. Agara, Makanjuola, & Morakinyo, 2008), Kenya (e.g. Mbwayo, Ndetei, Mutiso, & Khasakhala, 2013) and Ghana (e.g. Ae-Ngibise et al., 2010; Konadu, 2006).

The methods used to treat mental disorders have received considerably less attention than the healers' causal beliefs. Some African studies have described the process of becoming a healer (e.g. Berg, 2003; Makgopa & Koma, 2009; Sodi et al., 2011; Xaba, 2002). Others have reported methods such as exorcism, rituals to appease the spirits and the use of protective charms as common modes of treatment for illness in different cultures. However, to our knowledge, no documented study has described the specific methods used in the Ghanaian context.

The aim of this article is, therefore, to discuss the aetiological beliefs and treatment methods for mental disorders by one group of traditional healers in Ghana, a low-income country which has documented widespread use of traditional medicine (Ae-Ngibise et al., 2010; Ofori-Atta et al., 2010; Read, 2012). Although some studies have discussed the use of traditional medicine by patients, little attention has been given to the methods themselves and how the healers understand mental illness.

Organisation of traditional healing systems in Accra, Ghana

The Traditional Medicine Practice Act, 2000 (Act 575) of Ghana (World Intellectual Property Organization (WIPO), 2017) defines traditional medicine as 'the beliefs, ideas and practices recognized by the community to provide healthcare' (p. 14). Traditional healing systems draw predominantly on the cultural beliefs and practices of the community (Sodi et al., 2011) and are mostly directed at re-establishing physical and spiritual balance in the patient. Therefore, traditional healing systems reflect a social ecological process by incorporating folklore, herbal remedies, traditions, rules and values which are important to the particular community (Tabi, Powell, & Hodnicki, 2006; Twumasi, 1975).

Various categories of traditional medicine practitioners (TMPs) are recognised in the Ghanaian context, including herbalists, Christian and Islamic faith healers, and traditional medicine-men/diviners (Tabi et al., 2006). This article centres on the work of traditional medicine-men from the Greater Accra Region of Ghana in treating mental disorders. These healers are believed to be conduits or servant-mediums of gods or deities. The spirits are believed to give them power and ability to treat illness, to provide protection against enemies and (in some cases) to do harm to others (Field, 1961).

The ethnic group indigenous to the Greater Accra Region is the Ga-Dangme group. The Ga-Dangme belongs to the Kwa cultural classification, which is found along the West African coast, from southeast Ivory Coast through to Southwest Nigeria (Kropp-Dakubu, 1988). This ethnic group is made up of two similar but significantly different sub-groups, namely, the Ga and the Dangme. They have noticeable differences in language, chieftaincy and social organisation. We focus here on the work of medicine-men of the Ga people.

The Ga people believe in the existence of a supreme, all-powerful creator (*Ataa Naa Nyɔŋmɔ*), who is believed to have both male and female attributes, and is seen as the source of all life (Abbey, 2001; Field, 1961). The creator is believed to be accessible only through intermediaries, due to his omnipotent nature (Odotei, 1991). He is, therefore, represented on earth by gods or deities (called *jemawɔji*; sing. *jemawɔng*) who inhabit various sacred shrines, such as rivers, oceans, lagoons, groves and hills.

Each community has its own *jemawɔji*, depending on the sacred shrines found there. The *jemawɔji* are sometimes referred to as lineage gods (Odotei, 1991) and have shrine priests and priestesses who serve them and convey their wishes to the people. On special occasions, the *jemawɔji* may be invoked to bless the people.

Although the *jemawɔji* are believed to have the ability to heal, most treatments for illness are believed to be carried out by yet-smaller deities called *wɔji* (sing. *wɔng*). These are believed to inhabit such objects as skulls, wooden carvings and unusually shaped trees. Their power can be harnessed and placed in herbal infusions, animal bones, beads and porcupine quills for healing by medicine-men who have been called or trained to work for specific *wɔji* (Adokwei, 1993; Field, 1961). Some medicine-men specialise in particular disorders (such as mental disorders), and others have more generalised abilities surrounding ill-health in general (D. Kpobi, personal communication, 13 June 2017).

Methods

Research setting and participants

The data reported here form part of a larger study of different categories of healers in the Greater Accra Region of Ghana. In other papers, we have reported on the work of

the other categories of healers (for herbalists' methods, see Kpobi, Swartz, & Omenyo (in press); separate manuscripts for Christian faith healers and Muslim faith healers are currently under consideration elsewhere). Initial recruitment was done through the Ghana Federation of Traditional Medicine Practitioners Associations (GHAFTRAM), an umbrella body for the various groups of traditional/alternative healers. GHAFTRAM introduced us to some members of the Ghana Psychic and Traditional Healers Association, a sub-group of GHAFTRAM, through whom potential participants were identified. Subsequently, snowballing was used to obtain additional participants. Our participants were drawn from the rural communities on the outskirts of Accra. Participants were medicine-men representing various *wɔji*. Individual, semi-structured interviews were conducted with eight healers.

Participants were included in the study if they could speak English or Ga, and if they had practised for at least 5 years. Their ages ranged from 53 to 73 years; and the average number of years of practice was 45 years. Interviews were conducted with one female and seven male healers.

Procedure

Following institutional ethical approval from Stellenbosch University Humanities Research Ethics Committee, we sought further clearance from the Ghana Health Service Ethics Review Committee and the Ghana Traditional Medicine Practitioners' Council. Permission was also obtained from GHAFTRAM and the sub-group for traditional healers. Once approval was granted, we identified potential participants from the Association's registry. These participants were informed of the study objectives and requested to participate. Once consent was provided by the participants, interviews were conducted. Interviews were in English or Ga, depending on which the participant was most comfortable with, and took place in the homes or workplaces of the participants (often these were the same).

The first author (L.K.), who is a trained psychologist and native Ga, conducted all but one interview and supervised a male psychologist enlisted to interview one participant who requested to be interviewed by a male because the god did not approve of him speaking directly to a female. Participants were asked questions relating to their work with mental disorders, including questions like 'How are you able to identify what the patient's illness is?', 'How would you treat [this illness]?' and 'What are the most important results you hope to achieve from this treatment?'.

Data analyses

The data were inductively analysed using thematic analyses using ATLAS.ti (v8) qualitative data analysis software. Following Braun and Clarke's (2006) recommended six-step process of thematic analysis, L.K. identified initial codes from the healers' explanations of their beliefs about mental disorders and treatment processes. Through discussion with the second author (L.S.), the codes were grouped into notable patterns and trends. Themes were, thus, generated from emerging information provided by the participants. These were subsequently revised and properly defined and are presented as results below.

Results and discussion

In exploring the mental health care practices of the participants, we identified two broad themes. First, the specific diagnostic means used to identify disorders, and second, the methods used to treat these disorders. However, these were greatly influenced by their ideology surrounding the aetiology of illness as well as their roles as healers. Therefore, we begin this section by discussing these ideologies, and subsequently, discuss the methods.

Beliefs about mental disorders

All participants described mental illness as manifesting in a change in the individual's behaviour, mostly presenting as unprovoked aggressive behaviour. For instance, one of the male healers described mental illness as follows:

> [Mental illness] is something that changes a person completely … the person's whole behaviour is very strange … they can get angry very easily when you can't even tell what the problem is … and they cause trouble everywhere … That is how the real mad people behave. (F5)

Participants' beliefs regarding the causes of such erratic behaviour were dominated by the belief in supernatural causes. One participant explained this as follows:

> … it is due to witchcraft; someone who hates you can buy illness from a witch and cause an evil spirit to attack you with madness. For some people, they may have done something bad to someone, and the person will be so hurt … that he will cry to the gods … and then they will inflict madness on you or sometimes it can even be death. (F1)

The above quote summarises the different dimensions of belief in the supernatural nature of mental disorders. There is the belief in jealousy resulting in people using evil spirits to cause mental illness; there is also the possibility of the individual's actions towards others causing the illness. Again, all our participants held this belief. However, they did acknowledge that the causes were not always spiritual:

> … there are some kinds of mental problems that come from a problem in the person's body like maybe their blood is not good … or he had a [car] accident and his head hit the road … that can also cause him to become mad. (F4)

In addition, some participants acknowledged that physiological or genetic factors could play a role in the aetiology of mental disorders, these originating from a spiritual cause which had afflicted an ancestor, and now affected generations afterwards. Our oldest participant explained the following:

> Sometimes it can be something that runs in the family. [The patient's] ancestor may have gotten such a sickness before … Our people believe that when someone does something wrong, the gods can inflict him with [mental illness] as a punishment. Then it begins to run through the family … when it happens like that … almost everyone will get it. (F2)

Thus, the medicine-men's beliefs about mental illness were dominated by the notion that there was often an interplay of spiritual and physical factors responsible for mental illness. These beliefs greatly influenced their diagnostic and treatment methods.

Diagnostic processes

Diagnostics through divination was based on the belief that the gods knew what was ailing the patient and the cause. Therefore, they needed to enquire from the gods in order to identify the problem. Given the different 'gods' that the participants represented, the divination methods varied based on what the deity required. However, the act of divining the problem was similar for all the healers. For example, one participant explained his process in this way:

> Before I start the work, I have to pray to the god … Because it is the god who has the power to give us everything in this world. So that if you have any problem at all … when we pray to the gods, we can solve it for you … They will tell me what the problem is and why it has come, and then they will tell me the solution. (F8)

These prayers were more than just verbal supplications, involving various rituals and processes. One participant described the visions that he sought as part of the divination process:

> I will collect some herbs … I will soak them in water, and look into [the bowl of water] while I am praying to the god. And through that he will reveal everything to me … the vision will appear clearly for me to see who is causing the problem or how the person can get well. (F1)

Another participant reported that his divination process involved 'listening' for the voice of the god through a bead necklace:

> We use these beads. These are special beads made from seeds into this chain. It is given to you by the gods when they call you … when you have been given that calling, you can hear the god speaking to you from the beads … when you pray to them … They cannot talk to you as a human being because we cannot stand it. So they will … tell us everything about you. (F2)

A third method involved burning of herbs. Our only female participant described her process as follows:

> We have to ask the gods to give us the answer. So you have to open your spirit so that the gods can talk to you … and so that you can understand. So we burn herbs in the fire … so that there will be smoke in the whole room. That is how we can talk to the gods … we will [inhale] the smoke from the herbs and then we become possessed by the gods … they will show us everything that is happening. (F7)

The above process appears to be invoking a trance state which they believe opens them up to communication with the god and facilitates their investigations into the nature of a patient's problem or what could be done to heal them.

The common ideology behind the divination process, therefore, existed in participants repeatedly emphasising the fact that they could do nothing without the direction of the gods.

The treatment process for mental disorders

The next theme relates to the treatment methods that were used by the healers. Despite similarities, the methods generally differed from one healer to another, and in some cases, from one patient to another. This is likely because of the reliance on communication from the gods to indicate the direction of treatment.

Depending on the identified cause of the illness, the treatment may target either removing the external influence or changing the consequences. When the individual's actions were identified as the cause of the problem, the foremost means of seeking relief was through confession:

> Sometimes it is the person who has done something wrong, and so his soul will be judging him … when we say his soul is judging him, the outward manifestation is a depressed and withdrawn person … Or sometimes he feels uneasy and tortured so he will be talking to himself, and easily angered. Such people … need to confess … and then he gets some relief. (F6)

This participant further explained,

> After he has confessed, he has to … beg for forgiveness from the [offended] person. Sometimes … he has to take some money and wrap it up in a cloth or something and … give it to somebody that he does not know … then he will be free from the madness. (F6)

On occasions when the illness was believed to have been caused by malevolent 'spiritual' actions of others, the healers reported that they needed to use similar 'spiritual'

means to set the patient free from the spell that had been cast on them. One participant put it this way:

> … he has to sacrifice to [the god] … take some eggs or schnapps and make a sacrifice to the god to banish the evil spirit that is causing the madness. At times the gods will tell us to send the person to the sea and he must submerge himself in the sea … and then … he will be well from that madness. (F4)

Sometimes, the illness was reportedly sent back to the person who caused it:

> If someone is causing the problem, we can make a charm for the [patient] to go and bury at a crossroads where that person normally passes; and then … whatever he has done to you will go back to the sender. (F4)

With the banishment of the evil spirits, and/or protection of the patient from further attacks, other means were employed to restore the patient to full health. These usually involved herbal remedies like herbal baths, infusions, incense or ointments. Sometimes dietary restrictions and abstinence from specific activities or places were prescribed to complete the healing.

The role of traditional healers in the healing process

All the participants were adamant that they did nothing of their own volition. Instead, they were directed by the gods whom they served. As a result, their methods may differ with each case. For instance, the female participant explained,

> We can't do it [healing] on our own … where will the power come from? Because we are also human beings … so it is the gods who show us what the problem is and who is causing it … then they can show us how to heal the person. (F7)

The healers thus believed themselves to be conduits of the gods. According to them, they were as human as the patients and held no power of their own. As a result of this belief, they claimed no credit for the outcomes of their treatment methods, whether positive or negative.

Discussion

The beliefs of the medicine-men concerning causes of mental disorders were predominantly supernatural in nature. These are not new and have been reported in early studies of Ghanaian illness beliefs by authors like Rattray (1924, 1927) and Field (1940, 1960). These explanations are not limited to Ghana, having been reported in other African studies in Nigeria (e.g. Agara et al., 2008; Jegede, 2005), Zimbabwe (e.g. Kajawu et al., 2016) and Ethiopia (e.g. Monteiro & Balogun, 2014), among others.

The beliefs of our participants identified specific, tangible answers to what they perceived as unexplainable changes in behaviour, which were perceived to completely take over the individual's behaviour and attributed to an evil influence. This contrasts with reported beliefs in other countries where mental illness has been conceptualised as a channelling of ancestors (e.g. Mufamadi & Sodi, 2010; Ngubane, 1977; Semenya & Potgieter, 2014). The participants in our sample viewed mental illness as a consequence rather than a calling.

These beliefs fit into what has been described as a distinctly African notion of illness (Anderson, 2004), which includes the belief in illness or misfortune being a consequence of a person's behaviour or punishment. These views may also be common in other non-western contexts (Marsella & White, 1982; Worthington & Gogne, 2011).

The ideology behind trances and spirit possession in traditional healing in Ghana has also been documented by Field (1960), who discussed the belief that the wisdom of the gods could be concentrated on better and more swiftly when the mind was dissociated in some way. This belief appears to still exist among this group of modern traditional healers. Similarly, the use of beads and incantations in divination is reportedly employed by West African cultures, namely, Yoruba healers in Nigeria (e.g. Bascom, 1991; Rinne, 2001) and the Fon of Benin (e.g. Asante & Mazama, 2009).

However, reports of traditional healing in southern African cultures emphasise the influence of the ancestors in healing (e.g. Berg, 2003; Sodi, 2009; Sorsdahl, Flisher, Wilson, & Stein, 2010). In contrast for our sample, although there was an acknowledgement of the presence of ancestors, the focus rested more on gods who were believed to be able to heal a person.

The treatment methods described by the participants in this study may be specific to the cultural context within which they operate, but there are some similarities to that which has been reported in other cultures. Shoko (2007) discussed the use of confessional medicine among Karanga traditional healers in Zimbabwe, and confession was widely used by healers in Nigeria (e.g. Adekson, 2003; Offiong, 1999) and among the Akan of Ghana (e.g. Konadu, 2008). Mpofu, Pelzer, and Bojuwoye (2011) provide more general discussions of the use of confession in sub-Saharan African cultures.

The processes undertaken to remove evil spirits, or to undo negative consequences of behaviour, all stem from the belief in the presence or influence of supernatural elements in the manifestation of mental disorders, whether through the patient's actions or the actions of others. As such, the healers' methods sought to achieve physical and spiritual equilibrium as a way of restoring social balance for patients.

The healers constantly emphasised the fact that without the gods, they were mere humans. This is similar to what has been reported in other African countries. For instance,

Pinkoane, Greeff, and Williams (2001) described Sotho healers' reliance on directives from ancestors in their work. Similar explanations have been reported by others like Berg (2003) and Sorsdahl et al. (2010).

These studies are based on southern African healers, and the focus appears to be on the intervention of the ancestors. For our sample, the abilities were attributed to the deities whom the healers represented. Such ideas are similar to that which has been described in research on Yoruba traditional healers in Nigeria (e.g. Jegede, 2005; Obinna, 2012).

Despite the modesty that these statements may suggest, they also perhaps suggest a shift in responsibility on the part of the healers. That is, the healers' actions were to be considered above reproach and any negative consequences of their actions were attributed to other factors and not effects of the treatment.

Summary and implications

In this article, we describe the beliefs about mental disorders held by traditional medicine-men in Accra, Ghana. Generally, their beliefs about aetiology revolved around supernatural factors, including attacks from evil spirits as a result of the individual's actions, and those resulting from envy of other people. Our findings are similar to other studies conducted in Ghana (e.g. Ae-Ngibise et al., 2010; Ofori-Atta et al., 2010; Read, 2012).

We also discussed the methods that traditional medicine-men used to treat mentally ill patients. These were influenced by their belief systems and were primarily done through divination, which differed based on the healer and the specific deity that he represented. The different divination processes included visions, incantations and trance states or spirit possession. Confession of wrongdoing and application of herbal remedies were used to complete healing or to protect the patient from future episodes.

The beliefs of the healers about the origin of mental disorders are similar to what other studies have reported from laypeople in the Ghanaian context (e.g. Ae-Ngibise et al., 2010; Ofori-Atta et al., 2010; Read, 2012), which suggest that the general beliefs of Ghanaians regarding mental disorders are based on spiritual causes. These factors may have implications for the patient in terms of their choice of health care, especially in a context where formalised resources for mental health are limited.

However, this emphasis on supernatural causes for mental disorders may be problematic, as it could potentially prevent patients who may have benefitted from biomedical treatment, from receiving treatment. It may also result in suspicion and hyper-vigilance in patients, which may be precursors of mental disorders such as anxiety or depression. In addition to these, the focus on finding someone to blame as the cause of the problem could potentially result in strained social and familial relations.

Our data suggest that the methods employed by the medicine-men are quite unstandardised, due to their strong reliance on what they perceived as orders from the gods. They are thus difficult to regulate, given that they may change from one case to the next. This makes it difficult to assess how effective their methods truly are. There are real risks of potentially adverse outcomes for patients who seek treatment, given the intuitive manner in which treatments are administered. Particularly for those who prescribed herbal remedies that had to be ingested, there is a danger of exacerbating the condition, or inducing other conditions (Akpan & Ekrikpo, 2015). The inducing of trance states, and possibly hallucinations, for information on a patient's conditions are considered to be visions from the gods and used to determine treatment, to the potential detriment of the patient.

Despite attempts by governing bodies like the Traditional Medical Practitioners' Council and the Food and Drugs Authority to regulate the work of healers, this has likely been difficult to monitor effectively because of the mysticism that drives their work. The variations and diversity in their methods may explain why attempts at collaboration between healing systems in Ghana have been largely unsuccessful. In order to succeed at incorporating alternative methods into the health care system of Ghana, a keener understanding of their ideologies is needed, through large-scale studies which examine the methods of traditional healers and explore the pathways to potential collaboration. With this article, we believe we have made a small first step in achieving that understanding.

Conclusion

Traditional healing processes for mental disorders have existed in many cultures for centuries (Rathod et al., 2017). There is the need for collaborative efforts between traditional and biomedical health systems to be strengthened. However, there has been a lack of knowledge of what traditional healers actually do for mentally ill patients. As a result, collaboration has been difficult (Chowdhury, 2016; James, Igbinomwanhia, & Omoaregba, 2014; Musyimi, Mutiso, Nandoya, & Ndetei, 2016).

This study has explored some of the methods used by traditional medicine-men to treat mental disorders. Despite the similarities in their core ideology about the origin of illness and the reliance on the directions of the gods, obscurity exists in the care that they offer. Their reliance on guidance from the gods makes their work unpredictable in determining the proper treatment regimens.

Despite positive patient responses to the spiritual engagement of the healers, affirmation of their methods cannot be assumed without a deeper exploration of quality and effectiveness (Gureje et al., 2015; Musyimi et al., 2016) before collaborative efforts can be formalised, or before their treatments are recommended for patients.

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CHAPTER TEN: ARTICLE 7

'The threads in his mind have torn'*: Conceptualization and treatment of mental disorders by neo-prophetic Christian healers in Accra, Ghana*

10.0 Introducing Article 7

Similar to the previous three articles, Article 7 examines the work of charismatic Christian faith healers with respect to mental disorders. In this paper, I examined the beliefs about mental illness that were held by leaders of neo-prophetic Christian churches. I also looked at the ways in which they allegedly healed illness.

The pastors were positioned somewhat between the herbalists and the shrine priests. Like the shrine priests, they saw themselves as representatives of God. However, like the herbalists, they believed the ability to heal was theirs (albeit God-given). The pastors and prophets in this study used exorcisms, deliverance, fasting and spiritual directions to treat illness.

These healers were not opposed to referring patients for biomedical care and indeed were keen to work in hospitals alongside biomedical professionals.

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RESEARCH

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'The threads in his mind have torn': conceptualization and treatment of mental disorders by neo-prophetic Christian healers in Accra, Ghana

Lily N. A. Kpobi* and Leslie Swartz

Abstract

Background: In many low- and middle-income countries, faith healing is used alongside biomedical treatment for many health problems including mental disorders. Further, Christianity in Africa has seen much transformation in recent decades with the growth of charismatic or neo-prophetic churches whose doctrines include healing, miracles and prophecies. As such, many charismatic pastors have been engaged in faith healing for many years. Such faith healers form a significant portion of the mental health workforce in these countries, partly due to the limited number of biomedically trained professionals. In this study, we sought to examine the beliefs of charismatic/neo-Pentecostal faith healers about mental disorders, as well as to examine the treatments that they employed to treat such disorders.

Methods: We interviewed neo-prophetic pastors who undertook faith healing, and examined their work relating to mental disorders. Ten pastors from eight churches in the Greater Accra Region of Ghana were interviewed using semi-structured interviews.

Results: The data suggest that the pastors' conceptualization of mental illness was generally limited to psychotic disorders. Their beliefs about causation were predominantly supernatural in nature although they acknowledged that drug misuse and road traffic accidents were also potential causes. The pastors' expectations of healing also showed different perceptions of illness chronicity. Their diagnostic and treatment methods revolved around using prayer, prayer aids such as oils and holy water, as well as spiritual counselling for patients and their caregivers. However, they were not opposed to referring patients to hospitals when deemed necessary.

Conclusion: We discuss the above results with emphasis on their implications for collaboration between biomedical and alternative healing systems in Ghana. In particular, we advocate a mutual understanding of illness perspectives between biomedical practitioners and faith healers as an important component for integrating different health systems in Ghana.

Keywords: Ghana, Neo-prophetic, Pastors, Faith healing, Mental disorders

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Background

In many sub-Saharan African countries, alternative healing systems exist alongside allopathic systems of care. These alternative systems, such as traditional and faith healing methods, are utilized for a wide range of conditions, including mental health care [1]. One of the reasons for the popularity and widespread use of traditional and faith healing in mental health is the perceived similarities of disease causal beliefs between the healers and their clientele [2]. However, another factor is the real shortage of trained mental health professionals in many low- and middle-income countries [3].

In Ghana, some studies have estimated that there is one psychiatrist for every 1.2 million people, as well as one mental health nurse for every 200,000 people in the population [4]. A further constraint is that a majority of these professionals are located in the urban towns of the country [4, 5]. In addition, all three public psychiatric hospitals are located along the southern coast of Ghana. Although in recent years small psychiatric units have been set up in most of the ten regional hospitals across Ghana, these are invariably located in the urban/semi-urban towns of those regions. Therefore, a large segment of the Ghanaian population has limited or no access to formal mental health professionals and services. In fact, some studies have argued that only 2% of Ghanaians requiring mental health care have access to formalized care [5–7].

On the other hand, Ae-Ngibise et al. [8] estimated that there was one traditional/faith healer for approximately every 200 people. Given this, it is further argued that the first point of call for approximately 70% of the population of people who need psychiatric care would likely be an alternative medicine practitioner such as a faith healer [8, 9].

There is limited data on national prevalence rates of actual use of traditional/faith healing systems, perhaps due to the frequent use of multiple healing systems by patients. While faith healing is popular, it is often not the only help-seeking avenue explored. Gyasi et al. [10] in their study of the use of alternative healing therapies among a cross-section of Ghanaian tertiary students, reported that approximately 89% of participants had utilized more than one form of health care (including herbal, spiritual, and biomedical) in the last 12 months. Furthermore, Ofori-Atta et al. [5], in their situation analysis of mental health services in Ghana, also reported that the use of faith and traditional healing was often unreported by patients. This was largely believed to be due to the distrust that the biomedical field was perceived to have for alternative therapies [5]. Thus, prevalence rates of the use of traditional/faith healing are difficult to estimate.

A few small-scale studies have however explored the use of traditional vs. faith healing by patients in Ghana. According to Read and Doku [11], the past 30 years have seen a shift in the religious landscape of Ghana, with the perceived role of Christian healers and prayer camps showing a significant increase. 14% more people admitted turning to Christian faith healing, in addition to or instead of biomedical therapies, rather than traditional religious healing centres as had been the case in the 1970s [11]. Christian religious healing has therefore seen an increased acceptance and use in Ghana.

In the most recent census, approximately 96% of Ghanaians self-identify as being religious, spanning Christian, Muslim and indigenous African religious beliefs [12]. Of this number, an estimated 71% classify themselves as Christians [12]. Further, 28% of the estimated percentage of Christians belong to the charismatic/neo-prophetic tradition [12]. Considering this high level of religious identification, and given the shortage of mental health professionals, calls have been made to explore the benefits of engaging faith-based organizations in care for mental illness [5, 13, 14]. The calls for collaboration came particularly because many such organizations have already been involved in providing spiritual healing to their members for years [15–17].

Many studies on alternative healing practices tend to group practitioners together, and hence overlook the nuances that may exist between the different categories of healers, particularly in those which are based on faith. In addition, for religions which are not considered indigenous to the people, cultural values and practices may influence how that religion is understood and expressed. Therefore, the practices of faith-based healing systems will be influenced by both religious and cultural factors. In this paper, we focus on the perspectives of Christian healers in Ghana.

Faith healing and the neo-Pentecostal/charismatic Christian movement

The spiritual healing provided by Christian faith-based organizations is largely carried out by those of the neo-Pentecostal/charismatic tradition. The neo-Pentecostal/charismatic Christian theology (also sometimes referred to as the neo-prophetic movement) is built on the experience of the Holy Spirit and its gifts such as prophecy, miracles and speaking in tongues [18]. There is also a distinct emphasis on success and prosperity, and as such, any illness or misfortune is often attributed to spiritual efforts targeted at preventing the achievement of those goals [19]. Therefore, much of the healing provided by charismatic Christian organizations focuses on re-establishing a balance between the individual's corporeal life and their spiritual life in order to achieve the desired prosperity [17]. According to Asamoah [20], the neo-Pentecostal Christian doctrine differs from the doctrine

of initial African Indigenous Churches (AICs) in that, the latter's doctrine overtly incorporates elements and practices of indigenous African religious belief whereas the former rejects indigenous cultural practices as demonic, but is built on the framework of an African worldview.

As an illustration of this difference, Gifford [21] compared the charismatic churches' emphasis on cosmological balance to ideologies which are dominant in indigenous African religious thought. However, instead of ancestral spirits and deities working in them (as is common in African traditional religion), the charismatic healers believe the healing is done through the Holy Spirit working through them [22]. Thus, the neo-prophetic churches have elements of African beliefs in their doctrine [19, 20], yet are different from the AICs' syncretic fusion of traditional religious practices into their mode of worship. This influence is reflected in beliefs about the causes and impacts of illness and disorders, as well as their approach to healing.

According to Omenyo and Arthur [23], the methods employed during faith healing include prayers, fasting, deliverance/exorcism, as well as spiritual directives of required behavior. These processes are carried out through the laying on of hands, sprinkling of holy water, as well as anointing oils and incense. These form prayer aids for the healing process, with the ultimate aim of expelling or banishing the evil spirits which are perceived as preventing the success of the patient and/or his family [19]. 'Exorcism' thus refers to the process of removing evil spirits which are believed to possess and/or attack people and cause illness or misfortune [24].

Thus, neo-prophetic Christian faith healers employ specific methods in treating their patients. In order to achieve successful collaboration between the various health care systems in Ghana, the different elements of the work of faith healers must be contextually examined and understood. This includes obtaining more knowledge on the beliefs, methods, and perceived impact of mental disorders. Against this backdrop, the aim of this paper is to examine the beliefs of charismatic Christian faith healers about mental disorders and their perceived effects, as well as to describe their treatment methods, as a contribution to the discourse on finding holistic collaborative care for mental disorders in Ghana.

Methods

Research design

In this study, we used a qualitative approach to answer the question: "How do Christian faith healers in Accra understand and treat mental disorders?" We examined the lived experiences of the healers in treating mental disorders through an experiential qualitative design [25]. This design was useful for exploring the participants' views on mental disorders based on their own experiences.

Research setting and participants

The data reported in this paper are part of a larger study of different categories of traditional/faith healers in the Greater Accra Region of Ghana, which is a small coastal region in the south of Ghana. The Greater Accra Region is home to the nation's capital city, Accra. It is cosmopolitan in nature, with a large number of inhabitants having migrated from other parts of the country. The region also has smaller rural and urban settlements on the outskirts of the region which are predominantly inhabited by indigenes of the region.

The participants for this study were pastors and leaders from self-styled Charismatic churches within and around the Greater Accra Region. These churches often hold healing services where people with all manner of ailments, including mental disorders, are treated. Ten pastors from eight churches were interviewed through individual semi-structured interview questions until data was deemed to be saturated. Although all eight churches were in the Greater Accra region, two of the participants had prayer camps located outside the region. A prayer camp is a facility run by a faith organization where sick people seeking spiritual treatment can be housed [16]. Various healing activities and programs are conducted at these camps for the patients who come there. Three of our participants were therefore pastors who sometimes performed their healing work at these prayer camps. In this study, we use the terms 'charismatic healers' or 'neo-prophetic healers' to refer to healers working within neo-Pentecostal/charismatic churches.

The churches were included in our study if they identified as neo-prophetic or charismatic in their style of worship. The pastors from these churches also needed to have worked as faith healers for at least 5 years, and be able to speak English, Ga or Twi (these are the most commonly used languages in the region).

We conducted semi-structured interviews with eight male and two female pastors/healers. Their ages ranged from 31 to 66 years with a mean age of 44.5 years. The number of years they had practiced ranged from 7 to 41 years. In the results section below, the participants are described with the titles which they used to describe themselves. Although we acknowledge that there may be different understandings of titles, we use terms such as prophets, seers, pastors, etc. as requested by the participants.

Procedure

Following institutional ethical clearance, we approached several churches for permission to

conduct the interviews. At the first three churches that we approached, the head pastors declined to participate and did not provide consent for their associate pastors to be interviewed either. They cited reasons such as conflicting schedules for this refusal, but some stated outright that they were suspicious of our true intentions. As a result of these initial difficulties, we engaged suitable gatekeepers in our subsequent recruitment efforts. These gatekeepers were members of the desired churches whom we identified beforehand to facilitate introductions to the pastors. We also used snowballing to recruit additional pastors in some cases.

The first author, who is a female, conducted all interviews, some with the help of a trained male research assistant. Both the first author and the research assistant are trained psychologists. Both are also fluent in English, Ga and Twi. Potential participants were approached, and the objectives of the study were explained to them, as well as their rights as research participants. Individual informed consent was obtained from each participant before any data were collected.

The participants were asked a range of questions pertaining to a number of different variables. Regarding their healing work for mental disorders, they were asked questions such as 'what do you think caused the illness?'; 'how are you able to identify what the patient's illness is?'; 'how would you treat [this] illness?', and 'how do you think this illness will affect the patient?', among others.

All the interviews were audio-recorded once we had received verbal and written informed consent for participation and recording. The interviews took place at the workplaces of the participants. These were either in an office in the church, or in a quiet location at the prayer camps. The interviews lasted an average of 40 min and were conducted in English, Ga or Twi depending on the language that the participant was most comfortable with; in most cases, this involved a combination of English and one of the local languages.

Data analysis

All interviews were transcribed verbatim in the language that they were conducted in. Where necessary, the local languages were translated into English, and then back translated into the local language by an independent linguist, to check for consistency and accuracy.

All data were analyzed using the ATLAS.ti qualitative data analysis software (v.8). The data were analyzed using Braun and Clarke's [26] six-step thematic analysis guidelines. This method allows for systematic analysis of the data to unearth emerging patterns and ideas. In the first step, we familiarized ourselves with the data by reading the transcribed interviews several times. By this, we sought to understand the nature of the data and to search for the core ideas which ran through the data. Subsequently, the first author generated initial codes related to the pastors' descriptions of their beliefs about and methods of healing mental disorders. These formed the basis for identifying patterns and meanings in the participants' accounts. In the third step, we classified similar trends and patterns which had emerged from the data as tentative themes. The second author checked the tentative themes, and both authors discussed areas of disagreement or inconsistency. These initial classifications were then reviewed and refined by both authors in the next step, in order to properly define the themes. The revised themes that emerged from the data are presented as results below.

Results

In this section, we discuss three themes that emerged from the participants' accounts of their work in healing mental disorders. First, their beliefs about mental disorders. Second, we discuss their perceptions of the impact of mental disorders on the lives of their patients. Finally, we discuss the methods that they use to diagnose and treat mental disorders.

Beliefs about mental disorders

In exploring the views that participants held about mental disorders, the predominant belief was that mental disorders resulted in what they considered strange behaviors. They all agreed that the behaviors displayed by people with mental disorders suggested a malfunction in their brains. For instance, one male participant, a 32-year-old pastor, stated the following:

> *When we say mental illness, it means that the brain is not working well. Something has torn in their mind. Some of the old people will say, the threads in his mind have torn, you see? So it means that the person will be doing things that he is not supposed to do.* (P6)

Another participant described how individuals with mental disorders behave:

> *We all know that the mad people…the way they behave is different from us… it is not normal like how you and I will behave. Like walking around naked, eating from rubbish dumps and so on. They are very rough…if they get angry they will go and look for a knife to come and stab the person…it is not normal.* (P8, 42-year-old male)

Apart from these, we also had descriptions about the different types of mental disorders. All the participants used the term 'madness' to describe what they

considered as mental illness. For instance, a 41-year-old pastor described the types of mental illness as follows:

> *When someone is mad, you can see it as soon as the person comes…it is something that has been added to the person and it is changing the way he behaves from a human being to, excuse me to say, an animal…for some of them, they don't walk about naked but they will be talking to themselves… Some of them don't eat rubbish but they will walk the whole day and you can't tell where he is going… Some of them, they will be sitting in their corner quietly, and they look normal. But as soon as they get angry, they will start throwing things, and hitting people and stuff like that… So there are different types of madness.* (P1)

The above description was typical of all our participants. Generally, their explanations for what constituted mental illness pertained to descriptions of psychotic behavior. When we probed further with examples of other forms of common mental disorders (such as depression, anxiety, etc.), the consensus was that these were not the same as madness but could lead to that if not checked:

> *No, that one is not a mental problem…but if she does not go for healing, then she can also start talking to herself or maybe even remove all her clothes!* (P5, 52-year-old prophetess)

Despite this perspective about psychotic disorders representing all mental disorders, some of the participants described different types of psychotic behavior as different disorders. For instance, one prophet explained that the different types of mental disorders were as follows:

> *But we have three different types of madness. Some people…you may think that they are fine but when you trace their [speech] to a certain level, you will see that the person is communicating with you but it doesn't make sense to your satisfaction…to give you the specific answer that you need from the person… It is like he is talking to somebody that only he can see. And then we have another group… when you are communicating with them you will see that their minds cannot focus or concentrate on anything to do it well…they always jump from one thing to another and do it shabbily… Then we have those people who are deeply sick with that sickness. Those ones you see them they will be drinking water from the gutters, they will be eating from [rubbish dumps] and all kinds of strange things… that is also another group.* (P3, 48-year-old prophet/seer)

In addition to the views on mental disorders and the different types, we also explored their beliefs about causes of the disorders. Perhaps unsurprisingly, the predominant belief was that mental disorders were caused by evil or unclean spirits and witchcraft. All ten participants shared this belief. One participant described it this way:

> *Witchcraft, idol-worship, and family gods can all be linked to spiritual factors that can affect the person's mental health. Especially when you're young, and you start behaving like that then you have to start suspecting that there is a spiritual dimension that is responsible for what is happening. Because you know with us Black people, that is, we the Africans…we have all these family gods and spirits that are still around us and if they don't like something that you are doing, they can attack you and torment you and you will never feel happy.* (P7, 39-year-old prophet)

Some of the reasons that they cited for the attack by the unclean spirits included envy or jealousy from others:

> *I have recognized that some of the mental sicknesses are brought by unclean spirits from various families… when they see the future of someone, then they throw that sickness to that person…yes, because they have seen the person's future! And they want to destroy it. They don't want him to succeed in the future.* (P3)

Although this was the predominant view of the healers, all participants acknowledged that sometimes the disorder was not brought about by spiritual factors alone. Some of the other factors described were drug or alcohol misuse, as well as traumatic brain injury resulting from road traffic accidents. Nevertheless, they believed these other causes invariably included a spiritual dimension as well.

A third component of the healers' beliefs was their perceptions about the chronic nature of mental disorders. To most participants, treatments were meant to 'cure' illness; therefore, if the patient has been taking medication for the same illness for a prolonged period, then it was ineffective. One prophet was quite emphatic in his views on this:

> *How can you take medicine for one problem for the rest of your life? Have you heard of something so strange before? What kind of sickness does not go away? If the mosquito bites you, it leaves something inside your body, and then you get malaria. So the medicine that [the doctors] give you will kill that thing that the mosquito put inside you. But if you take the medicine every day for so many years and*

> *the malaria is not going [away], then it means the medicine is not good, yes…because it is not working! How can you be taking medicine for the same mental problem for so many years and it still keeps coming back?* (P9, 31-year-old pastor)

Such views obviously confirmed their beliefs about spiritual causes for mental disorders. Since they believed most mental disorders had a supernatural origin, they firmly believed that they needed to be involved in its treatment. All the participants believed that once the illness that afflicted a patient was spiritual, biomedical methods would always be ineffective in the long term because doctors were not equipped to treat spiritual problems. As such, the emphasis was very much on making sure that the symptoms disappeared completely, which was taken as an indication that the treatment was efficacious because the patient had been cured.

Perceived impact of mental disorders

Considering the strong emphasis on spiritual causation of disorders, we also explored the participants' perceptions of how living with a mental disorder affected the lives of their patients. All the participants believed that nobody should have to experience living with a mental disorder because it was damaging to their livelihood and to their future:

> *Such a sickness…it won't allow you to progress in life… Your goals will be delayed, and you lose your glory and pride in life… You can also lose your friends and even your money. In fact, you can lose everything because you will be looking for answers and so you won't be able to work… And if you can't eat or sleep, you will lose weight… your health will also decline and so on. So you won't be happy, and you know, every human being needs to feel happy for you to live well.* (P4, 56-year-old prophet)

> *It makes the person die early. He loses his school or his work, and in fact, everything in their life because of the way the [illness] comes upon them. In fact, they lose the joy of life when they have this illness.* (P10, 39-year-old prophetess)

Some of the participants also made statements suggesting the deep stigma that they believed was attached to living with a mental disorder:

> *Hmmm, this illness it can destroy your life, oh! Because she won't be able to do anything normally, so her life will definitely be difficult… And many people don't want to marry someone who is mad… even if someone in your family is mad, nobody wants to go to that family. Because, excuse me to say, she is a human being but she is not one of us…* (P6)

Thus, there is a lot of stigma attached to having a mental disorder and this stigma extends, by association, to members of the patient's family. Despite such apparently negative views, all the participants believed firmly that these disorders could be healed and the associated difficulties and stigma could disappear.

This relates to supernatural beliefs, particularly those regarding attacks from jealous or envious people. Paradoxically, their accounts suggest that since such conditions are the result of malicious spiritual attacks, the patient bore no responsibility for having this illness. This may very well be a means of addressing the stigmatizing nature of living with (or having a relative who has) a mental disorder, by believing that the illness could be cured by a higher power.

Diagnosis and treatment of mental disorders

A third theme that emerged related to the methods that the pastors used to diagnose and treat mental disorders. What quickly became clear was the fact that healing depended on the abilities of the pastor. Some of our participants spoke about the different types of pastors that existed and the level of divine anointing that each category possessed. This anointing determined the success of their methods. For instance, one of the participants explained the categories in this way:

> *We the prophets, we have three different categories when it comes to the office of prophecy. We have the minor prophets, we have the major prophets, and then we have the seers. The minor ones are the ones who are now up and coming; they see things but they don't see too far spiritually. And then, as to the major ones, they see it, speak to God and speak the mind of God to people, and through the word of God that is revealed to him, they can heal some people but not all. But then the seers, when they see someone, they will be able to identify the kind of problem that person has immediately, and once they speak, every sickness on this earth will flee. I am beyond the major prophets; I am a seer. I am on the mantle with God. I see God face-to-face, Jesus is my friend, and I move with the armies of God. Do you understand? It is not a simple thing…it depends on how deep someone is able to align himself with the gift that God has given to that person. So when I see people, I am able to see what the problem is; then I discern spiritually how to heal the person.* (P3)

All the participants stated that their treatments always started with some preliminary investigations of the symptoms or behavior of the patient. These preliminary investigations included interviewing the patient and/or

their family, observations of their behavior, and sometimes physical examinations of the patient's body:

> *When they come, I have to first interview them, or if the mind is not stable, then I will have to ask the relatives why they have brought him to me. I will ask them when it started, and if it is on and off, or if it has been happening continuously since it started… then I will also do my own observation of the person for some time.* (P5)

All the participants also stated that they used prayer to identify the disorder and its causal factors, as well as to treat the problem. However, what became evident was the fact that prayer involved much more than verbal supplication. They used the blanket term prayer to refer to a range of activities whose ultimate aim was to exorcise the demon from the patient. Further, exorcism appeared to be used to deliver individuals who were believed to be possessed by evil spirits, as well as to ward off the evil spirits which attacked and tormented people. The exorcism activities included issuing verbal commands (sometimes referred to as 'binding and loosing'), dreams, and speaking in tongues. All these were divination methods that were used to identify the spirit causing the problem in order to remove its influence:

> *When they bring [a patient] to me, maybe the person has been hearing voices in his head, or he will be hearing that someone is commanding him… So when they come, I first have to pray over the person using the tongues, and sometimes I even have to ask the people to go and come back the next day so that maybe I will ask God to speak to me in a dream about the issue. And when I am praying I ask God to show me who is causing the problem and also how I am supposed to treat this.* (P4)

Some others credited their healing ability to the special gift that they had been given by God:

> *Everything that I do here, it is God who reveals it to me. Everything depends on how God uses someone. When we speak in tongues, we are able to ascend to the throne of God and he reveals to us everything that we are supposed to know about the case… It is not easy to heal the mentally ill people… But I have been healing people not by my might, not by my power, but by the spirit of the most high God.* (P3)

> *You see, God has given us the power to do wonders. The Bible says that whatever we bind on earth will be bound in heaven, and whatever we loose on earth will be loosed in heaven. So whenever they come here, once we start praying and start speaking in tongues, we can bind the demons that have caused that sickness for the person and command it to loose [its hold over] the person's life [sic].* (P2, 66-year-old prophet)

The mode of diagnosis was therefore reliant on the healers' God-given ability to discern the spiritual causes of the illness, and by extension, the treatment also relied on that ability. Because the method of treatment was predominantly prayer, the regimen tended to change from case to case:

> *I won't be able to tell you that for this type of case, we pray for one week or for that type of case it is intensive fasting, because everybody's case is different. Sometimes we have to pray continuously for one month before we will see any improvement.* (P8)

Prayer was therefore used for both diagnostic purposes and for treatment purposes. Apart from prayer, the prescribed treatment sometimes included fasting by the patient:

> *Sometimes the patient will have to fast before he gets his healing…the fasting means denying yourself of something so that you can elevate yourself to a higher level in the spirit… Sometimes people think fasting is all about food or that you have to starve yourself. No, it is more than that… Although fasting with food is very important, you can also fast with other things, like your time or your work… If you want to elevate yourself to another spiritual dimension, you deny yourself of that thing and then you concentrate on the spirit. But food is the strongest way to fast because it forces you to take your mind away from the physical and to focus on God.* (P1)

When questioned about a mentally ill patient's ability to fast appropriately, some of the participants explained that other people could fast for the patient:

> *Yes, if we see that his mind cannot focus on God because of the way the sickness has made him, then we can get one of his family members to fast for him, or even we the pastors can fast for him, and intercede for him.* (P5)

In addition to prayer and fasting, some of the participants spoke about using prayer aids such as anointed oils and holy water to exorcise the evil spirits:

> *We don't normally lay hands on them straightaway… we will first apply anointing oil and they will rub it all over their heads so that the brain comes back a bit…then you can sprinkle some holy water on them before you tackle the real healing.* (P6)

This participant's account suggests that the actual healing is considered as the laying on of hands by the pastor. Others also stated that once the patient had been 'primed' by prayer, fasting, and the use of different prayer aids, the healing could be completed when the pastor laid his hands on them. According to some participants, this was the final act which would expel the evil spirit completely.

Another method that was used to complete the healing process was what many of the participants called 'spiritual counseling' or 'spiritual directions'. This was explained to us as similar to the counseling offered by professionals but having a spiritual focus. According to the participants, when patients relapsed, it was because they had either made a mistake that had allowed the spirit to re-enter their bodies, or they had failed to adhere to some prescribed guidelines. As a result, some patients needed to receive special counseling to show them how to prevent another episode. Sometimes, these directives were also to complete the healing process, especially if they needed to make restitution for some sin. One participant explained this process to us:

> *Sometimes, we have to listen to their problem and give them some counseling on how to solve it... Sometimes, they have to go and give a gift to someone... and I am told [by God] the number of people that they have to go and see, for instance they have to give something to five people or ten people or whatever... Sometimes, you have to do it at a particular time of the day, or sometimes it has to be money; sometimes you have to cook a large meal and invite people to come and eat it... So once you do these things, it forces the spirit to leave your body and then you can come back to normal... So this is an example of the direction... we have to explain everything to the person so that he can go and do it well, then the spirit causing it cannot come back again.* (P4)

Even though participants emphasized the need for spiritual healing for mental problems, they did not deny that biomedical care was also necessary. All the participants believed that patients needed to receive biomedical care for the physiological effects of their illness. They believed this could be done alongside the spiritual care that they provided. Some participants also stated that sometimes, God revealed to them that the appropriate treatment was from the hospital:

> *Like I said, he can go to the hospital for treatment as well because God sometimes works through such people too... There are some things that are not for God to do himself; they must be done by people... God is the one who gave them the wisdom and the ability to know how to treat people. There is no way God will come down from heaven to come and inject anybody with any medicine the way the nurses go round and inject people. He works through people that he has given the ability to use the medicines to heal people. So if it is necessary, he can go to the hospital after he leaves the prayer camp.* (P1)

Therefore, the biomedical treatment was believed to augment the spiritual treatment in order to complete the healing. Many of the participants believed that evil spirits could cause even non-psychiatric disorders. Although caused by spiritual forces, they may manifest in physiological ways. Thus, all ill health potentially had a spiritual component.

Discussion

In this paper, we have examined faith healing for mental disorders from a neo-prophetic Ghanaian Christian perspective. We described the pastors' beliefs about the causes and impacts of mental disorders. We also examined their diagnostic and treatment methods.

The general perception of the participants was that evil or unclean spirits caused most mental disorders. Despite this prevailing belief, most participants acknowledged other potential causes of mental disorder such as drug or alcohol misuse. However, these were mostly seen as a moral failing on the part of the patient. Because of these beliefs, their methods of diagnosis and treatment involved activities aimed at exorcising or warding off the demons from the patient. Such methods included using prayer and prayer aids like holy water, as well as fasting, speaking in tongues and counseling. This spiritual counseling, as described by some of our participants, was strikingly similar to what has been reported as being used in traditional African shrines [27–29].

Even though our participants emphasized a spiritual focus for healing mental disorders, they were not opposed to patients receiving biomedical care in addition to the spiritual care; in fact, many reportedly frequently referred patients to hospitals. This seems contradictory to the apparent beliefs about the spiritual management of spiritual illness. Given the perceived expectations of curing sickness, it was a bit surprising that they reported referring patients to the hospital for management; especially for the treatment of illnesses that they considered to be supernatural in origin. But although they referred patients to hospitals, the expectation of a cure was still present and as such, they did not expect their patients to continue presenting with symptoms. Although there is mixed evidence in biomedical thought about recommending prolonged pharmaceutical treatment of psychotic disorders [30], our participants believed that an effective treatment of illness should not be prolonged.

This is seen in the participants' own treatment where remissions are explained as a patient's failure to adhere to instructions. To our understanding, the participants did not seem familiar with the concept of partial remission in serious mental disorder.

The findings reported in this study are consistent with what has been reported in other studies in Ghana. For instance, Asamoah et al. [15] examined the perceptions of Pentecostal clergy in Ghana on the causes of mental disorders, among others. Like our participants, their findings suggested a strong belief in supernatural causes of mental illness, as well as the role that they needed to play in healing the mentally ill. Therefore, the dominant perception of Ghanaian clergy appears to be that mental disorders result from diabolical intentions [1, 17, 20].

This supernatural perception of illness causation is not limited to clergy alone. Yendork et al. [31] reported that congregants of charismatic churches also attributed mental illness to supernatural and diabolical forces. However, Opare-Henaku and Utsey's [32] exploration of indigenous Akan concepts of mental illness suggests that such notions are likely influenced by cultural perceptions of illness causation, further emphasizing the syncretic nature of the neo-prophetic churches.

Again, this is not different from what has been reported in other countries. In their exploration of conceptualization of psychosis by indigenous and religious healers in Uganda, Teuton et al. [2] reported that their participants regarded mental illness as communication from family spirits, persecution by others and punishment. What was different in our study was that our participants did not view mental illness as originating from ancestral communication, although the belief that persecution and punishment could cause such disorders was present.

Unlike what has been reported in some other African studies [2, 33], unheeded ancestral communication which results in mental illness is, to our knowledge, not very common in the Ghanaian context. Instead, much emphasis has typically been placed on illness and misfortune arising due to the displeasure or punishment of gods and deities, or from witchcraft activities of malevolent persons [22, 27]. This is reportedly a feature of indigenous religious thought. Thus, the spiritual factors associated with mental illness also reflect the influence of indigenous ideas.

With regard to the methods employed, Agara et al. [34] also reported that their sample of Nigerian clergy employed methods such as prayer, fasting, and prophecy to diagnose and heal mental disorders, just as our findings suggest. However, their participants reported beating the patients as a means of banishing the evil spirit; this was different in our sample, as some of our participants stated that they did not believe in such methods. But this could very well be a matter of providing socially desirable answers by some of the participants, given that some media stories in recent times have reported that patients were being beaten in some prayer centers in Ghana [35].

These findings can also be examined with respect to neo-Pentecostal/charismatic churches in non-African countries. For instance, in a study of explanatory models of mental illness among clergy from different ethnic backgrounds in the East London area, Leavey et al. [36] reported more mixed etiological notions among their participants, including supernatural, biomedical, as well as social/situational explanations for mental disorders. The participants' ethnic backgrounds included English, African, Caribbean, and South Asian. Although some similarities can be drawn between these beliefs and those of our participants, there was a higher endorsement of biomedical and situational explanations for mental disorders among the non-African participants in their study. Thus, the African cultural influence on Christianity is seen here also. These similarities have also been reported in studies with immigrants in other contexts [37, 38].

Implications of our findings

These findings have varied implications. In the first place, it seems clear that the clergy strongly believed that because of the supernatural etiology of mental disorders, they needed to be part of patient care. This willingness may be a good opening for collaborative efforts, particularly given the fact that many of their congregants reportedly hold similar causal beliefs. However, it would be wrong to deny the factors which may make such partnership difficult. Foremost are the varied methods that are used for diagnosis and treatment. Their reliance on divine revelation for these purposes implies that there is a high level of subjectivity in their work. Therefore, standardizing these treatments would be difficult, and without standard procedures the potential for abuse (even inadvertent abuse) can make collaboration problematic.

The clergy also had a high level of confidence in their abilities. According to the participants, this was because they represented God. They therefore expected to be obeyed, and through such obedience, the patients would receive their healing. Their belief in the divine source of their abilities, it seems, may have led to a belief that theirs was the only legitimate way to understand disorders and to practice healing. The expectations that patients should comply with a treatment regime because of its divine origins can be worrying because it can potentially deny patients agency. Their reliance on the pastor for direction can become an unhealthy dependency, affecting their ability for personal decision-making. It may also foster cognitive dissonance in some patients when symptoms

remain or recur, despite their faithful adherence to the directives given [39, 40]. All these are potential trigger points for exacerbating their conditions, or contributing to the development of other mental disorders.

Despite the beliefs in the spiritual nature of most mental disorders, the participants acknowledged that biomedical care was sometimes warranted. However, they relied on their observation of behavior changes to confirm whether healing had been completed. Therefore, patients who continued presenting with symptoms were considered unhealed and thus, the treatment was potentially ineffective. In contrast, the healers' reliance on behavioral changes as indication of healing could suggest that patients in their care could potentially remain in that state for prolonged periods. The absence of clear timelines for treatment is concerning and can present problems in collaborative efforts.

Due to the belief in spirits causing mental illness, it appears that blame is removed from the patient to outside influences. Thus, the level of stigma attached to living with a mental disorder is reduced, because the patient is seen as a victim. However, this may cause social and familial strains because blame is always placed on someone within the patient's circles. Despite its usefulness for removing stigma, it may create further challenges if not redirected properly.

Although patient blame may be removed with respect to initial onset, our data suggest that patients do get blamed for relapse of the illness. As was indicated in previous section, when symptoms recurred, the patients were believed to have defaulted in the prescribed treatment. This also highlights the high level of confidence in the healing process. Although perceptions of patient non-compliance are not unusual in any healing system, such beliefs are important to acknowledge as they may be triggers for dissonance, distress and potentially other conditions. The beliefs are also important to consider in biomedical interventions given the perceived pluralistic nature of mental health care in Ghana.

The clergy also appeared to hold different notions about what can be considered universal mental disorders. Their assertion that every case is different is a divergence from the idea of standard packages of care for mental health. This lends support to the idea of rethinking the emphasis on westernized models of mental health in the scaling up of services in non-western contexts [41]. This is an important point to consider when establishing pathways to collaboration between faith healing and other therapeutic systems.

The above points are not to suggest that there is no place for Christian healers in the Ghanaian mental health system. The benefits of having congruent healer-patient beliefs is known; as is the value of spirituality in illness recovery and management. Therefore, some of the difficulty in collaboration may perhaps be resolved if the role of the clergy in mental health care is reinterpreted. The pastors' positions and their influence as leaders are potentially beneficial for partnerships with other health systems to drive public mental health education and health promotion efforts. Thus, given that their concepts of mental illness were dominated by psychotic behaviors, some training on recognizing different disorders could further help the pastors to play an important role in facilitating appropriate referrals for care. In addition, the participants' accounts show that the pastors already do some counseling of patients. Again, this means that they are well placed to facilitate psychosocial rehabilitation and community re-integration programs. The pastors can also be valuable partners in fostering behavior change and treatment compliance for patients who require added support.

Conclusions

In this study, we explored the perspectives of neo-prophetic Christian healers about mental disorders. The healers were heavily reliant on divine revelation as a means of diagnosing and treating mental disorders. As such, their methods varied from one patient to another. Given the perceived high patronage of these facilities [8], their use of prayer, fasting, and holy oils appears to be accepted by patients and their families.

We do not have data on the relative efficacy of faith healing versus biomedical approaches at this time (and this is clearly an important topic for further research) so we do not wish to claim here that biomedicine is definitely more efficacious than faith healing. At this stage of knowledge, and given the pattern of resources in Ghana, it is important that different systems of healing have a better understanding of one another. So if faith healers receive psychoeducation, it should be in a context in which mental health practitioners are also open to learning about faith healing. In fact, our own research, and this article are designed partly to provide such avenues for education of mental health practitioners on this issue.

In order to effectively partner with faith healers, these factors need to be carefully considered. It is noteworthy that participants' descriptions of mental disorders were limited to severe and disruptive mental disorders, whereas most mental disorders as understood in the biomedical system are not necessarily severe or socially disruptive. This suggests that a further area for exploration would be a discussion with pastors specifically regarding common mental disorders and their care. In addition, perspectives and experiences of patients who have attended such healing services would also be helpful in determining effectiveness. Regulations must also be

enhanced in order to assess quality and efficacy. All these need to be explored if collaboration between the various systems of care is to be achieved in order to transform mental health care in Ghana.

Study limitations

This study had a few limitations which are important to acknowledge. First is the fact that the churches which were included in this study were limited to neo-prophetic/charismatic churches. Although the participating churches were chosen due to their popular healing activities, we do acknowledge that other church denominations (such as AICs or western mission churches) may have provided different perspectives on mental health. Secondly, limiting participants to those living/working in Accra certainly also influenced the perspectives that were shared. As has been described above, Accra is a peri-urban setting which may present a worldview which differs from those in rural settings. A third limitation was the fact that the first author (who is female) conducted the interviews with a largely male population. Although this was not overtly experienced, the first author's gender may have influenced her engagement with the participants.

Authors' contributions

LK and LS together conceptualized the study; LK collected, analysed and interpreted the data, all under the supervision of LS. Both authors read and approved the final manuscript.

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Competing interests

The authors declare that they have no competing interests.

Availability of data and materials

Data were collected through recorded and transcribed interviews. To protect participant confidentiality, relevant sections of these transcripts are presented within the text of the manuscript, with de-identified markers. Further qualitative data is available from the corresponding author upon request.

Consent for publication

Not applicable.

Ethics approval and consent to participate

Ethics approval for this project was obtained from the Stellenbosch University Humanities Research Ethics Committee (Protocol ID: SU-HSD-002388); as well as from the Ghana Health Service Ethics Review Committee (Protocol ID: GHS-ERC 03/07/16). All procedures contributing to this work comply with the ethical standards of these committees. Individual informed consent was obtained from each participant.

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PART 4: COLLABORATION WITH BIOMEDICINE

In Part 4, I discuss the healers' views about collaborating with biomedical practitioners in mental health care, by examining the views of the different categories of healers.

Part 4 therefore contains:

i. Chapter Eleven (Article 8): The implications of healers' power and position for collaboration

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CHAPTER ELEVEN: ARTICLE 8

Implications of healing power and positioning for collaboration between formal mental health services and traditional/alternative medicine: The case of Ghana

11.0 Introducing Article 8

Article 8 is the concluding article for the results section of this dissertation. Having examined the ways in which the different categories of healers conceptualised mental disorders, as well as the methods that they used in treating these disorders, I assessed their views about collaboration with biomedicine.

For some years now, there have been increased calls for the biomedical and the non-biomedical field to work together. These calls come from a desire to narrow the treatment gap in mental health care, and to promote and regulate the work of alternative practitioners in different contexts. However, the dialogues about collaboration so far have placed biomedicine on one end of the spectrum, and a wide range of indigenous/faith approaches on the other.

In this paper, I argue that such a position fails to recognise the plurality of health care systems that exist. Furthermore, it fails to consider the diversity which may exist in how the different healers position themselves on that spectrum, and the resultant implications for their willingness to work with biomedical systems. I thus explored the perceptions of the different categories of healers about their own power and position to heal, and how that potentially influences their openness to collaboration.

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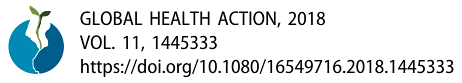
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ORIGINAL ARTICLE

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Implications of healing power and positioning for collaboration between formal mental health services and traditional/alternative medicine: the case of Ghana

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ABSTRACT

Background: Many current debates about global mental health have increasingly called for collaboration between biomedical and traditional medical health systems. Despite these calls, not much has been written about the variables that would influence such collaboration. To a large extent, collaboration dialogues have considered biomedicine on the one hand, and a wide range of traditional and faith-based treatments on the other hand. However, this dualistic bifurcation does not reflect the plurality of healing systems in operation in many contexts, and the diverse investments that different non-biomedical healing approaches may have in their own power to heal.

Objective: We set out to explore the diversity of different healers' perceptions of power, and the relationship between that power and the perceived power of biomedical approaches.

Methods: Through a qualitative design, and using the case of medical pluralism in urban Ghana as an example, we conducted interviews among different categories of traditional and alternative medicine (TAM) practitioners living and/or working in the Greater Accra Region of Ghana.

Results: Through thematic analyses, differences in the notions about collaboration between the different categories of healers were identified. Their perceptions of whether collaboration would be beneficial seemed, from this study, to co-occur with their perceptions of their own power.

Conclusions: We suggest that an important way to move debates forward about collaboration amongst different sectors is to examine the notions of power and positioning of different categories of TAM healers in relation to biomedicine, and the attendant implications of those notions for integrative mental healthcare.

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Ghana; traditional medicine; collaboration; power; mental health

Background

In many low- and middle-income countries (LMICs), access to and use of formal mental health services is limited for various reasons, including shortage of trained professionals, limited resources and perceived high cost of care [1–3]. As a result of these and other factors, alternative and complementary healthcare methods such as traditional and faith healing are popular avenues for receiving care in many LMICs, including many African countries [4–7].

Some previous studies have explored the use of traditional and alternative medicine (TAM) by patients and caregivers of people living with mental illness in different African contexts [6–11]. These small-scale studies have argued that generally, patients and caregivers seek the services of TAM practitioners because they are more easily accessible and often more flexible in terms of payment structures, but also because their values, concepts and beliefs are similar to those of the patients. Therefore, there was the inclination for service users to seek their services first. Even for those who did not seek traditional remedies as a first point of call, the strong side effects of psychotropic medications often made them undesirable for continued use [12].

Other lines of research have examined the beliefs that are held by TAM practitioners about mental disorders [13–18]. In these studies, the prevailing notion about causation was supernatural in nature. That is, traditional/faith healers generally believed that evil spirits, demonic possession, curses and spiritual punishment manifested as mental disorders. Even though their views were dominated by supernatural factors, many of the healers did acknowledge that other factors such as drug misuse and traumatic brain injury were possible causes of mental disorders.

In addition to their causal beliefs, there have also been studies on how TAM practitioners treat mental illness [19–24]. The treatments varied based on the orientation of the healer. The common treatments reported included herbal remedies (such as infusions, decoctions, inhalants and ointments), dietary restrictions, psychosocial counselling, prayers and incantations, among others.

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In current debates about global mental health, it has become commonplace to call for a closer collaboration between biomedical, or psychiatric, approaches to treatment, on the one hand, and a wide range of faith-based practices on the other, given the popularity of alternative treatments in many LMICs. There have been some examples in the literature of (generally small-scale) attempts at collaboration between mental health professionals and traditional healers [25–31], but, though the call for collaboration continues as it has done for many years, it is somewhat surprising that there have not been more studies on how collaboration may or may not work.

The World Health Organization (WHO) strategy document on traditional medicine [32], as well as its mental health action plan [33], acknowledges the need to recognise the diversity that exists in traditional and alternative treatment options, and advocate for country-specific strategies to be developed based on contextual needs. However, there is a strong emphasis on co-operation and regulation of TAM practitioners along the medical model. The recommendations are fundamentally for biomedicine to provide pharmaceutical care while TAM provides complementary care along psychosocial and spiritual lines. They also advocate for more research to be done on the quality, effectiveness and forms of TAM, taking into account the environmental and social as well as spiritual factors which make up TAM approaches to healing [34].

Despite these acknowledgements, the dualistic bifurcation between western medicine on the one hand and traditional/faith healing on the other does not reflect the plurality of healing systems in operation in many contexts – there are many different kinds of healers, using differing systems of justification for their work, and engaging in complex and at times unpredictable ways [35]. Consequently, part of what has not been fully explored in the study of the potential for collaboration between western medicine and other approaches to healing is the question of the diverse investments that different non-biomedical healing approaches may have in their own power to heal, and the relationship between that power and the perceived power of biomedical approaches. Using the case of medical pluralism in urban Ghana as an example, in this paper we argue that an important way to move debates forward about collaboration amongst different sectors is to examine the notions of power and positioning of TAM healers in relation to biomedicine.

The case of Ghana

As part of a larger study, we conducted interviews among different categories of TAM practitioners living and/or working in the Greater Accra Region of Ghana. For ease of presentation, we have used four categories of practitioners; we do, however, acknowledge that the Christian, Muslim and indigenous African religious healers may be classified collectively as faith healers. Thirty-six practitioners were interviewed, made up of 8 herbalists, 10 Islamic healers, 10 Pentecostal/charismatic Christian faith healers and 8 traditional shrine priests/medicine-men (see Table 1 below for a summary of the demographic characteristics of the participants). In other papers, we have discussed in more detail the work of each of these groups of healers (for herbalists' methods, see [20]; separate manuscripts for Christian faith healers, Muslim faith healers, and shrine priests are currently under consideration elsewhere).

Pentecostal/charismatic Christian healers

The Christian faith healers all subscribed to the Pentecostal/charismatic doctrine of Christianity which places much emphasis on prophecies, miracles and the gifts of the Holy Spirit [36]. These pastors claimed that they had received special gifts of healing from God, through which they performed miracles of healing for people with various ailments. They set up healing centres (called prayer camps), which were often filled with patients and their caregivers seeking divine intervention for their illness. Some of the camps offered housing for patients and their caregivers, while they sought healing from God. Their healing methods included prayer, fasting and exorcism. Some pastors used these methods alone while others combined them with prayer aids such as holy water and anointing oil. Some pastors advertised their services through radio and television programmes, billboards and posters. In addition to these, witness testimony was an important means of creating awareness of the camps.

From our interviews, the pastors considered themselves to be operating at a higher level of efficacy than biomedical professionals. They considered their methods to produce more enduring results given their use of the gifts of the Holy Spirit, whom they considered all-powerful. They demanded respect and reverence, and expected their instructions to be followed closely in order for the patient to receive com-

Table 1. Summary of demographic characteristics of participants.

Characteristic	Number (%)
Gender	
Female	5 (13.9%)
Male	31 (86.1%)
Type of healer	
Herbalist	8 (22.2%)
Shrine priest	8 (22.2%)
Mallam	10 (27.8%)
Pastor	10 (27.8%)
Mean age	54.6 years
Mean years of practice	28.1 years

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plete healing. Despite the self-perception of power that this expectation of obedience may suggest, there was a strong desire among the pastors to be formally recognised for their work and abilities. Many of them envisioned a system in which they worked alongside doctors to provide services to patients in hospitals. As one pastor put it, 'they have their area – which is the physical side – and we … handle the spiritual side'. This was said to emphasise the need for recognition and collaboration with the formal health system. Thus, despite their assertion that their methods worked better than biomedical methods, they acknowledged the place of biomedicine. They also perceived biomedicine to have greater recognition and respect in the national health discourse, and, by extension, greater power and legitimacy in the eyes of the government.

Muslim healers (mallams)

The Muslim healers were learned Islamic clerics who had been trained in how to apply the words of the Qur'an and other Islamic texts like the Hadith in treating various illnesses. Some had received further training to incorporate plants and animal parts in the healing process. Those who incorporated herbs in their healing work held informal clinics on specific days where patients requiring the combined therapy could be brought for care. These were also the healers who used posters, billboards and radio to advertise their services. However, those who relied solely on the Qur'an were typically leaders of local mosques and did not advertise their services. The Muslim healers, called mallams in local parlance, were all male.

Similar to the pastors, the mallams viewed their healing as being more efficacious than biomedicine, in their case, due to their use of the words of Allah and his prophet. Unlike the pastors, however, they did not ascribe any power to themselves and constantly emphasised their position as servants of God in the work of healing. According to them, to take credit for the outcomes of their work would be inappropriate given that their role in the healing process was to recite the words that they had been given – words which contained the power to restore health to the patients. They did not desire association with biomedical professionals because they believed the two systems functioned on different planes. This is not to suggest that they were opposed to biomedicine completely, but rather their belief was that disorders which they could treat were not physiological in nature and hence did not require the intervention of doctors. Yet they also believed that doctors had been given wisdom by God to treat physiological problems. To them, each system of care had its place, and both were necessary for the complete well-being of the patient.

Shrine priests

The shrine priests, or medicine-men, were devotees of indigenous African deities. These traditional religious healers represented and carried out the wishes of various deities or gods. Their shrines were typically located in remote, isolated areas such as groves. Through their association with the gods, they divined the nature and causes of whatever disorder the patient presented with. Their healing methods depended on the directions received from the gods and could involve actions to be undertaken by both the patient and their family. In some cases, the healers used herbal remedies to supplement the spiritual intervention.

The shrine priests expressed similar sentiments as the mallams regarding their own power. These healers also viewed themselves as conduits for the gods that they represented. They did not ascribe any supremacy to themselves; however, they considered themselves powerful as agents of the gods whom they served. Given that power, they demanded fear and reverence be shown to them as befits the gods' status. On the other hand, this also suggests that they believed they bore no responsibility for the consequences of their actions, given that they were relaying the wishes of a higher power. Despite this perceived ambiguity, they always emphasised their obligation to not harm the patients, an action which they believed would result in dire consequences for them. The shrine priests sought no recognition from biomedicine, and showed no drive for legitimacy because, as one priest indicated, 'Whether they work with us or they don't work with us, [the god] will still be powerful.' Thus, they were powerful only by virtue of their association with the powerful deity. As such, they did not require recognition from formal bodies to know their worth and abilities.

Herbalists

The last group of healers, the herbalists, considered themselves scientists who harnessed the properties of herbs and plants to heal patients. Some of them had established herbal clinics where patients came for consultation and where they produced various tonics and ointments. Others sold their herbal remedies on buses and in marketplaces. Many of them advertised their goods through media such as posters and billboards, as well as radio and television advertisements. Although most of them treated a wide variety of sicknesses, some of them indicated that they had specialised in treating mental disorders.

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The herbalists viewed themselves as 'work[ing] the same way the doctors do'. By this they meant having an affinity with the systematic methods of diagnosis and treatment used by biomedicine. However, many of them repeatedly emphasised the fact that they were using time-tested methods that had been handed down from their ancestors, unlike the 'white man's system' which was used by conventional doctors. According to them, these herbal methods were developed within the indigenous cultural context of the targeted people, and as such served a greater purpose than simply ridding the patient of symptoms. Ironically, this notion was held even by herbalists who self-identified as Christian or Muslim. As a result of this view, many of them included an aspect of spirituality in their treatment regimens. It was therefore common to have treatment programmes which included prayer and fasting, or the recitation of incantations.

By asserting that their methods were culturally sensitive, yet systematic as in biomedicine, the herbalists appeared to occupy a position of liminality [37] within the field of global pharmaceutics. That is, they situated themselves between biomedicine and indigenous knowledge, providing a more holistic, more affordable and easily accessible service which was built on an understanding of cultural values and ideas [38–41], added to an appreciation for the methodical nature of modern medicine. Consequently, they believed this afforded them greater power for healing. However, the herbalists sought collaboration with biomedical professionals, perhaps as a way of proving their legitimacy and asserting their influence in healthcare.

Discussion

For any healthcare system, the extent to which the methods are considered powerful for treating specific conditions is influenced by perceptions of efficacy and effectiveness of the beliefs and practices employed by that system [42]. This notion of power is not limited to the ability to prescribe/produce appropriate medication (whether biomedical or herbal), but also suggests an ability to recognise and identify the causal elements of a sickness [12,43]. Thus, a biomedical practitioner who prescribes psychotropic medications which 'cure' a patient's physical disorder may be considered just as powerful as the pastor or shrine priest who is able to discern witchcraft as the cause of a spiritual disorder and perform an effective exorcism. The two may be considered equally powerful, yet operating in parallel dimensions.

When illness is conceived as a punishment or the consequence of some moral failing, the search for healing may be directed towards aligning with a source of moral power [44]. This source of power is typically reflected in the work of religious healers. However, the assertion that certain physiological processes can be present in the body of one who is mentally ill would result in an alignment with so-called physical remedies in the form of psychotropic medication or herbal remedies. At the end of the day, patients search for the treatment option which will bring relief from their ailment.

Thus, the perceived efficacy of the treatment is echoed in the perceived power of the healer to cure the ailment. At the core of these notions of power lies an expectation that the outcome of treatment will be a complete cure of the disorder [12,35]. This cure is manifested when the treatment restores patients to their previous state of productivity, and they are able to reintegrate into the social strata of the community. Therefore, patients' search for healing would not rest solely on identification with a particular healing system. Instead, they would utilise the system which in their view yields the desired cure. Similarly, healers measure their power and authority over illness in relation to the capacity of their methods to cure illness.

Given this premise, for any efforts to collaborate and scale up mental healthcare in African countries to succeed, the strategies for TAM must not ignore the illness beliefs of the populace. They must also appreciate the real challenges (such as the strong side effects of psychotropic medication) that exist for patients and their families in the use of biomedicine [12].

But a further consideration would be an appreciation of the diversity that exists in the relationship between the various healers' claims to power and the power they see afforded by biomedical approaches, and, by so doing, revising the dualistic view of health-seeking. The recent movement for global mental health advocates the development of standard packages of care as a way of affording universal western psychiatric care, particularly in LMICs [45]. Again, such goals need to be situated within the pluralistic framework of healthcare in these countries, and cannot overlook the scientific uncertainties around aetiology and course of mental disorders [12], as well as the competing notions of power that exist among the various categories of healers.

In this article, we have made a small first step in exploring the diversity of power claims made by different sorts of healers. To suggest to biomedical practitioners that they should collaborate with TAM systems is important given resource constraints, but it is clear that the bases for collaboration with different kinds of healers may be different. In our study, the Pentecostal Christian healers and herbalists were more desirous of working with biomedicine, whereas Muslim healers and shrine priests were less interested

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in collaborating. Interestingly enough, it is also the Pentecostal/charismatic pastors and the herbalists who are more closely positioned in relation to the formal economy. Pentecostal and charismatic churches are hugely popular and financially profitable in Ghana and other African countries [46,47], and it is possible that collaboration with biomedicine could extend the power of the already powerful and lucrative church practices.

Similarly, herbalists operate in a lucrative global pharmaceutics market [38,39] and could also gain by being part of a referral network with biomedicine. By contrast, both Muslim healers and shrine priests operate on smaller and more local scales and appear to have less to gain from collaborating with biomedicine. They do not see themselves as powerful but as instruments of spiritual power. Alternatively, their reluctance to integrate into the mainstream health system may be as a result of their reluctance to lose their position of prominence in contexts where respect for biomedicine dominates perceptions.

Two points of caution are necessary here. First, our data come from a relatively small sample, and it is clear that much more work needs to be done to tease out the potential complexities of collaboration by biomedicine with healers of different kinds. Second, we do not wish to suggest that the reasons Christian healers and herbalists in our sample were interested in collaborating with biomedicine were mercenary and purely self-serving. We are suggesting simply that questions of the benefits of collaboration amongst health systems must be considered not only in terms of potential patient welfare, but also in terms of whether there are perceived advantages to different healers to collaborate. In our study, different types of healers were positioned differently in terms of this question, and the gradient of perceived benefit to the healers seemed, from this small study, to co-occur with the perceptions by healers themselves of their own power. Clearly, more work on this question needs to be undertaken.

Conclusions

The WHO and other bodies have called for collaboration in mental health between biomedical practitioners and TAM, for a range of good reasons. Given its widespread use in LMICs, as well as the popularity and cultural relevance of TAM among minorities in high-income countries, it is important that an in-depth understanding of all facets of these systems of healthcare be understood in order to achieve the desired integration [48,49]. From the discussions with our participants, it is clear that TAM is not an undifferentiated field. There are some similarities across different healing sectors regarding illness beliefs; however, the perceptions of practitioners' understandings of their own role and power show some variation.

These differences may well be important for collaborative efforts. Specifically, in our study, it appears that the healers who considered themselves to be most powerful were most willing to work with other health systems. On the other hand, the Islamic and shrine healers, who insisted on not taking credit for the health outcomes of their patients, were less desirous of working with biomedical healers to treat mental disorders. This suggests, perhaps, that the eagerness to collaborate may in part be a move towards achieving legitimacy and recognition, as perceived to be held by the biomedical field.

These different notions of place also reflect different collaborative models held by the healers [50]. The pastors' eagerness to work alongside biomedical practitioners may be a reflection of their endorsing an incorporation of TAM with biomedicine, where aspects of each paradigm are selectively utilised for patient care. However, the disinterest of the mallams and shrine priests, as well as the ambivalence of the herbalists, is reflective of the pluralisation model, where each remains largely independent of each other while acknowledging the service users' right to choose treatment options.

The important question for integrative healthcare systems must therefore be more nuanced than simply a call for collaboration. In Ghana, and likely in other countries, we need to know more about who, and from which groups, would wish to work together for mental health, and for which reasons. Questions of place, power and claims to legitimacy may form an important component of the collaboration dialogue. Collaborative efforts, we suggest, may be less likely to succeed if these contextual factors regarding different types of healers are not considered. There is clearly still a great deal of work to be done in this area.

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Author contributions

LK and LS together conceptualised the study; LK collected, analysed and interpreted the data, all under the supervision of LS. Both authors contributed to, read and approved the final manuscript.

Disclosure statement

No potential conflict of interest was reported by the authors.

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Ethics and consent

Ethics approval for the project was obtained from the Stellenbosch University Humanities Research Ethics Committee (Protocol ID: SU-HSD- 002388); as well as from the Ghana Health Service Ethics Review Committee (Protocol ID: GHS-ERC 03/07/16). The authors assert that all procedures contributing to this work comply with the ethical standards of these committees, and in accordance with the ethical standards laid down in the 1964 Declaration of Helsinki and its later amendments. Written individual informed consent was obtained from each participant.

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Paper context

Recently, there have been calls for integration of different mental healthcare systems in LMICs. These calls do not appear to consider the different views on collaboration which may exist among different categories of traditional/faith healers, based on their perceptions of their power to heal. We examine this diversity by analysing medical pluralism in Ghana, and suggest that questions of place, power and claims to legitimacy should form an important component of the collaboration dialogue.

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PART 5: CONCLUSIONS

In Part 5, I conclude this dissertation by reflecting on my research experiences. I also draw together the various findings and discuss potential next steps for taking my research findings beyond this dissertation.

Part 5 thus comprises the following chapters:

ii. Chapter Twelve: Reflexivity

iii. Chapter Thirteen: Concluding thoughts

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CHAPTER TWELVE: RESEARCH EXPERIENCES & SELF-REFLECTION

12.0 Introduction

The process of self-reflection in research is an important step in interpreting and analysing research data. According to Etherington (2004), reflexivity allows the researcher to critically assess his or her own personal beliefs and to seek to understand how these beliefs influence their engagement with the participants as well as with the data. Thus, a self-reflection process allows researchers to take into consideration the relationships that they develop with the participants and the degree of influence that they may potentially exert on them, and vice versa (Gilgun, 2010). In this chapter, I therefore reflect on some of the areas where my identity, my position and my personal beliefs may have influenced my engagement with the participants and with the data.

Reflexivity was an ongoing process for me during this study, and through discussions with my supervisor, it allowed me to refine my work at the different stages of the research process (Sandeen, Moore, & Swanda, 2018). Each of the sections below represents an area of self-awareness and learning that I experienced during this process. During my fieldwork, I kept a journal of my experiences, negotiating the landscape of my research area. These reflections draw heavily on that journal and include both data collection experiences and writing experiences.

12.1 Understanding and respecting participants' positioning

As I described in earlier chapters, my initial attempts at recruiting participants was somewhat difficult. Due to these initial difficulties with recruitment, I tried to use snowballing as a further technique for recruiting participants. Although this worked in some cases, there were incidences when the participants were not pleased with my asking for another healer's

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opinion. When I probed further, the prevailing sentiment was that by doing so, I was inadvertently suggesting that the information they had provided me with was inadequate in some way. This was deeply offensive to them, as can be expected, and required some tactful explanation to navigate. In subsequent interviews, I had to explain from the outset that I was seeking different points of view in order to get a fuller picture of the field of alternative healing.

Their reactions reiterated some of the sentiments I had identified during my interviews. These sentiments revolved around the healers' perceptions that Western-trained professionals held no respect for them and their work. I am a biomedically trained clinical psychologist, working in a recognised public institution, and in most cases, possessing more years of formal education than the participants. By asking my participants to refer me to other practitioners, I was inadvertently re-echoing their perceived notion that their work was considered to be sub-par. Such sentiments were most often reported by the herbalists, and required of me to re-emphasise my genuine desire to learn from their perspectives.

My request was perceived to be especially offensive because, initially, I asked this at the end of our interview, when the healers had taken the time to explain their work to me. Throughout most interviews, the participants were eager to teach me about their work, and many of them were glad that I was interested in "returning to my roots" to learn about indigenous ways of health care. In one case, a participant told me he was proud of me for being interested in the ways of our ancestors. Thus, my asking for another opinion was sometimes taken as an insult and I was typecast as being a disdainful, educated girl who was looking to exploit them for their knowledge. These feelings were apparently drawn from their previous experiences with researchers.

Given the initial pride and acceptance that the healers expressed in my work, I was mortified to realise that I had inadvertently offended my participants, and quickly learned that

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respect for participants as an ethical consideration also included an appreciation of the cultural connotations of respect, not only for their positions, but for their knowledge as well. These notions of position and authority were also identified during the consent process, where some participants objected to my stated intention to use pseudonyms in reporting the outcomes. They expected to be duly and publicly acknowledged for the information they had provided. According to Hammersley and Atkinson (2007), understanding social rules of behaviour is an important skill to take into the research arena and often, the researcher is required to be in a position of vulnerability in order to unearth the nuances that inform the relationship between them and the participant. This lesson was an important one for me, particularly given the fact that one of the reasons for undertaking this research was a desire to identify the means to foster open, mutually respectful dialogue between the different healing systems in Ghana.

12.2. Old rules, new lessons: Learning the rules of expected behaviour

To some extent perhaps, I may have underestimated the need for learning about a culture before going into the field because of my background as a Ghanaian. Even though I am Ghanaian by birth and upbringing, and a native of the region where the research took place, I periodically found myself floundering with regard to what the appropriate cultural rules and expectations of behaviour entailed. In particular, when interviewing the shrine priests, certain behaviours were expected of me, which I was unaware of. For instance, on entering one shrine, the priest indicated that we (a gatekeeper and myself) could sit down. Given that there were no chairs or stools available save the one on which the healer sat, I politely declined and stated that I was comfortable standing during the interview. I immediately realised from the reactions of the healer and my gatekeeper that I had made a mistake. The gatekeeper signalled me to sit on the floor as he had done, and later explained to me that it was not allowed for the priest to look up at anyone (especially not a woman).

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By sitting at the healer's feet, we were in a position to be blessed by the gods, if they approved of our requests. This was apparently common knowledge (as I discovered when I asked around afterwards), but was completely unknown to me. In a similar incident, I was offered a drink of water by one participant. When I declined by showing that I had a bottle of water with me, I was told that it was rude to turn away an offer of water because the healer's offer was an indication of welcome, and showed that he was willing and ready to have a conversation with me. Therefore, I was expected to sip at the water even if I was not thirsty, as a show of gratitude for the welcome.

Similarly, at the home of one of the *mallams*, I was directed to crouch beside my gatekeeper while he greeted the healer in a lengthy process. He explained to me later that we had sought the blessing of the *mallam* and had to be in a position of subservience to receive it. This way of greeting is traditionally practised by some northern tribes in Ghana, such as the Dagomba tribe (the Dagomba tribe is one of the largest in the northern region of Ghana, where Islam is predominant, and where many *mallams* in Accra migrated from).

In these experiences, I had learned vividly how (Western) education influenced our knowledge of social norms. The participants were also aware of my lack of awareness about what was appropriate behaviour, and attributed it to my "book-long" background. The term book-long is used in Ghana to describe educated people whose knowledge about "real life" and social rules is perceived to have been corrupted by Western education, and thus limited to theory. My blunders were received with indulgence from some participants, who patiently explained what I had done wrong or what I was expected to do, but also with some disdain from others.

12.3 Religious identification in fieldwork

While interviewing the faith healers, I had mixed feelings about some of their methods due to my own Christian faith. On a number of occasions, I had to make a conscious effort to

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bracket off these sentiments in order to collect the data. However, I confess that in the first few interviews this dissonance likely influenced the extent to which I probed and engaged with some participants.

To illustrate, in most of the shrines, the healers proudly displayed their talismans and amulets as the tools which they used in their work. In some cases, they invited me to take these out to examine them. Although I had often scoffed at the idea of spiritual matters in the past, I found myself hesitating to touch the objects in question. In preparing for the interviews, I knew that I was required to play the role of a person who held an appropriate amount of fear and awe for the power of the deities and gods. However, my actual discomfort surprised me and resulted in subsequent self-reflection about my beliefs about the supernatural and their influence on behaviour.

Closer to my own beliefs, there were instances when I found myself questioning the practices of the Pentecostal pastors, and the extent to which they differed from what I understood as a person of Christian faith. I grew up in a Presbyterian household, and as such, was unaccustomed to the exuberant charismatic way of worship. Although I had seen these services carried out in the past, I had never been in a position to ask questions about what drove the leaders' behaviour. In particular, the pastors' use of scripture in ways that seemed out of context to me was especially difficult to ignore. Furthermore, in analysing and interpreting the data, my own knowledge of what some of the scriptures meant needed to be bracketed off, in order to present the participants' own perspectives. Although I acknowledged the need for separating my beliefs from the data, the pastors' views periodically gave me pause.

Through discussions with my supervisor and with fellow students, however, I was encouraged to see these experiences as an opportunity to nurture a personal religious self-assessment. As Probst (2015) suggested, I made a choice to reflect on my own beliefs and to

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use this as a way to normalise my experiences, in order to find a balance between my research needs and my personal needs. These experiences further reflect the way researchers periodically need to efface themselves when in the field, and the impact of the researcher's position on how the data are collected and engaged with.

12.4 Beyond the field: The researcher-researched relationship after the interview

Another component of the researcher-researched relationship, which I had to learn to navigate, was the participants' expectations of continued involvement in my life. On more than one occasion, some of the healers would call to see how my fieldwork was progressing, enquiring about the information I had received from other participants. This also required careful explanations of confidentiality without belittling their genuine interest in my work. In other instances, they would call simply to see how I was faring.

By these actions, I felt that the outcome of my work mattered to them. This indicated to me a sense of trust in the information that they had shared with me, and further drove me to ensure that I represented them accurately. Although to a certain extent I may have gone into the field with some preconceived ideas about indigenous healers and their work, I left with a great deal of respect for people working in a field which had survived changing attitudes and support. I found most of my participants to be open and helpful, and committed to their work.

The continued involvement was not limited to my life. On some occasions, some participants would call me to give me updates on things that were happening in their own lives. For instance, one herbalist went out of his way to inform me when his wife had a new baby, and specially invited me to attend the naming ceremony (which is usually attended by family and close friends). Another participant, a pastor, called to invite me to the wedding ceremony of his daughter. As Karnieli-Miller, Strier, and Pessach (2009) explain, researchers must develop a relationship built on rapport, sympathy and mutual trust and respect with their

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participants in order to gain a clearer understanding of the reality of their world. The invitations that were given to me by the healers were strong reminders to me that the relationship went beyond the interview, and that the participants trusted me.

On the other hand, there were a few occasions when the relationship was more problematic. A few of the participants believed that my studying abroad meant that I was wealthy. Therefore, I would get repeated phone calls with requests for money. Once again, I had to be very tactful in explaining my inability to assist them. In other instances, some male participants would make sexual advances towards me, and some would be quite upset when I politely turned them down.

Despite the few difficult instances, maintaining a good rapport with the participants was useful in undertaking respondent validation. I learned that the relationship between the researcher and the participants is highly nuanced, and extended beyond the data collection process (Råheim et al., 2016). It is often an ongoing, active relationship of mutual exchange.

12.5 Evolving views and perceptions

As indicated above, my training as a clinical psychologist was deeply situated within biomedical understandings of mental illness and treatment. As a result, there was inevitably some scepticism on my part about the work of indigenous healers. Inasmuch as my interests in understanding indigenous and faith healing partly stemmed from my observations that many patients frequently used their services, I had never considered working with the healers in patient care. Like many professionals in the formal sector, I was admittedly dismissive of their methods beyond providing social and spiritual support to patients. However, coming into closer contact with the healers through their associations and during interviews, I developed much respect for them and their work. Unlike my previously held beliefs about their random and (what appeared to me to be) disorganised treatment methods, I discovered that their approaches were considered by the healers to be quite systematic.

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My engagement with the healers and with the resultant data transformed my perceptions about indigenous healing. I found myself actively thinking about what working with them would entail and what it would look like, rather than dismissing them as second-rate health providers.

These experiences reiterated for me the need for actual contact between the different types of mental health care systems. I believe that much of the difficulty in working together may stem from the lack of contact between different healers, as well as periodic misinformation that circulates about one group or another. In saying this, I do not deny the fact that there are instances of abuse and unethical practice, but such things have also been reported to occur among biomedical practitioners. This was a big lesson for me in this research process, especially as a clinician.

12.6 Issues of language and translation

As I have described elsewhere, most of my interviews were conducted in English and/or one of the local languages. During the transcription process, the interviews were first transcribed verbatim in the language in which they were conducted, before being translated fully into English. As can be expected, this process resulted in some change in the structure and meaning of what the interview had entailed. As van Nes, Abma, Jonsson, and Deeg (2010) asserted, a large component of qualitative research involves making interpretations of participants' responses. The process of translating and back translating therefore may have inadvertently resulted in the loss of some meaning. In addition to this difficulty, African speech is commonly interspersed with idioms and proverbs, and the literal translation of speech may result in a loss of intended meaning (van Heerden, 2013). This was the case in the transcription process for some interviews. For example, the Ga word for "to be discouraged" translates literally as "my hands have lost their bones". A literal translation of this phrase obviously does not accurately reflect the intended meaning. Although language

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experts may engage with such descriptions differently, a discourse analysis was beyond the scope of this dissertation.

One of the ways that was used to mitigate the translation problem was through constant checking and comparison of the audio tapes with the transcripts and the translations. This was made necessary after the first few interviews were transcribed early in the research process. Following discussions with my supervisor, I kept a journal of not only my reflections of the fieldwork and participants, but also on the transcription and translation process. In addition, I enlisted the help of a language expert at a local university for the back translation of transcripts, and continuously engaged her in discussions of meanings.

12.7 Publication experiences

My decision to do this dissertation in the publication format came with many advantages, but it also came with some challenges which I had to overcome. In the first place, I had the option of looking at my data in smaller units first (through each manuscript) before assessing the bigger picture. Given that the amount of data can be overwhelming, this was a useful way of understanding my data step by step. However, this method also required that I approach each manuscript differently based on the specifications of the journal to which I sought to submit. Furthermore, there was sometimes the need to submit to another journal with a different structure. Although I was fortunate to have the services of a language editor, the repeated focus on the same paper was sometimes discouraging, as it felt as though I was in the same spot for long periods of time.

My publishing experience also included learning to navigate the world of peer review. My experience with reviewers was beneficial in that it allowed me to get an idea of how others were engaging with my work, lending some objectivity to my writing. On the other hand, I also learned that some reviewers could be difficult and by their suggestions, potentially alter the intended focus of a paper. To me, these were valuable lessons for my

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own career in academic circles, and through my supervisor's expertise and guidance, I learned how to dialogue with journals through the submission process all the way to publication. As Merga (2015) explained, the opportunity for external review and scrutiny may constitute an extension of supervision, and can serve to expand one's own expertise. This was certainly true for me.

12.8 Summary of research experience

My experiences in conducting this PhD research were varied and sometimes multi-layered. In all of the above experiences, I constantly had to remind myself of a number of personal characteristics which influenced my positionality and hence my decision-making. In particular, my age, gender and level of education had a direct influence on the manner in which participants related to me. Being a product of that culture, these factors also influenced how I related to the participants, and to the data that I analysed. In addition to the outcomes relating to the research, I have also experienced personal growth and maturity through this process. I have gained an appreciation for my background and culture, and also an awareness of my capabilities as an academic through publishing.

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CHAPTER THIRTEEN: CONCLUDING THOUGHTS

13.0 Introduction

In this study, my main aim was to explore the perspectives and views of different categories of indigenous and faith healers about mental illness. In Parts 2 and 3 of this dissertation, I examined the beliefs and specific methods used by the different types of healers to treat mental disorders. I also investigated the healers' views about collaboration with biomedical health systems in Ghana in Part 4 of this dissertation. In order to answer these questions, I conducted individual semi-structured interviews, with Kleinman's (1980) EMs of illness as a guiding structure.

In this concluding chapter, I shall discuss how the different articles together provide important information in the area of non-biomedical mental health care in Ghana. I will also share my thoughts regarding the potential implications of my findings and ideas about what these may mean for the anticipated development of mental health services in Ghana. I will conclude this chapter and this dissertation with some thoughts on future directions for mental health in Ghana.

13.1 What were the indigenous and faith healers' beliefs about mental disorders?

In Chapters Four to Six, I outlined the different ideas that the healers held about different disorders. Through the different vignettes, it was evident that the healers held varied classificatory beliefs regarding what constituted a mental disorder. As has been reported in other studies (e.g., Read, Doku, & de-Graft Aikins, 2015), psychotic behaviour was clearly seen as a mental disorder. There was, however, some variation between the different types of healers about non-psychotic mental disorders. Some of the participants, particularly those who had more exposure to formal Westernised education, appeared to identify biomedical classifications of mental disorders more consistently. Although this was not asked of the

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participants directly, the influence of biomedical names for certain disorders was clear in the similarities between their labels for certain disorders and those of biomedical systems.

This is not to say that their identification with biomedical classificatory ideas were solely due to formal education. Other participants who did not have experience in formal education likewise showed some awareness of biomedical classification and nomenclature. This finding corroborates Kirmayer's (2004) assertion that "traditional" systems are constantly transforming in the context of increasing globalisation. Moreover, the biomedical mental health literacy of the healers was likely reflected by their exposure to biomedical ideas through globalisation processes. However, as Ganasen et al. (2008) argued, the idea of mental health literacy as knowledge of biomedical classifications of disorders does not quite answer all the questions about health literacy because it fails to account for knowledge of culturally accepted meanings about mental illness. In this study, the healers were knowledgeable of what was culturally accepted as mental disorder, even if these differed from biomedical ideas (Njenga, 2007).

Although most of the healers expressed beliefs in supernatural causation, there was also an acknowledgement of other factors as potentially causing mental disorders, some of them even suggesting physiological/biomedical reasons. These findings are similar to what some recent studies (Kajawu et al., 2016; Sorsdahl et al., 2010) have reported about indigenous ideas of mental illness, unlike early beliefs about dominant spiritual beliefs about mental illness (e.g., Field, 1955; Monteiro, 2015; White, 2015).

While my findings lend support to the reported variances and fluidity in beliefs about illness, I cannot overlook the fact that there are opposing ideas about so-called African concepts of illness. For instance, in a recent paper by Kpanake (2018), he discussed the concept of African personhood as involving three interconnected components which informed and influenced their help seeking behaviour. These three components (self-agency,

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social agency and spiritual agency) were reported as constituting the African's worldview. Although such descriptions are potentially useful in mental health care as the author posits, they discount the inherent heterogeneity of help seeking processes, as Cooper (2016) asserts. These two apparently parallel approaches to understanding help seeking behaviour (that espoused by Kpanake, 2018; and that by Cooper, 2016) highlight the fact that ideas on how to conceptually approach the work of indigenous healers remain unresolved.

Part of the reason for these different accounts may exist in the extent to which different authors accept the idea that there are readily separable world-views, or believe, in contrast, that people make (conscious and unconscious) choices about their lives and about healing based not on a "world-view" as something static and inherent, but based on a plurality of options in shifting, complex contexts. It may also be the case that a contributory factor to different views may lie with the nature of the subject matter itself. By its nature, the work of indigenous and faith healing and the process of passing down knowledge, is highly subjective and thus has resulted in a paucity of information about concepts and ideas. This is an important factor to consider with regard to identifying methods of scaling up mental health care, and warrants further exploration.

The healers also showed considerable discomfort with derogatory or stigmatising labels, particularly in relation to intellectual disability. They appeared to be keenly aware of the impact that such stigma could have on the individual and, in some cases, vehemently opposed the use of negative labels. In this aspect, there was again little differentiation among the different categories of healer. Also with regard to impact, the healers believed that mental illness could have a serious and negative impact on the lives of individuals. These were believed to also affect the individual's family, and influence their engagement with their social networks. These findings are encouraging for public health promotion and education. Given the number of healers who purportedly treat mental disorders in Ghana, they are in

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positions of influence to transform mental health narratives. Their positive attitudes can be a useful tool to drive intentional inclusive and transformational agendas within the mental health system.

The findings also suggest that indigenous healers themselves hold multiple beliefs about mental disorders and their perceived impact. These views are not static; they are dynamic and fluid, and are understood based on the healers' perceptions of cause, severity and outcomes (Read et al., 2015). As Helman (2007) observed, beliefs about an illness are reflective of how the illness is experienced within a specific context. The indigenous healers' understanding of mental illness can similarly be argued to be a reflection of their experiences and positions within those contexts.

13.2 How did the indigenous and faith healers treat mental disorders?

A further objective of this study was to scrutinise the diagnostic and treatment methods of the healers. These methods were presented in Part 3 (Chapters Seven to Ten), and were analysed separately for each type of healer. The methods that were described consequently varied based on the orientation of the healer, and often required specific systematic processes. For most types of healers, there were specific ways of not only diagnosing and treating the condition, but also specific ways of administering the treatment for it to be considered effective. The methods included the use of herbal products, prayers and/or incantations of different kinds, as well as various counselling methods.

Although the healers believed in the effectiveness of the methods that they employed, I did not assess effectiveness at this time. As was mentioned in Chapter Two, it is difficult to determine the effectiveness of the healers' methods. Quantifying treatment outcomes can be difficult in most psychiatric care (Nortje et al., 2016; van der Watt et al., 2018), and this is made even more difficult given the highly pluralistic context within which indigenous/faith

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healers operate. Despite this ambiguity, the healers and their patients reportedly believed in the treatment methods.

Although this study outlined some of the treatments for mental illness that were used by indigenous healers and their perceived effectiveness, further research is certainly needed before we can conclude that the methods are effective. Much of the scepticism surrounding the efficacy of non-biomedical treatments is due to the perceived absence of systematic evidence-based data about treatment outcomes and the limited knowledge of cultural methods of care (Kajawu et al., 2016). Consequently, the usefulness of a biomedical lens in assessing indigenous cultural healing can be alluded to only tentatively. Conducting randomised trials (such as what has been attempted by Ofori-Atta et al., 2018) of the different methods of treatment is certainly warranted and the results of these can further inform practice.

13.3 What were the healers' views about collaboration?

In this study, I also examined the healers' views about collaboration amongst themselves and with biomedical professionals. Again, the healers' views were different across the different categories of healers, and were influenced by their ideas about their own power to heal and how that power positioned them in the mental health care milieu. In general, it appeared that the healers who saw themselves as possessing great power to heal (such as the Pentecostal pastors) were also most interested in collaborating with other professionals. In contrast, healers such as the *mallams*, who saw themselves merely as conduits of healing, were less interested in working with other health care professionals.

These different notions about collaboration raise questions for the way forward in mental health care in Ghana, and may explain why previous attempts at collaboration were unsuccessful. In particular, questions about the perceived usefulness of the need to collaborate come to mind. Although some of the healers expressed interest in collaboration, the anticipated outcome of collaboration was often to achieve greater legitimacy and

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influence in the health system. Similarly, those who showed less interest in collaboration were not necessarily opposed to the work of other systems, but believed that they could work in parallel with one another. Thus, indigenous and faith healers may hold different ideas about the usefulness of collaboration.

In much of the dialogue on collaboration, the need for the different medical systems to work together has been emphasised. However, based on the findings of this study, one of the key factors, which appears to be missing in the discussions on collaboration, is the intended outcome that is expected to result, particularly from the perspective of the healers. As stated above, from our participants' accounts, what the different systems of health care have in mind with regard to transforming health care through collaboration may be different. Therefore, there is a strong need to look specifically at the issue of the usefulness of collaboration, not only for the intended benefit to patients, but also for the healers involved. This can be done through, for example, developing action research protocols to analyse case examples. In particular, a process of assessment to identify who is interested in working together, and what they would require to optimise the different approaches to care, would be useful in taking the collaboration dialogue to the next level. Based on the findings discussed in Chapter Eleven, perhaps the best place to start answering such questions would be with practitioners who are already more open to collaboration. Once case examples from these collaborative frameworks are presented, they may serve as foundations for developing appropriate programmes with other healers.

Additionally, the work on collaboration must not be limited to transformation of the work of indigenous healers only. It is important that biomedical professionals' involvement is encouraged in the development of pathways for collaboration. With a bi-directional understanding of collaborative views, appropriate measures can be identified and put in place to drive the transformation of mental health care in Ghana.

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13.4 Study limitations

Although I identified some important perspectives and views in this study, there were limitations which are important to acknowledge. The first limitation was the fact that only healers who lived and/or worked in the Greater Accra Region were included in this study. Although the decision to focus on Greater Accra was taken for practical reasons, it resulted in an exclusion of participants from the other regions of the country. As I have described in earlier chapters, Greater Accra is a cosmopolitan, urban region. Hence, the experiences and views of the healers would likely differ from those of healers in rural parts of Ghana. These experiences will also be shaped by the kinds of patients who seek their services, who may have more of a choice of health seeking avenues than those in underserved regions of Ghana. Given that biomedical facilities are available in Accra, the healers are more likely to have contact with biomedical professionals, which may influence their views on collaboration. As a result, the findings cannot be generalised to the population of traditional healers in Ghana.

Secondly, the use of GHAFTRAM and GPCC as a means to recruit participants may have resulted in my overlooking some healers who did not belong to these groups. Although my use of snowballing as an additional recruitment technique provided access to other participants, the referring participants were often inevitably members of these Associations, and thus more likely to know colleagues who also belonged to these groups. Again, this means that the findings are not generalisable.

Thirdly, the types of participants that I interviewed were limited to indigenous and faith healers. I did not include patients and/or their caregivers in this study. The views and perspectives of these service users would provide additional nuance on the health seeking avenues in Ghana, as well as the perceived effectiveness of indigenous methods. In addition, exploring the views of biomedical professionals about collaboration with indigenous healers would have lent a different perspective. Furthermore, an assessment of the healers' views

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about working with other non-biomedical healers would have presented another layer for exploration. In a similar way, the views of policymakers and the leadership of GHAFTRAM would have provided further layers of discussion about collaboration.

Finally, my methods for this research were limited to individual interviews. An expansion of these methods, to include for instance observations or photo voice research methods, could have provided additional rich data for assessing the nature of indigenous/faith healing in Ghana. Despite these apparent limitations, the findings of this study are potentially useful for policymakers and government bodies like the Mental Health Authority as pathways are explored for scaling up mental health care in Ghana.

13.5 Conclusions and questions for future directions

In this dissertation, I explored some cultural connotations about mental illness. Although I have discussed some aspects of culture and mental health, I recognise that some fundamental questions about understanding culture within contemporary medical contexts (Kirmayer & Swartz, 2013) have been left unanswered.

The work reported in this dissertation started out as an interest in what indigenous healing entailed. By examining the ideas and methods of these healers, I found some of the answers to how they worked, but I also found different ways of thinking about them and their work (*why* they worked). I have certainly been influenced by my interactions with the participants, both as a student and as a mental health professional. Given my own experiences, it begs the question of what intergroup experiences can be enabled to change perspectives about the other. In light of the tensions that exist between the different systems of health care in Ghana, perhaps an exposure to the work of other health practitioners is the way forward (as was the case for me).

I am, therefore, left with ideas about next steps; questions like how to disseminate my findings to professionals so that it is useful for health care are important to explore. I also

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ponder on how the findings can be used in places like schools so that the training of students in mental health care (at different levels) is expanded in order for them to have a more nuanced appreciation of the different systems of care that the average Ghanaian has access to. How can my findings be used by different types of healers in understanding not only their work, but also the work of other health care workers?

One potential way to begin to answer some of these questions is to organise a dissemination meeting with the different categories of healers, including biomedical healers. While this would be the simplest way to discuss the findings of my research, there remain questions of whether the different healers would be willing to meet together. Although I anticipate the herbalists, shrine priests and *mallams* to be comfortable meeting together (as they already do through GHAFTRAM), I have some uncertainty about whether the Christian healers would be comfortable meeting with the other healers.

One way around this quandary would be to set up individual meetings with the different healers to discuss the best way forward for a dissemination meeting. This would allow me to take into consideration the different positioning of the healers. The dissemination meeting would therefore be beneficial for discussing the outcomes which I found important and useful, and to assess the healers' agreement or otherwise. These steps would be necessary before any formal collaboration project is undertaken.

Given the uncertainty about whether or not the different healers would be willing to work together, another potential way forward would be to develop a small collaborative framework with just one group, as a beginning step. This might be in the form of bi-directional training programmes, periodic debriefing meetings, and perhaps opportunities to observe the work of other healers. The outcomes of this joint venture may be a useful platform to drive wider collaboration.

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The area of alternative health care in Ghana is therefore laden with unexplored territories. While I cannot tell if my proposed projects would be successful, I believe that in order to transform mental health care in Ghana, we must be intentional about including the different healers that work in the country. I hope that these questions will provide directions of interest for further work, which can inform service delivery and ultimately improve care for mental illness in Ghana.

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APPENDICES

Appendix A: Interview guide and case vignettes

Interview questions for healers

Interviewer to say: Thank you for consenting to be a part of this study. As was explained to you when you were recruited for this study, I am going to ask you a series of questions related to your work in treating people who are mentally ill. Please feel free to answer the questions I ask in any way that you want (there are no right or wrong answers; all that is important is for you to tell me what your experience has been). Remember that you are free to not answer questions that make you uncomfortable, and you can indicate to me anytime during the interview if you would like to stop altogether. You can also ask me any questions that you have in mind (either now – before we start, or at the end of the interview).

Are you ready? /Can we begin now? / Do you have any questions for me now?

1. Please tell me more about yourself:
   a) Gender (*researcher to indicate*) __________
   b) Age: ________
   c) Type of healer: Pastor/Mallam/Fetish priest/Herbalist
   d) How long have you practised as an herbalist/mallam/pastor/shrine priest?
   e) How did you become a herbalist/mallam/pastor/priest (or: please could you describe the training you underwent?)
2. Tell me more about your work
   i. How do you understand illness (in general)?
   ii. How does it (illness) work? (what does it do to a person?)
   iii. What do you believe causes illness (in general)?
   iv. What kinds of conditions do you treat?
   v. Are there things (conditions) that you can't treat?
3. As we discussed when you were recruited, I am interested in your work on treating mental illnesses. I am now going to describe to you some examples of people with certain symptoms, followed by some questions about each of the disorders that I

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described in order to look at how you think about such cases. Please answer the questions in any way that is appropriate for you.

(Researcher to read each of the dummy cases to participants) Use each of the cases described below to answer the following questions:

1. What do you think is happening to this person?
   a) What do you call this (illness)?
2. What do you think caused the problem?
3. Why do you think it started when it did?
4. What do you think the sickness does (to the patient?) How does it work?
5. How severe is the sickness?
   a) Will it have a long course or a short course?
6. What kind of treatment should the patient receive?
   a) What are the most important results you hope to achieve from this treatment?
7. What are the main problems the sickness (can) cause for the patient?
8. What (should) the patient fear most about the sickness?
9. Are there any other methods/treatments that can be used to treat this illness?
   a) Would you recommend any of these to your patients?
   b) Are there any disadvantages with using any of these methods?

A. Dummy case 1: Schizophrenia

17-year old Kwame has over the past 3 months behaved in an unusual manner. His parents report that he can often be found whispering to himself and seemingly having a conversation with someone he calls ‘Sir’, whom he says is ‘in the heavens’. He insists that the voices he hears run a commentary on his behaviour. Whenever his parents try to speak to him during these conversations, Kwame becomes aggressive and threatens to kill them because he believes they ‘want his downfall’. On other occasions, he is extremely terrified and believes his teacher is out to get him because he has been ordained by God to redeem his country. As a result of his fears, Kwame has become withdrawn, no longer bathes or changes his clothes, and his school performance has seen a marked decline.

B. Dummy case 2: Depressive episode

Elsie complains that she just can’t get out of her sad mood. She can’t seem to find the energy to do anything these days, and gets tired easily with very little exertion. Her work as a journalist, which used to excite her, has suffered because she can’t concentrate, she has lost

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interest in all aspects of the work, and she feels incompetent at her job. Although she feels tired all the time, she can barely sleep through the night anymore and constantly finds herself waking up after only a few hours of sleep. This has been going on for about a month.

C. Dummy case 3: Posttraumatic stress disorder (PTSD)

Esi was with her sister when they were involved in an accident six months ago on the Kumasi road. Her sister was crushed to death right beside Esi. After this accident, Esi has not been herself; she feels guilty about the loss of her sister because they were travelling to an event that she had arranged. She is unable to concentrate on any tasks, and sometimes she feels like she is not present in her body. Over the past six months, Esi has flashbacks of the accident and sometimes has bad dreams about it. She then becomes agitated and is unable to sleep. Since the accident, Esi has not been able to travel on that road, and sometimes feels afraid when she sees a car which resembles the one that they were in. She startles very easily when she hears a car screeching, and has become quite irritable.

D. Dummy case 4: Intellectual disability (ID)

Effie was slower in reaching her developmental milestones such as sitting, crawling and walking, and learned to speak later than her peers. Her mother reports that at eight years old, Effie is unable to bathe and dress herself, and often requires assistance in eating and using the toilet. Effie also struggles in school with reading and writing, and has been held back twice due to her difficulties at school.

E. Dummy case 5: Epilepsy

Etornam is an 18-year-old boy with a history of convulsions since he was six months of age. Although these were infrequent in his early childhood, they increased to three to four seizures per day when he reached puberty. When describing the onset of an episode, he said that the initial feeling was usually a tightness in his head and chest, followed by sweaty palms and then he would briefly lose consciousness. His family reported that sometimes when Etornam had an episode, he would smack his lips, and was generally unresponsive to those around him. During the seizure, he is unable to talk but he says he can hear, although he cannot fully process information.

Additional questions

Now I would like to ask you about your views on working with other medical providers.

4. What are your views on collaborating with doctors/hospitals in patient care?
    a) How do you think this can be done?

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5. Have you ever worked together with doctors/nurses/hospitals in treating patients? If yes:
   a) What has been your experience working with them?
   b) What kinds of illnesses have you worked on with them?
   c) Do you think their methods are more or less effective? Please explain

If no,

a) Is there any particular reason why you have not?
b) Would you consider working with them in the future?

6. Would you recommend/refer a patient to a doctor/hospital?
   i. If yes, under what circumstances would you refer a patient to a doctor/hospital?
   ii. If no, why not?
7. In your opinion, why do you think collaboration with doctors/hospitals has not been done yet?

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Appendix B: Ethics approvals

Appendix B1 – Stellenbosch University Humanities Research Ethics Committee approval

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Approval Notice

Stipulated documents/requirements

01-Sep-2016

KPOBI, LILY LN

Ethics Reference #: SU-HSD-002388

Title: TRADITIONAL & COMPLEMENTARY MEDICINE PRACTITIONERS IN ACCRA, GHANA: WORLD VIEWS & BELIEFS ABOUT MENTAL DISORDERS

Dear Ms LILY KPOBI,

Your Stipulated documents/requirements received on 22-Aug-2016, was reviewed and **accepted.**

Please note the following information about your approved research proposal:

Proposal Approval Period: 25-Apr-2016 - 24-Apr-2017

Please take note of the general Investigator Responsibilities attached to this letter.

If the research deviates significantly from the undertaking that was made in the original application for research ethics clearance to the REC and/or alters the risk/benefit profile of the study, the researcher must undertake to notify the REC of these changes.

Please remember to use your **proposal number** (**SU-HSD-002388**) on any documents or correspondence with the REC concerning your research proposal.

Please note that the REC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

We wish you the best as you conduct your research.

If you have any questions or need further help, please contact the REC office at 218089183.

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Appendix B2 – Ghana Health Service Ethics Review Committee approval

GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

In case of reply the number and date of this <u>Letter should be quoted.</u>

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Lily Naa Ayorkor Kpobi
Stellenbosch University
South Africa

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol.

GHS-ERC Number	**GHS-ERC 03/07/16**
Project Title	"Traditional and Complementary Medicine Practitioners in Ghana: World Views and Beliefs about Mental Illness"
Approval Date	8th August, 2016
Expiry Date	7th August, 2017
GHS-ERC Decision	**Approved**

This approval requires the following from the Principal Investigator

- Submission of yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months,
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report **after completion** of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.

Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED...
PROFESSOR MOSES AIKINS
(GHS-ERC VICE-CHAIRPERSON)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra

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Appendix C: Permission letters

Appendix C1 – Traditional medicine practice council letter

The Secretariat
Traditional Medicine Practice Council
P. O. Box M44
Accra.
Tel:0302684270/684212/684253/684241/
028-9551047

In case of reply the number
and date of this letter should
be quoted

My Ref: TMPC/GAD/HS/01

10TH MAY, 2016

THE PRESIDENT
GHANA FEDERATION OF
TRADITIONAL AND ALTERNATIVE MEDICINE
ACCRA

RE: PERMISSION TO ACCESS MEMBER REGISTRY

We forward herewith a letter dated 24th and 29th March, 2016 from Ms. Lily Naa Ayorkor Kpobi from the Universiteit Stellenboch University on the above subject matter.

We would be grateful if you could furnish her with the necessary information as requested, if any.

We count on your usual cooperation.

TORGBUI YAKA IV
REGISTRAR

Cc:
- Lily Naa Ayorkor Kpobi
- File.

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Appendix C2 – GHAFTRAM permission

GHANA FEDERATION OF TRADITIONAL MEDICINE PRACTITIONERS ASSOCIATIONS (GHAFTRAM)

P. O. Box AC 402, Arts Centre-Accra, Ghana-West Africa Tel: +233-302- 765291

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Nana Kwadwo Obiri

PRO
Margaret Anderson

Ms Lily Naa Ayorkor Kpobi

20th May, 2016

Dear, Madam

RE: PERMISSION TO MEMBER REGISTRY

The Ghana Federation of Traditional Medicine Practitioners Associations (GHAFTRAM) has studied your letter dated 24th March, 2016 and wish to inform you of our intensions to give you access to some of our members whom you may need their support for your project.

GHAFTRAM, as the mouthpiece of all the Traditional Healer in Ghana is ever ready to support research students of your caliber who intend to promote and develop Traditional / Herbal Medicine across the world.

We are by this letter accepting to cooperate with you anytime you arrive in Ghana for your project. You are to contact the National organizer for details of practitioners that will be of help to you.

Thank you.

Yours faithfully

Nana Kwadwo Obiri (National Organizer)
Telephone: 0277587387
(For President)

Cc: Leslie Swartz, PhD
Clinical Psychologist
Distinguished Professor
Stellenbosch University

File

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Appendix C3 – GPCC permission

THE CHURCH OF PENTECOST

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Fax: +233-302-774721 / 760295
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Trinidad & Tobago
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Ukraine
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Zimbabwe

June 24, 2016

To Whom it May Concern

Dear Sir,

PERMISSION TO ACCESS MEMBER REGISTRY-LILY N. A. KPOBI

Warm Christian Greetings.

The bearer of this letter, Lily N. A. Kpobi is a clinical psychologist registered with the Ghana Psychological Council. She holds a master's degree (*cum laude*) from Stellenbosch University in South Africa.

She is embarking on a PhD designed to highlight aspects of work of religious healers in Ghana. Ms. Kpobi intends to interview various faith healers about how mental illness is recognised and treated from their perspective.

Kindly find attached a letter of introduction from the Stellenbosch University. I will be grateful if you could provide her with the needed assistance to facilitate her research work.

May the Lord be with you.

Yours faithfully,

OPOKU ONYINAH (APS. DR.)
CHAIRMAN

cc: The General Secretary, GPCC, Accra

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Appendix D: Participant information sheet and informed consent form

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STELLENBOSCH UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH

Traditional & complementary medicine practitioners in Ghana: World views & beliefs about mental disorders

Good day! I would like to invite you to participate in a research study conducted by Ms. Lily Kpobi (*BSc. Psychology; MPhil Clinical Psychology; MPhil Public Mental Health*), from the Psychology Department at Stellenbosch University. The results of this research will form part of her doctoral dissertation. You were selected as a possible participant in this study because you are registered with the Ghana Federation of Traditional Medicine Practitioners Association (GHAFTRAM) as a traditional medicine practitioner or with the Ghana Pentecostal and Charismatic Council as a faith healer (NB: *researcher to cross out non-applicable category*).

BACKGROUND
Previous research has shown us that traditional and faith healing is a common source of help for many Ghanaians. But in mental health, we do not know much about the traditional and religious methods used to treat mental illness. This study will therefore explore what methods you use in treating mentally ill patients.

1. PURPOSE OF THE STUDY
The aim of this study is to understand the beliefs and practices of traditional and complementary medicine practitioners with regards to mental illness in Ghana.

2. PROCEDURES
If you volunteer to participate in this study, we would ask you to do the following things:

We will ask you to take part in an interview which will be voice-recorded for later analysis. This is to find out your views about various mental illnesses and how to identify and treat them. We will also ask questions about yourself for demographic purposes. If you agree to take part in this study, the interview will take approximately 45 to 90 minutes.

3. POTENTIAL RISKS AND DISCOMFORTS
We do not anticipate that you will experience any risks or discomfort as a result of participating in this study.

4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY
Although there will be no direct benefits to you if you take part in this study, the information you provide us will help us to better understand traditional medicine practices in Ghana and their role in mental health care.

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5. PAYMENT FOR PARTICIPATION

There will be no monetary remuneration for participants in this study.

6. CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by ensuring that no identifying information is used in the audio recordings or transcripts. All files pertaining to the research will be password-protected on computers with the researcher having sole access. It is your right as a research participant to review or edit the tapes in validation sessions which will be organized by the researcher. The recordings and transcripts will be kept for a period of five years after the conclusion of the research after which they will be destroyed. Information obtained from the interviews will only be shared with relevant academic persons strictly for academic purposes. Such information will still not have any identifying details in them.

The results of the research may be published in academic and scholarly articles or used to facilitate workshops. If this is done, no details or identifying information will be used and your identity will be strictly held anonymous.

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so. If any such circumstances arise, the researcher will inform you of it.

8. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact any of the following:

Principal Investigator: Lily Kpobi

Tel.: +233-24-488-3854 or +27-62-343-9207

Email: 20619006@sun.ac.za

OR

Supervisor: Professor Leslie Swartz

Tel.: +27-21-808-3584

Email: lswartz@sun.ac.za

9. FURTHER INFORMATION

If you would like some more information about this study or would like to know more about your rights as a research participant, please contact the following:

1. Ms. Maléne Fouché

Stellenbosch University

Division for Research Development

Tel.: *+27 21 808 4622*

Email: *mfouche@sun.ac.za*

Stellenbosch University https://scholar.sun.ac.za

2. Ms. Hannah Frimpong

Ghana Health Service

Research & Development Division

Tel.: *+233 30 2960 628*

Email: *hannah.frimpong@ghsmail.org*

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RESEARCH SUBJECT/REPRESENTATIVE CONSENT TO PARTICIPATE

The information above was described to [*me/the subject/the participant]* by ____________ [*name of relevant person]* in **English/Ga/Twi** and [*I am/the subject is/the participant is]* in command of this language or it was satisfactorily translated to [*me/him/her*]. [*I/the participant/the subject]* was given the opportunity to ask questions and these questions were answered to *[my/his/her]* satisfaction.

[I hereby consent voluntarily to participate in this study/I hereby consent that the subject/participant has agreed to participate in this study.] I have been given a copy of this form.

____

Name of Subject/Participant

____

Name of Representative (if applicable)

____ _______________

Signature of Subject/Participant or Representative *Date*

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to ___________________ [*name of the subject/participant]* and/or [*his/her*] representative _____________________ [*name of the representative]. [H*e/she] was encouraged and given ample time to ask me any questions.

____ _______________

Signature of Investigator *Date*

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CONSENT TO RECORD

[I hereby consent voluntarily to have my interview recorded/I hereby consent that the subject/participant has agreed to have their interview recorded.] I have been given a copy of this form.

____

Name of Subject/Participant

____

Name of Representative (if applicable)

______________________________________ ______________

Signature of Subject/Participant or Representative *Date*

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to __________________ [*name of the subject/participant]* and/or [his/her] representative ____________________ [*name of the representative]. [H*e/she] was encouraged and given ample time to ask me any questions.

______________________________________ ______________

Signature of Investigator *Date*

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Appendix E: Co-authors' declarations
Appendix E1 – Co-author's declaration (Chapter 4 & Chapters 6-11)
Declaration by the candidate

With regard to Chapter Four (article 1) and Chapters Six to Eleven (articles 3–8) of this dissertation, the nature and scope of my contribution were as follows:

Nature of my contribution	Extent of my contribution (%)
• I conceptualized the study together with my supervisor. • I conducted the interviews and analysed the data under the guidance of my supervisor. • I wrote the articles with expert input, correction and contribution from my supervisor	60%

The following co-authors have contributed to Chapter Four & Chapters Six to Eleven:

Name	Email address	Nature of contribution	Extent of contribution (%)
Professor Leslie Swartz	lswartz@sun.ac.za	Supervised the conceptualization of the study; the collection and analyses of data; and writing of the articles	40%

Signature of candidate: Declaration with signature in possession of candidate and supervisor

Date: 19 July 2018

Declaration by co-authors
The undersigned hereby confirm that

1. The declaration above accurately reflects the nature and extent of the contributions of the candidate and the co-authors to Chapter Four & Chapters Six to Eleven
2. No other authors contributed to Chapter Four & Chapters Six to Eleven besides those specified above, and
3. Potential conflicts of interest have been revealed to all interested parties and that the necessary arrangements have been made to use the material in Chapter Four & Chapters Six to Eleven of this dissertation

Co-author signature	Institutional affiliation	Date
Declaration with signature in possession of candidate and supervisor	Stellenbosch University	19 July 2018

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Appendix E2 – Co-author's declaration for Chapter 5 (Article 2)

Declaration by the candidate

With regard to Chapter Five (article 2) of this dissertation, the nature and scope of my contribution were as follows:

Title: Ghanaian traditional and faith healers' explanatory models of epilepsy	
Journal: ***Epilepsy & Behavior*** **(2018; online first version)**	
Nature of my contribution	**Extent of my contribution (%)**
• I conceptualized the study together with my supervisor. • I conducted the interviews and analysed the data under the guidance of my supervisor. • I wrote the article with expert input from my supervisor and the underlisted co-author	60%

The following co-authors have contributed to Chapter Five (article 2):

Name	**Email address**	**Nature of contribution**	**Extent of contribution (%)**
Prof Leslie Swartz	lswartz@sun.ac.za	Supervised the conceptualization of the study, collection and analysis of data, and contributed to the writing of the article	20%
Dr Mpoe Johannah Keikelame	Johannah.keikelame@gmail.com	Provided expert advice with respect to content, structure and relevant literature; corrected and contributed to the writing of the article	20%

Signature of candidate: Declaration with signature in possession of candidate and supervisor
Date: 5 July 2018

Declaration by co-authors

The undersigned hereby confirm that

4. The declaration above accurately reflects the nature and extent of the contributions of the candidate and the co-authors to Chapter Five (article 2)
5. No other authors contributed to Chapter Five (article 2) besides those specified above, and
6. Potential conflicts of interest have been revealed to all interested parties and that the necessary arrangements have been made to use the material in Chapter Five (article 2) of this dissertation

Author name	**Author signature**	**Institutional affiliation**	**Date**
Prof Swartz	Declaration with signature in possession of candidate and supervisor	Stellenbosch University	5 July 2018
Dr Keikelame	Declaration with signature in possession of candidate and supervisor	Stellenbosch University	5 July 2018

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Appendix F2 – Permission from Taylor & Francis Ltd. (for Article 1)

Title: Explanatory models of mental disorders among traditional and faith healers in Ghana

Author: Lily Kpobi, Leslie Swartz

Publication: International Journal of Culture and Mental Health

Publisher: Taylor & Francis

Date: May 8, 2018

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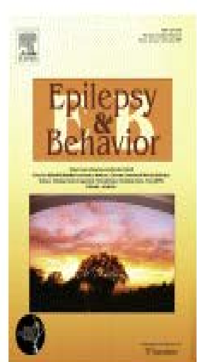

Title: Ghanaian traditional and faith healers' explanatory models for epilepsy

Author: Lily Kpobi,Leslie Swartz,Mpoe Johannah Keikelame

Publication: Epilepsy & Behavior

Publisher: Elsevier

Date: July 2018

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Licensed Content Date	Jul 11, 2018
Licensed Content Pages	1
Type of use	Dissertation/Thesis
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Format	Electronic
Portion	Full article
Will you be translating?	No
Title of your thesis / dissertation	Indigenous & faith healing for mental disorders: An exploratory study of healers in Accra, Ghana
Expected completion date	Dec 2018
Expected size (number of pages)	1

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Licensed Content Title	Muslim Traditional Healers in Accra, Ghana: Beliefs About and Treatment of Mental Disorders
Licensed Content Author	Lily N. A. Kpobi, Leslie Swartz
Licensed Content Date	Jan 1, 2018
Type of Use	Thesis/Dissertation
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Portion	full article/chapter
Will you be translating?	no
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Author of this Springer Nature content	yes
Title	Indigenous & faith healing for mental disorders: An exploratory study of healers in Accra, Ghana