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Healing and Mental Illness in Ghana: Why Prayer Camps in Ghana are Sometimes Alternatives to Psychiatric Hospitals

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Abstract

Prayer camps serve as an environment for healing rituals and continue to play an important role in the lives of many Ghanaians spiritually, economically, and socially. In this article, I present the reasons for prayer camps' continuing reliance as institutions of healthcare for individuals suffering from mental illnesses in Ghana. The article argues that prayer camps will continue to exert public influence and play a dominant role in the treatment of mental health sicknesses due to underlying religio-cultural beliefs and notions associated with illness, especially from the traditional Ghanaian Akan perspective and the inadequate resources at the disposal of state-owned psychiatric hospitals.

Keywords: *prayer camps, healing, mental health, hospitals, psychiatry*

In this article I present the underlying worldviews associated with mental illness in Ghana and attempt to examine why prayer camps continue to serve as an alternative to psychiatric hospitals in mental healthcare. In doing so, I offer both a theoretical and empirical perspective on health and healing by contextualizing their conception from the traditional Akan¹ perspective. I delineate how the practice and understanding of health and healing found at prayer camps is cast in the framework of traditional interpretation, and I present plausible factors that have accounted for both the religious and public significance of prayer camps in mental healthcare in Ghana. Ghana has been shown to be one of the most religious countries in sub-Saharan Africa: 71.3 per cent self-identify with Christianity, 19.9 per cent with Is-

¹ The Akan constitute more than half of Ghana's population and are arguably the largest ethnic group in Ghana, comprising the Ashantis, Fantes, Nzema, Ahanta, Akuapem, Sefwi, Bono, etc. (Buah 1998).

lam, and 3.2 per cent with traditional and/or indigenous religion, making a total of 94.4 per cent (Ghana Statistical Service 2021; Inglehart et al. 2014).

Prayer camps are prayer centres established for prayer, healing, deliverance, Bible studies, and counselling (Larbi 2001). Except for a few that were established or founded by churches, prayer camps are mostly private Christian religious organizations that are usually managed by individuals with prophetic abilities or gifts.² In terms of worship style and praxis, prayer camps are charismatic and Pentecostal in nature. Prayer camps thus form ‘part of the greater complex of Pentecostal deliverance ministries’ (Heuser 2015, 280). The operation of prayer camps in Ghana started in the 1940s and became more prominent in the 1980s (Quayesi-Amakye 2011; Onyinah 2012). The leaders of these camps promote beliefs in miracles, consultation with angels, and spiritual healing. Pneumatic ingredients like prophecies, visions, dreams, speaking in tongues, and so on are also very much evident in their practice of worship.

Prayer camps play a major role in providing a ritual context for individuals with diverse problems and ailments seeking a spiritual antidote to or remediation of their problems (Larbi 2001; Onyinah 2012; Arias et al. 2016). With limited state resources in psychiatry and mental healthcare³ and a lack of support and commitment on the part of successive governments to make mental health a priority of the general healthcare system, for more than fifty years prayer camps have served as ‘healing homes’ or surrogates for mental health hospitals. Despite the attempt to plug the gap resulting from the paucity of specialists and government defunding of the sector, prayer camps have also received overwhelming criticism for some of their practices and methods or approach to healing (Selby 2011). Previous studies have reported practices such as chaining, forced fasting,

2 The description of prayer camps as private Christian religious organizations refers to their independence from centralized religious bodies or churches. However, there are camps that operate under well-established churches such as the Church of Pentecost, which operates more than thirty prayer camps across different regions in Ghana. Even with those under the oversight of churches, the leaders of the camps are allowed to operate without regular interference from the church. In essence, prayer camps are not churches but healing centres which draw their adherents from various denominations or churches during healing or prayer sessions (see Onyinah 2012).

3 Currently, the country can boast of only three mental health institutions: the Accra Psychiatric Hospital, Pantang Hospital, and the Ankaful Psychiatric Hospital – all in the south of the country, leaving the middle belt and the Northern Region with no facilities. As of 2017 there were only eleven practising psychiatrists in the public sector, 1,500 mental health nurses, three clinical psychologists, fourteen medical assistants, and 250 community health officers across the country.

and the deplorable conditions in which patients are kept (Edwards 2014; Carey 2015; Onyinah 2012; Arias et al. 2016). There is widespread public knowledge of forms of abuse that occur at some prayer camps in Ghana. The global media has also exposed some of the perceived violations of patients' human rights at some prayer camps in Ghana and elsewhere (BBC 2018; Carey 2015). Some literature and media reports have argued that the government and state authorities should close the camps because they support neither the healing nor wellbeing of mental health patients, claiming the practices of some camps result in various forms of victimization and the devaluing of patients that produce self-regressive narratives that erase any eventual promise of restoration (Edwards 2014; Human Rights Watch 2012; Selby 2011). Despite these criticisms and negative views, camps continue to wield much public influence and garner goodwill among citizens (Ae-Ngibise et al. 2010).

The central question this article seeks to answer is: why do research participants perceive healing rituals at prayer camps as valid and adequate alternatives to medical treatment at psychiatric or mental health hospitals? To answer this question, I address two subsidiary questions: first, what is the general understanding of health and healing among Ghanaians? Second, how do participants' understandings of disease causation and the processes of social stigmatization influence their views of prayer camps as healing places for the mentally sick?

Recent studies of prayer camps in Ghana describe the sustained belief in evil supernatural forces as the cause of most mental illnesses (Arias et al. 2016). Despite the response provided by some transcultural psychiatrists and anthropologists concerning the need to recognize traditional notions and beliefs of illness in the categorization and treatment of mental illness (Read 2017), there remains a hierarchy of knowledge in Ghana (and in a global context) in which 'natural' or biomedical knowledge is deemed superior to 'supernatural' thinking in the theory of disease causation. Although culture and religion have been highlighted as important factors in psychiatry and mental healthcare (Koenig 2018; Kleinman 1980; Kirmayer and Swartz 2013), much of the previous literature on the subject in Ghana and elsewhere has paid insufficient attention to these factors. This study extends the current debate on the relationship between cultural and religious beliefs of mental illnesses and the discourses on the theory of disease causation in the non-Western context. It seeks to provide a response to the challenges of operation of and competing views on prayer camps as healing centres for those with mental illnesses.

Next I discuss methodology, then the concept of health and healing, and tease out how these two are relevant theoretically to this article's discussion. I argue that the practice and understanding of health and healing at prayer camps resonates with the worldview of the people because it is cast in the framework of traditional interpretation. Second, I explore how the causal narratives surrounding mental illness influence help-seeking behaviours or the kind of therapeutic approaches employed. I argue that the significance attached to the health and wellbeing of the individual in the healing process at the camps makes the healing rituals more influential. Third, I examine why prayer camps continue to serve as alternatives to state interventions in dealing with the problem of mental illness. The fourth section presents the conclusion.

Material and methods

The study employed Interpretative Phenomenological Analysis (IPA), which aims to explore in detail how participants make sense of their personal and social worlds. At the core of this approach 'is the meanings that particular experiences, events and states hold for participants' (Smith and Osborn 2015, 25). In this vein IPA was used both as a method for data collection and analysis (Smith and Osborn 2015). As IPA aims to explore the lived experience of research participants, the interview questions and discussions focused on extracting information about their experience of living at the camp and what they made of it. Throughout the study the participants were allowed to share how the experiences of engaging in these activities had affected their general wellbeing. They shared their lived experiences at the prayer camps of prayer, fasting, and healing as a means of dealing with mental illness. Issues discussed during the interviews included their views of fasting, the importance or meaning they ascribed to their stay at the camp, and so on. This approach was necessary to reveal participants' own shared experiences against the etic construction of the camps to avoid unsubstantiated claims.

My background as a Ghanaian with a training in religious studies and an understanding of the cultural milieu I addressed in this study gave me the necessary skills both conceptually and theoretically in examining the issues it discusses. In other words, the camps I studied were from a familiar environment, and this helped provide an informed critique, analysis, and personal reflections from both emic and etic perspectives.

The data for this article were gathered during two separate fieldwork periods conducted at four selected prayer camps in the Eastern and Central Regions of Ghana. The first set was conducted between October 2019 and January 2020. The second spanned the period between February 2021 and April 2021. The camps selected were chosen because of their long history and the significant role they have played in the treatment and care of those with mental illnesses with sanatoriums for the mentally ill, for example. The selected camps are very prominent among other camps in Ghana and have attracted public attention both locally and internationally.

Semi-structured interviews were conducted with 21 individuals at the selected camps, including pastors, caregivers, and patients. The selection of interviewees was based on the participants' experience of the studied issues. I also relied on the staff of prayer camps, here referred to as caregivers, to select patients for the interviews. I am aware that my inability to personally select respondents for interviews has several implications for this study's analysis and findings. However, this was expected and mitigated with IPA, which provided the opportunity to critically examine participants' responses through engagement and interpretation. For example, in engaging with the participants' shared experiences, attention was paid to the consistency of the claims they made. The sharing of lived experiences opens participants' world to the researcher about some things of which they are themselves unaware (Smith and Osborn 2015) or would otherwise hide from the researcher during the interview. This helped the researcher reflect on and critically analyse participants' claims. The approach was useful in removing biases while presenting an opportunity of not uncritically assenting to participants' claims. All the interviews took place at the camps, which gave me the opportunity to fully enmesh myself in the participants' environment. For example, I participated in healing ceremonies and had the privilege of observing the camps' everyday life. This also became important in my analysis, allowing a richer analysis.

The patient participants had a history of mental illness but had experienced some wellness and were still living at the camp. They included four male pastors and six caregivers, five of whom were males, and one female. Eleven patients were interviewed. They included seven males and four females, with ages ranging from 26 to 65. The pastors had practised for between fifteen and thirty-five years. The caregivers I interviewed had no formal training in psychology or psychiatry but had had between twelve and twenty years' experience of caring for the mentally ill at the camps. I conducted the interviews in both English and Twi. The choice of language

depended on the interviewee's fluency. As a native speaker, I translated the interviews conducted in Twi to English. In some cases some of the translations were checked by language experts to ensure accuracy.

I began my study with a visit to the camps. During my visit the study's objectives were first explained to the camp staff, and permission was granted to conduct interviews. As most of the participants were from vulnerable groups, several measures were undertaken to ensure that the principle of 'doing no harm' was achieved. This included anonymizing all the study's participants, as well as excluding any sensitive information that would be prejudicial to the participants. All the interviews took place at the prayer camps with the permission, supervision, and assistance of prayer camp staff. The participants gave their informed consent orally. Voluntary participation and withdrawal from the study at any time were assured. The participants were also made aware of their right to refuse to answer any question during the interview and assured of their confidentiality. All interviews were audio-recorded with permission. Each interview lasted approximately forty-five minutes. Participants were asked about the story of their experience of illness, their personal experience at the camp, and how the camp may have helped in the management of their illness. Ethical clearance for all aspects of this research was also granted through Åbo Akademi University in Finland.

The author transcribed all the audiorecorded interviews. For the analysis Microsoft Word was used in coding the transcribed interviews following IPA. This was done by closely studying one interview transcript and then examining the others one by one (Smith and Osborn 2015), following an idiographic approach to analysis. This approach does not mean eschewing generalization but painstakingly working on individual cases and very cautiously moving to more general claims (Smith and Osborn 2015). This method helped in classifying and presenting themes (patterns). For example, attention was paid to the aspect of the data in which participants reported the beliefs and causes of mental illness, and how prayer, fasting, and their stay at the prayer camp had aided their recovery from the illness. Other aspects of the coding captured their preferred treatment approach to mental illness.

Contextualizing health and healing

The concepts of health and healing are culturally nuanced and complex but are rendered intelligible if interpreted within a given social and cultural context. Healing is always contextual and often takes place at many different layers: spiritually, emotionally, socially, and physically (Ryle 2011). An understanding

of the concept of health, and what might count as healing in a given cultural context, may be inexplicable in another context. I attempt to do this in this section.

In Akan perception people are connected to one another through blood, which forms the *abusua* (the clan or family). An individual is thus not an isolated being but is bound to the family through blood. In other words, an individual remains the property of the clan (*abusua*), and the *abusua* is supposed or expected to take good care of its members. If something unexpected or a misfortune (such as illness, poverty, barrenness) happens, '*abusua na woko abisa*, that is, the family takes the responsibility [of consultation (*abisa*)] to find out the causes, with the aim of restoring the *odehye* (prince/princess) to the family' (Onyinah 2012, 27). The issue of this consultation (*abisa*) will be discussed in detail later, as it has many implications for the wellbeing of an individual.

Health and wellbeing are expressed to connote a person's holistic wellbeing – body, soul and spirit. A disharmony among these three components that form the human person is considered a diseased condition. This hinges on the belief that an individual is primarily a spirit being, and a spirit working on a spirit can cause damage (Atiemo 1998). Among the Akan, if a person becomes vulnerable to evil spirits for some reason, it is believed that this can cause sickness and misfortune for the individual. The notion of health and wellness is interpreted as a state of cosmological balance in the individual's physical, mental/emotional, and social life (Onyinah 2002). Health, which is conceived as total wellbeing (wholeness), is concomitant to all that is valued in life, including mental, physical, social, spiritual, and cosmic harmony.

For example, among the Akan, when an individual is confronted with a serious trauma or sickness, it is said that *ne kra adwane* ('their soul has fled'), or if a person is sick for a long time, it is said that *ne sumsum nyinaa afiri ne mu*, or 'their spirit has left them'. In other words, the essential component of the person is separated, and the separation causes sickness and therefore death. If we speak of healing, we are talking about wholeness – when the person is properly integrated into their body, soul, and spirit. This explains why the ritual aspects become crucial in the healing process. The rituals constitute part of the process of restoring and reconciling broken relationships. Thus, 'during healing rituals, issues may be raised that are relevant to others who attend the ritual, and some of the effect of the intervention may be through its ability to change the afflicted person's relationship with family and community' (Kirmayer and Swartz 2013, 48). Kirmayer and Swartz (2013) further argue that 'healing then works not only to relieve symptoms and resolve

illness but also restore proper relations with ancestors and within the community'. The importance of the rituals for restoring broken relationships lies in the fact that a distressed relationship with one's relatives or neighbours could also result in sickness. A healthy person is thus properly integrated within their personhood and is also in appropriate social relations.

The central goal of life for the Akan is health, success, and prosperity (Onyinah 2012). When such goals of life become elusive, the Akan resort to their religiosity, usually by consulting a religious functionary to divine and provide answers to the problems, questions, and complexities of everyday life. It is from this purview that an *abisa* (consultation) becomes prominent. An *abisa* is thus a 'divinatory consultation or the desire to know the supernatural causalities of affairs' (Onyinah 2012, 85). An *abisa*, as Onyinah (2012) notes, is the focus of religious activities among the Akan and is very prominent in the work of the *akomfo*, the principal figure in *abosomsom* (the worship of the gods). An *abisa* is also one type of indigenous or traditional *akom* (possession) use of therapy to extract information from a patient. The need for an *abisa* is therefore to discover the supernatural agents associated with an illness and through rituals to ward off any evil spirit responsible for the sickness. In *Search for Security* (1960) Margaret Field documents extensive examples of people from rural Ghana going to healing shrines for an *abisa* to find the root cause of various mental disorders. She reports the following as examples of complaints and requests made at a routine *abisa*: an unspecified sickness; drunkards requesting rescue; depression; mental illness resulting from physical illness; involuntional psychoses, schizophrenia, and so on.

At prayer camps in Ghana supplicants also aimed to seek a solution to their mental illnesses by consulting prophets to diagnose the cause of their illness and then perform the appropriate rituals aimed to remedy the situation.

Prayer camps and healing of mental illness

It is known that how people view illnesses, what they believe about them, and how they explain what has caused them directly influence the kind of options they choose in seeking redress or a solution (Lynch and Medin 2006). They may not trust the potency or efficacy of treatment options that do not accord with their beliefs and consequently perceive such treatments as less satisfactory (Kucharski and Piot 2014; Koenig et al. 2012; Taylor 2003; Godin and Kok 1996).

In the following quotations some participants expressed the belief that their mental illness was supernaturally instigated, and they had therefore found the prayer camps as an alternative to remedy the situation:

My sickness was spiritual. If they had taken me to the asylum [mental hospital], I don't believe I would have recovered. I was for ever going to be in a state of lunacy because when they brought me here, no one gave me an injection or medicine. It was only prayer ... that made me receive my healing. My hair and beard had developed dreadlocks ... when I first came here – they took pictures of me. So when I recovered, I realized that although the asylum was good, it wouldn't help other people because if it was a spiritual attack like mine, there was no way the asylum could deal with it because you don't need those injections they give there. What you need is prayer! (Patient 1, 41 years).

In the above quotation the patient's claim that sickness is spiritual is associated with malevolent and/or evil spiritual forces such as witchcraft and juju. Although the direct cause may be unknown, it is believed that such forces are behind the sickness.

A patient also shared his view of the importance of the prayer camp to his wellbeing:

So I can really say that this is a very good place. If I had found this place earlier, I wouldn't be sitting here now. If I'd found this place ten (10) years ago, I believe God would have made me greater than I am today ... At first, they tied me up and brought me here. But now I take the bus myself and come here without any hesitation or compulsion. Even when the caregivers ask me to go home, I don't want to go because I don't feel I belong at home (Patient 5: 42 years).

Another patient also remarked:

My daughter and sister brought me here. Since I came here, the voices I used to hear have suddenly ceased. I've been here for three months. They said they would discharge me after Easter, but I have told them I want to stay a bit longer. The camp has really helped my situation a lot, especially through prayer (Patient 6: 52 years).

The two quotations from Patients 5 and 6 indicate the role prayer plays in their lives when they are staying at a prayer camp. They reveal the im-

portance of prayer and the communal relationship at the camp as factors contributing to their recovery. During the interviews the patients reflected on how prayer had helped them stop hearing voices at night and recover from an illness after ten years. This period included visits to psychiatric hospitals and other sources of healing.

One of the caregivers expressed the importance of the prayer camps in helping people deal with their problems:

Indeed, the prayer camps help a lot ... When you come to the prayer camp, we have our prophet there. The first welcome is to go and see him. He will pray for you and give you some directions (*akwankyere*). After three days he will ask you to bring the person back and through that the healing takes place. Sometimes he will also say God has done his part so take the person to the hospital for medical attention. When that is done, everything is balanced (Caregiver 3).

In this quotation, the caregiver specifically expresses the view that while prayer is good in addressing the problem of mental illness, they also combine it with or resort to biomedicine when necessary. Going to the hospital in the quotation above means using therapeutic interventions other than those found at the prayer camp. This becomes important especially when the sickness persists after periods of fasting, prayer, and directions from the prophet.

The quotations also reinforce the notion of spiritual causation and the theory of illness as embedded in local ontologies, and that hospitals do not know the art of divination and how to cure certain diseases. The combination of prayer with medicine, as argued by Caregiver 3, is similar to what Auli Vähäkangas (2012) and Carl Sundberg (2020) describe in their articles on healing in Tanzania and Congo. Such treatment is intended to offer the patient a holistic healing which hospitals are perceived as lacking the capacity to provide. In some parts of Africa 'traditional medicine' has been appropriated into the general healthcare system and reformulated as a new system of scientific knowledge to augment the development of biomedicine and healthcare, as well as to support the progress of modern scientific expertise (Meincke 2015).

As is reflected in the quotations, the healing process used at these prayer camps may include long periods of fasting, confession, and other spiritual activities that aim to hasten the individual's recovery and wellbeing. Faith healing, as typified in Pentecostalism and evidenced at the prayer camps,

has been categorized as more holistic and all-encompassing. The view is that the biomedical scientist-physician is a curer rather than a healer. The biomedical model or approach to medical care is seen as one that distances itself from the holistic psychological, emotional, and spiritual disturbances associated with disease (McGuire 2008). The title of a book by the Ghanaian author, Appiah-Kubi (1981) – *Man Cures – God Heals* – captures this succinctly.

Perceived causes of mental illness and the choice of therapeutic interventions

Although the biological or natural causes of mental illness are not entirely disregarded, the attribution of illness to supernatural causes remains pervasive in Ghana (Yendork et al. 2019; Kpobi and Swartz 2018a; Opare-Henaku 2013).⁴ It is very often perceived that mental illness is caused by supernatural forces and malevolent agents and therefore needs supernatural intervention. A view shared by a pastor during an interview at one of the prayer camps I visited corroborates this:

As black Africans – maybe others don't believe it but even when things become difficult for them to bear – they instead end up turning to God for help. For us, when you come here to do something, you have to believe that there is black power, there is African magic, witchcraft is there. You know those things? We the black people, there are curses too, envy is also there at the workplace – I will cause harm to you because I was there before you came. Why should you come for my position? We Africans, sometimes the home you come from too, no one does government work or is educated. If you try to go to school, they can make you go mad. If you try to get work in the public sector or get married, they can make you go mad. If you try to buy a car, designer shoes, and dresses, they'll make you go mad! These are there! For me, what I've seen with my eyes, no one can convince me that madness cannot be influenced or caused by evil forces. And if it is evil spirits that cause people to be mad, we also have to use the Spirit of God to drive the madness away (Prayer Camp Pastor 2).

4 The belief that mental illness can be influenced by supernatural evil forces is also common in the Western context as shown in multiple studies conducted in countries like the United Kingdom, New Zealand, and Australia among others (cf. Mehta and Thornicroft 2013). Thielman (1998, 3) asserts that 'historically, Western medical writers have held a variety of views on the relationship between religion, spirituality, and madness'.

This view is also shared by individuals who had had a history of mental illness. A patient I interviewed at one of the prayer camps said:

I used to hear voices in my ears. When I hear the voice then I feel like I should leave the house to go and sleep somewhere. The voice can be constant. I also see things that are very scary. The voice forcefully asks me to go, and I will take my things and go out. I usually hear the voice at night. So sometimes I go and sleep at the lorry station ... I went to the Pantang Hospital, but the doctor only said I had depression. To me I believe this wasn't only physical but spiritual (Patient 6: 52 years).

The above quotations from the respondents point to the sustained belief that witchcraft, curses, the breaking of taboos, a spirit, or demonic possession can all cause someone to become mentally ill.

My respondents' responses show a continuous trajectory from Ghanaians' approach to seeking healing for mental illnesses as described by Field (1960). The difference is the healing space or context from which the healing is sought and the religious functionaries involved. The prayer camps differ from the indigenous healing cults or shrines Field (1960) describes, though they share some affinities and cultural resonances in terms of the understanding and interpretation of mental illness as having a potential supernatural origin or being spiritually instigated. The prayer camps replaced the old healing shrines and provided an escape for their visitors from the severe sanctions, criticisms, and stigma that accompanied visits to the shrines by new converts or 'born-again' Christians. The healing shrines were discredited and demonized by the joint forces of Christian preaching dominated by a pronounced Pentecostal/charismatic culture (see Atiemo 2006; Kalu 2008).

At prayer camps *akwankyere* (direction) is often used in reference to the same act of *abisa*. These two terminologies or concepts may thus differ in theory but not in practice. *Akwankyere* at prayer camps involves elements of consultation. It is through the consultation that the prophet diagnoses the problem or cause of an illness and prescribes appropriate solutions or directions (*akwankyere*) to remediate the situation. According to previous research the Akan turn to the warding off of evil spirits as a last resort and not as a first response. People resort to warding off evil spirits after all initial attempts to find a cure (including biomedicine) or solution to sickness prove futile, and through *abisa* they find that the problem has a supernatural origin (Onyinah 2012; Busua 1962). My research participants also regularly

reported having first tried other solutions before visiting the prayer camps. Caregivers mentioned that for some of their clients the prayer camp was their 'last stop' after consulting several other healing sources, including going to a psychiatric hospital.

At prayer camps supplicants or individuals with problems consult the prophet, who is believed to be endowed with the supernatural ability to diagnose and prescribe solutions to their problems. Although this form of psychological methodology resembles traditional forms of *akom*, there are notable differences. In the traditional method it is the *akomfo* (the priests) that are possessed and thereby give a prognostication and give directions for the cure of the sickness. In the context of the prayer camps it is the clients or the patients who become possessed and report the cause of the disease. Yet the role of the prophet in this process must not be downplayed. As Onyinah (2012) points out, the presence of the prophet and 'his diagnostic ability that make *abisa* (divination) possible' are crucial. Some prophets can also diagnose the problem through their prophetic gifts as people with the ability to see beyond the physical realm (Asamoah-Gyadu 2015).

As previously mentioned, the approach to sickness and healing employed at prayer camps and in other Pentecostal streams of Christianity or churches corresponds to familiar cultural and religious worldviews, values, and perceptions. The prophets have become the Christian equivalents of traditional priests and diviners, and despite their resort to a Christian ethos or Christian beliefs, very much reflect 'ways in which religious mediations occur within primal societies in Africa' (Asamoah-Gyadu 2015, 86). Onyinah (2012, 203) surmises that 'prayer camps have replaced the services that the shrines formerly provided for the people'. Read (2016) has also noted the similarity of Field's (1960) healing shrines to the more recent growth of Pentecostal prayer camps, with the old minor gods now equated with the 'demons' of Christianity, and with a new power of healing through prayer restricted to the God of the Christians (cf. Meyer 1999). Prayer camps are thus a reinvention of the shrines and healing cults that emerged in the twentieth century in Ghana. People visit the camps to discover the supernatural causes of their problems and afflictions, find out their future, and seek protection.

In the context of mental health *akwankyere* works as a kind of divination in which the prophet employs diagnostic tools to determine the cause of the illness and ward off the supposed antagonistic evil spirits or demons associated with it through prayer and fasting. Healing and ritual praxis at the prayer camps are suffused with features that delineate an affinity with traditional Akan worldviews. In other words, discourses on health and

healing suggest both continuity and rupture with African indigenous cosmologies. Indeed, healing has become important in Ghanaian Christianity because it was important in the traditional culture. Ogbu Kalu has argued that the 'Pentecostal theology of health and healing recognizes that coping practices are mediated by the surrounding culture, worldview, symbolic systems, and healing myths' (Kalu 2008, 264). Kirmayer and Swartz (2013, 48) have argued that 'ritual healing is part of larger religious and sociomoral systems that cannot be simply replaced with psychiatric practices, because, even if symptoms are treated successfully, the existential meanings of the illness and the patient's social predicament are not addressed'. Social predicaments may include the traditional or societal view of illnesses as demonically influenced, with which hospitals cannot deal but are believed to be tackled through deliverance rituals in the camp.

In the next section I provide a further explanation of why prayer camps continue to remain attractive or serve as alternatives to psychiatric hospitals in Ghana.

Why prayer camps are alternatives to psychiatric hospitals

In the following discussion I examine some of the reasons prayer camps have continued to remain an alternative to the state-owned mental hospitals in the attempt to deal with the problem of mental illnesses in Ghana.

First, previous research (Opare-Henaku 2013; Kyei et al. 2014; Kpobi and Swartz 2018b) and responses from my informants – for example, Patients 1, 5, and 6 and Prayer Camp Pastor 2 – provide an answer to the question of why people turn to prayer camps: the healing they provide resonates with their underlying religio-cultural beliefs. Mental illness in Ghana is often attributed to external and supernatural evil forces such as witchcraft. Patients and their families therefore often view hospitals as lacking the ability to offer the necessary diagnostic or divinatory tools to establish the causes, consequences, and remedy of afflictions. However, prayer camps are believed to provide a ritual context in which individuals suffering from mental health disorders undergo a period of fasting and prayer and with the help of the prophet ward off any antagonistic spirit associated with the illness. The prophet or leader of the camp, who is believed to be endowed with the Holy Spirit, can communicate with the spiritual world and offer solutions to remedy the situation. The prophet can thus divine the 'why' of the supplicant's complaints. He can also understand his clients' needs from cultural, religious, social, and psychological perspectives, a

need which is completely absent in hospitals or biomedical care (see also Appiah-Kubi 1981).

There are also general prayers that serve as interventionist strategies to seek healing from the power of the Holy Spirit for other forms of illnesses that are not associated with any supernatural entities. Thus, not all illnesses are attributed to the devil, but even in situations where they are not, the participants still see the need to rely on God's grace and providence for 'total' healing. In such situations prayers are said over prescribed medications before they are taken or administered (Krause 2012). As one prayer camp pastor reflected, 'even the medicines, if you don't pray over them, won't work. Even some of the doctors who really know God very well – when they examine the situation, and he thinks there is more to it than being physical – will say send him or her to the prayer camp' (Prayer Camp Pastor 2).

Second is the view that hospitals cannot provide a solution to problems of a spiritual origin. For Patient 1, for example, although 'the asylum [mental hospital] is good, it doesn't help ... because if it is a spiritual attack ... there is no way the asylum can deal with it because you don't need those injections they give there'. For this respondent prayer was the only antidote to his sickness, which he claimed was spiritual. Another caregiver (Caregiver 4) argued that

'if the sickness has a spiritual origin, no medication can deal with it. If evil spiritual entities can cause illness in people, then we also need the power of God and the Holy Spirit to drive that demon out so that the person can have his or her healing. Because you can't use medicine. No, that won't help!'

Healing is also framed in a theological narrative about the essence and existence of the human person. For example, a caregiver asked:

Why is it that when someone purchases a vehicle, and it gets spoilt, they send it to the mechanic and not a different place? You see. So as a human being, when you are sick, it is God that created us, so you send it to the creator who is the source of life. We believe in the medicine all right, but even those who practise medicine, it is God that gave them the knowledge and wisdom. If God doesn't give you that, you can't [have it] (Caregiver 3).

The views shared by the respondents corroborate Brown's (2011, 8) argument that most Pentecostals do not reject modern medicine, but 'they do insist that God is able to heal even when medicine is unable to help'. Simi-

larly, Yong (2011, 6) notes that 'Pentecostals have always negotiated the tension between a robust belief in faith healing that repudiated medical technology entirely and the belief that faith healing and the use of medicine were indeed compatible'.

Third, prayer camps have remained an alternative because of the stigma attached to seeking treatment at a psychiatric hospital, and because people feel that the care provided in medical hospitals is not holistic. Some respondents argued that when people or even family members see them visiting the psychiatric hospital, they always assume they have a mental problem, and they hurriedly categorize them as 'mad people', or people who are 'insane'. In Ghana the stigma attached to seeking treatment at a psychiatric hospital not only concerns patients but also professionals who work in such institutions or the field of medicine (Buertey et al. 2020). Such labelling sometimes prevents patients seeking hospital treatment. However, those who still seek hospital treatment also find the care they receive to be non-holistic or incomplete. Indeed, some of the patients I encountered at the prayer camps claimed to have visited the hospital before going to the camp. When asked why, they shared the view that it was God who had given them the total healing they were seeking because He was the source of life and the master healer.

A personal conversation with pastors, caregivers, and patients suggests that a healing ritual at a prayer camp is believed to have the ability to offer holistic cleansing and foster personal transformation through invocations of God through Jesus Christ and the power of the Holy Spirit. The healing at the camp is thus seen as all-encompassing and more transformative than Western medicine. The prayer camps serve as a community and a support system that aids in patients' healing. There is a relationship between the patients and the community that affects their healing and social positioning. This finding supports the argument of the sociologist Meredith McGuire (1985, 272) that 'because western medicine is focused on the curing of "disease" rather than on the healing of illness, the provision of meaning is privatized and undermined'. In contrast with religious forms of healing, she argues that 'religious rituals and symbols may impart a similar sense of empowerment to those who believe in them. This symbolic empowerment may indeed have concrete physical and psychological effects', thereby raising the sick person's hope and reducing their social predicaments (McGuire 1985, 274).

Fourth, unlike hospital treatment, the healing practices at prayer camps offer protection to patients and enhance their reintegration into society. As already observed, seeking treatment at a psychiatric hospital contributes to patients' stigmatization and reduces their self-confidence. However, a

prayer camp is seen as a place of prayer, a community of faith where believers, Christians and non-Christians,⁵ gather to seek the face of God for the redemption of their problems. The camps help diminish a pattern of behaviour or an illusion the patients may have had in the aftermath of their hospital treatment. At the prayer camp the relationship that is developed between the patients and the community removes any fear that lurks in the personality traits of the patients regarding their social positioning after hospital treatment. The healing rituals reassure or symbolize to the wider community that a person is no longer dangerous because the associated evil powers that were influencing the illness have been destroyed. As others have observed, 'healing practices are embedded in local meaning systems that give them part of their social value and potential efficacy' (Kirmayer and Swartz 2013, 48). Through exorcism, healing, and deliverance rituals the individual is believed to be redeemed and purified. This increases their confidence, builds social capital, and enhances their reintegration and social positioning. Grimes's (2000) statement 'Cured, you are fixed; healed, you are reconnected' captures this point appropriately. This is supported by the view that 'Christian healing can be distinguished from other forms of religious healing in its appeal to Christ as the transcendent source of healing and prime symbol of personal and social integration', and that 'Christian healing situates people in community and establishes expectations and relationships' (Porterfield 2005, 9).

Fifth, the choice of prayer camps as an alternative to psychiatric hospital is sometimes influenced by financial constraints. My interaction with family members, caregivers, and patients also revealed that the cost involved in seeking treatment at a psychiatric hospital is one reason some resort to prayer camps for the required care and assistance. Medical treatment at a psychiatric hospital can be very expensive and beyond the means of the ordinary Ghanaian citizen who is economically and financially disadvantaged. As Kalu (2008, 263) argues, 'the popularity of divine healing in Africa arises from the poverty in the communities that are plagued by the collapse of [the] health care delivery system'. In such a situation a prayer camp becomes an alternative. Although patients at some of the camps I visited were made to pay a monthly fee for their subsistence, this was cheaper and more accessible than a psychiatric hospital. This accords with Gammelín's (2018) observation that in Tanzania, although biomedical is in theory accessible

5 My encounter at some of the camps indicates that Muslims also patronize them. For example, Patient 1 in this study was a Muslim before he was sent to the camp but converted to Christianity after his recovery.

to all, not everyone can afford it because of their financial situation. Some caregivers explained that the responsibility of taking care of the mentally ill was mostly shifted to leaders or the authorities of the camp, as most of the patients were unable to afford the amount being charged. However, these socioeconomic issues do not negate the premium placed on the spiritual root cause of the problem of mental illness, as it was also found that individuals with a high socioeconomic status who could afford the cost of seeking hospital treatment were also brought to the camp. These included the children of university lecturers, members of parliament, and ministers of state, revealing the utility value and pervasive influence of religion in matters of illness and healthcare.

Conclusion

In this study I have highlighted the perceived notions or beliefs associated with mental illness in Ghana. I have also discussed how these perceived beliefs influence health-seeking behaviours. The study has argued that mental illness is cast in the framework of traditional interpretation and is rearticulated in healing rituals at the prayer camps. This resonates with the Ghanaian understanding of sickness and healing, underpinning the decisions that are made by patients and their families in seeking help at prayer camps. Yet the prayer camps also serve as an alternative source of hope after repeated failed attempts to seek hospital treatment. However, the situation also reveals the social and material conditions of people in a limited resource setting and the paucity of mental healthcare specialists. As I have shown, the understanding, meaning, and interpretation people give to illness will always influence the approach and pathways they use in seeking treatment. I therefore argue that prayer camps will continue to be important for a long time, even when there are sufficient resources to build psychiatric hospitals, because of the religious beliefs and the desire for wholeness that encompass the spiritual and physical components of the lives of Ghanaians in matters such as healing. This is possible not because they do not believe in biomedical care, but because they are certain that biomedicine cannot always provide solutions to certain health problems or conditions, especially those deemed to be influenced by unseen evil forces.

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Research Interviews

Interview with Patient 1. 2020. Records of transcription are in the possession of the author.

Interview with Patient 6. 2021. Records of transcription are in the possession of the author.

Interview with Patient 5. 2020. Records of transcription are in the possession of the author.

Interview with Prayer Camp Pastor 2. 2020. Records of transcription are in the possession of the author.

Interview with Caregiver 3. 2020. Records of transcription are in the possession of the author.

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