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IM | POSSIBILITIES OF COLLABORATION

Community Psychiatry and Spiritual Healing in Rural Southwestern Ghana

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Community Psychiatry and Spiritual Healing in rural southwestern Ghana

By Cecilia Draicchio

ABSTRACT

Drawing on extensive ethnographic fieldwork carried out between 2013 and early 2022 in Nzemaland, a rural border area in southwestern Ghana, this thesis focuses on a particular Global Mental Health promoted practice: that of collaboration between psychiatry and so-called 'unorthodox' therapeutic resources (i.e. traditional and spiritual healing). Conceived of as an instrumental practice for the decentralisation of services and the general improvement of mental health provision, 'collaboration' is rooted in a long history of therapeutic pluralism in the country (and the area), but was promoted as an innovation within the framework of the 'Mental Health Act', a new law passed in 2012 with the aim of reforming the national mental health care system in line with WHO guidelines.

Looking at everyday practices of 'collaboration', that is what people (psychiatric nurses, charismatic pastors, traditional healers, patients, family members) actually do across different therapeutic traditions and at the intersections of different ideas of mental suffering and care, this thesis aims to challenge any dualistic conceptualisation of religious/spiritual experiences and mental health as separate spheres. At the same time, I also propose to question the ways in which the practice of 'collaboration' itself is framed at the national and international level, what contradictions it entails, what kind of care it contributes to make *possible* and/or *impossible* in light of current debates concerning the impact of economic inequalities, the role of psychopharmaceuticals and neurobiological reductionism, the tensions between care and control in mental health care. By doing so, I would also like to suggest the idea that a border area substantially framed as 'remote' in national terms and generally overlooked in the ever-growing

scholarship on mental health in Ghana could be a crucially 'global' site to observe how Global Mental Health is made, unmade and remade in people's everyday lives beyond its discursive dimension.

TABLE OF CONTENTS

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INTRODUCTION

Im | possibilities in times of Global Mental Health

In June 2022, on the occasion of the launch of the World Mental Health Report 2022 (World Health Organization 2022), UN Secretary-General António Guterres declared: 'We are living through a global mental health crisis'.[1] Mental health has become a keyword of the present across hemispheres, countries, and health systems, especially after the Covid-19 outbreak, which appears to have exacerbated feelings of isolation, anxiety, and the very conditions of inequality that often inform experiences of mental suffering across the world. The direct impact of the pandemic on people's mental health and living conditions more broadly varied greatly according to the context and it is probably too early to draw any conclusion, but actually the idea of a global mental health crisis is not new: indeed, the prospect of an 'epidemic of mental disorder' (Rose 2019: 25 ff.) predates Covid-19. As observed by Nikolas Rose in 2019, it has become very common in the last few years to hear and read international organisations estimating that the number of people affected by mental disorder across the world amounts to hundreds of millions – approximately 450 at the time Rose was writing, now nearly one billion (World Health Organization 2022): 'We used to count the number of mentally disordered persons in terms of the populations of thousands across Europe and the United States, not millions. How have we come to such a view of the prevalence of these conditions in our own times?' (Rose 2019: 25). The short answer would be that these figures have come to include not only people diagnosed with a mental condition, but also persons 'who live with a *diagnosable* mental disorder' (World Health Organization 2022: 5, emphasis added). This change in perspective is rooted in a process

[1] See: <https://www.un.org/sg/en/content/sg/statement/2022-06-17/secretary-generals-video-message-launch-the-world-mental-health-report-2022-transforming-mental-health-for-all>, last accessed 30 December 2022.

of 'globalisation of mental health disorders' that, as retraced by Harry Yi-Jui Wu (2021), was first conceived in the post-World War II period by a newly universalist social psychiatry aimed at overcoming the colonial and racist paradigms that dominated the discipline up until then. A few decades later, in a quite different international scenario characterised among other things by the rise of a global pharmaceutical industry, this process was revived within the framework of Global Mental Health (GMH). The new GMH paradigm was introduced in the early 2000s (Satcher 2001) and officially launched in 2007 by a group of psychiatrists, epidemiologists, and public health scholars in the pages of the medical journal *The Lancet* (Prince et al. 2007). Though named 'global', GMH focused on low and middle income countries with the aim of filling the 'treatment gap' affecting their populations, i.e. making psychiatric treatment available to those people assumed to be 'diagnosable' with mental disorders that remained undiagnosed and untreated. In order to do so, the Global Movement for Mental Health in synergy with the WHO started promoting a number of policies that included decentralisation, community-based mental health services, and the integration of mental health within primary care (Read et al. 2009). Global Mental Health policies have been significantly criticised as imperialist projects ultimately aimed at imposing the hegemony of Western psychiatry upon other forms of knowledge and epistemology conveying different conceptualisations and understandings of mental health and mental health care (among others, Fernando 2014; Mills 2014; Summerfield 2013). What is interesting is that while these policies are still being proposed and implemented in the Global South, in the Global North psychiatry appears to be going through a deep crisis: differently from the optimism that characterised it in the post-war period and to a large extent still animated it in the early days of the Global Mental Health era, the 'biological enthusiasms' (Harrington 2019) and strong faith in psychopharmacology that have been at the heart of the discipline in the last decades are now being increasingly called into question (among others, Ecks 2022; Scull 2022). In other words, there seems to be a disconnection between discussions about mental health happening, both among professionals and activists, in the Global North and in the Global South, as if African and other non-Western countries were located in another space and time.

This thesis would like to be a decentred contribution in the direction of bridging this gap in current discussions around Global Mental Health.

Drawing on extensive fieldwork carried out between 2013 and early 2022 in Nzemaland, a rural border area in southwestern Ghana, this work focuses on a particular Global Mental Health promoted practice: that of collaboration between psychiatry and so-called 'unorthodox' therapeutic resources (i.e. traditional and spiritual healing). Conceived of as an instrumental practice for the decentralisation of services and the general improvement of mental health provision, 'collaboration' is rooted in a long history of therapeutic pluralism in the country (and the area), but was promoted as an innovation within the framework of the 'Mental Health Act', a new law passed in 2012 with the aim of reforming the national mental health care system in line with WHO guidelines. By looking at everyday practices of 'collaboration', that is what people (psychiatric nurses, traditional healers, charismatic pastors, patients, family members) actually do across different therapeutic traditions and at the intersections of different ideas of mental suffering and care, I aim to challenge any dualistic conceptualisation of religious/spiritual experiences and mental health as separate spheres. At the same time, I also propose to question the ways in which the practice of 'collaboration' itself is framed at the national and international level, what contradictions it entails, what kind of care it contributes to make *possible* and/or *impossible* in light of current debates concerning the impact of economic inequalities, the role of psychopharmaceuticals and neurobiological reductionism, the tensions between care and control in mental health care. By doing so, inspired by the work of Charles Piot on the relational and inherently modern dimension of 'remoteness' in rural Togo (1999; see also Harms et al. 2014), I would also like to suggest the idea that a border area substantially framed as 'remote' in national terms and generally overlooked in the ever-growing scholarship on mental health in Ghana could be a crucially 'global' site to observe how Global Mental Health is made, unmade and remade in people's everyday lives beyond its discursive dimension (cf. Bemme and D'Souza 2014 on overcoming the 'global/local divide' in GMH analyses).

Before illustrating the structure of the thesis, in the next two sections I will briefly describe the context (both geographical and chronological) in which the research was carried out, the methods adopted, and the key interlocutors at the centre of my investigation.

The research/1: space(s), time(s), methods

A coastal territory lying approximately between the lower basins of the Ankobra River and the shores of the Aby Lagoon complex, the Nzema area is situated between the Western Region of Ghana and the Sud Comoé region of Côte d'Ivoire.[2] The Ghanaian side – also known as Nzemaland – has been the object of extensive ethnographic and historical research conducted since the 1950s,[3] but has been essentially neglected within the broader framework of the rich and continuously expanding multidisciplinary literature on mental health in Ghana.[4] Relatively far from centralised psychiatric institutions – the Accra Psychiatric Hospital and the Pantang Psychiatric Hospital in the capital city and the Ankaful Psychiatric Hospital in Cape Coast (Central Region) – and unprovided with mental health NGOs unlike other areas in the country, the Nzema area is a key site to observe how the innovations in community-based mental health care introduced in the last decade operate on the ground. In some ways, it is an area that, being geographically at the margins of the state, could be represented as 'remote' and was often deemed as such by many among my interlocutors, both people hailing from Nzema who complained about the boredom and lack of opportunities their small towns and communities had to offer, and people like nurses and other professionals who were posted there from other

[2] For a solid historically grounded analysis of the identity related issues associated with the multiple possible definitions of the Nzema area in territorial terms, see Valsecchi 2001.

[3] This stream of research was initiated by Italian ethnologist Vinigi Grottanelli, who founded the Italian Ethnological Mission to Ghana in 1954 and, together with his research team, embarked in an all-encompassing investigation of Nzema 'culture' conducted in the ethnographic fashion of the time with the aim of documenting it before its 'loss' at the hands of 'modernity' (Grottanelli 1977, 1978; see also the abridged English version: Grottanelli 1988). A new season of ethnographic and historical research started in the late 1980s with studies carried out on a wide range of topics including traditional medicine and spirit possession (Schirripa 1995, 1998, 2001, 2005; Schirripa and Pavanello 2008) and witchcraft (Pavanello 2012, 2017). On the history of the Italian Ethnological Mission to Ghana see, among others, Pavanello 2019.

[4] It is interesting to notice that in a recent mental health care assessment document issued by the WHO, the Ghanaian Ministry of Health, and the Global Mental Health Consortium at the University of Washington, the 'considerable amount of mental health research (...) generated in Ghana' is indicated as one of the 'strengths' identified in the Ghanaian case study (World Health Organization, Ministry of Health - Ghana, Global Mental Health - University of Washington 2021).

areas of the country and described it as a peripheral handful of rural villages. This is of course a narrative, a relevant one, but still a narrative, as the area – which was also the birthplace of Pan-africanist leader and Ghana's first president Kwame Nkrumah – is obviously a 'global' site embedded in a thick network of national and international relations with the 'outside' (cf. Harms et al. 2014).[5]

After a first visit in 2011, I carried out ethnographic fieldwork in Nzemaland for fifteen months between 2013 and 2022.[6] This thesis is the product of a research conducted in multiple phases, which started when I was an MA student carrying out fieldwork on the politics of mental health care in rural Ghana in the immediate aftermath of the mental health reform in the country. Though the Covid-19 outbreak[7] did not allow me to spend fifteen months in Ghana for my doctoral investigation alone as I had initially planned and forced me to limit the scope of the research, building on different experiences of fieldwork over a period of almost ten years allowed me not only to greatly complexify my own understanding of the context and establish long-term relationships with research interlocutors – some of whom have now become friends – but also to appreciate the deeply dynamic nature of mental health care in the country and the many changes occurred since I started the research. Indeed, similarly to the ways in which the Nzema area was originally narrated in anthropology as a 'remote' site somehow crystallised in a

[5] This is even more evident today, since Nzemaland has become a key site for the development of the Ghanaian energy industry after the discovery of oil and gas in commercial quantities offshore Nzema coasts in 2007 and the start of production in 2010, with consistent national and international investments in the area in the last decade.

[6] The research was conducted in six different fieldwork periods: October-November 2013, July-November 2014, June-July 2017, November-December 2018, January-March 2020, August 2021-January 2022 (with two short visits also in July 2019 and July 2022).

[7] Covid-19 makes a rapid appearance in the thesis (Chapter 4), but I do not thematise it as a topic *per se* because, for what I could preliminary observe in the last phase of the research, its impact was quite limited in the provision of mental health services in the area, which has been characterised by recurrent politics of 'emergency' requiring 'extraordinary measures' long before the pandemic outbreak (see Chapter 2).

present-past (that would have soon disappeared, see Grottanelli 1978: xiii cit. in Maltese 2017),[8] contemporary Western representations in the media often project a colonial depiction of mental health care in Ghana as if crystallised in time and essentially 'always backwards', providing sensationalist accounts of disturbing yet complex practices like chaining and abandonment. As suggested by Ursula Read (2021), who has been carrying out research on mental health in Ghana since 2005, in order to challenge this colonial narrative it is important to point out that in the last decade, since the passing of the Mental Health Act – as the voices of advocates and activists started multiplying and amplifying mental health discussions in the country – there have been important transformations, especially in terms of decentralisation. While, despite a considerable increase, trained psychiatrists in the country are still extremely exiguous in numbers[9] and mostly concentrated in psychiatric hospitals and big urban centres, there has been a major increase in the number of trained community-based mental health nurses: from 200 to now over 2000 in the whole country. This change was reflected in Nzemaland, where the number of community psychiatric nurses assigned to the district where I carried out my research[10] went from 4 in 2013 to 10 in 2022.

Between 2013 and 2020, I was based in a tiny community on the coast. During fieldwork, beside participating in community life and obviously engaging in numerous casual activities, interactions, and conversations arising from it, I carried out participant observation in specific

[8] It is interesting to point out that cracks in this hegemonic narrative can be found also in the wealth of Grottanelli and his team's ethnographic account, but this would be the object of a totally different research project.

[9] The figure went from 18 psychiatrists in 2011 to 39 at the beginning of 2022. See World Health Organization 2011; World Health Organization, Ministry of Health Ghana and Global Mental Health - University of Washington 2022.

[10] Though I am aware that there is an ongoing thought-provoking discussion on the uses of anonymity and pseudonyms in ethnography (McGranahan and Weiss 2021), in accordance with the ethics review application I submitted to the Ghana Health Service Ethics Review Committee in 2020 and 2021, in this thesis all the names of people involved and their hometowns were changed or omitted to preserve their anonymity. For the same reason, in order to avoid identifiable details, I do not indicate precisely the name of the district and the hospital where I conducted my investigation, nor the location of the healing sites, or the places where I lived during fieldwork.

sites in different communities and towns to which I travelled almost everyday in order to visit a multiplicity of spaces where mental health care is practised: namely the psychiatric unit of a district hospital, a health centre provided with a psychiatric nurse (since 2020), multiple prayer camps, churches and traditional shrines, and private households where people affected by mental suffering and/or their relatives lived; sometimes I also accompanied psychiatric nurses on their outreach activities and home visits. In 2021 and early 2022 I also rented a room in the town where the district hospital was located, in order to be closer to the psychiatric unit and to spend more time with some of my interlocutors who lived there. Being based for a long time in a community located quite far from the hospital and travelling almost everyday to different locations was a crucial experience in my research: having to move often from place to place by shared taxi and *okada* (motorbike) was a fundamental way to understand the relevance of mobility issues in people's lives, choices, and therapeutic paths, especially with regards to the accessibility of public health facilities. This is not to reinforce the already discussed stereotype of Nzema 'remoteness', but just to stress the fact that moving can be incredibly time-consuming and expensive, often even prohibitive, compared to the average income and occupation of large sections of the local population. Indeed, *TNT* (transportation fares) were often evoked as an obstacle – or at least a notable investment to be well pondered – in many of the conversations I had both with practitioners, especially mental health workers, and (former or prospective) patients' relatives.

Apart from 'hanging out' and carrying out participant observation in specific sites, I also conducted semi-structured and conversational interviews, and group interviews. However, these mostly 'neutral' and 'technical' expressions are obviously very far from the multiple, complex and personal dimension of the ethnographic experience, which ultimately is also 'simply' a part of life shared with other people. During fieldwork, I often had the impression that formal interviews represented just one layer of reality, one side of the story, so to speak, while meeting people repeatedly, conversing informally, spending time together, sharing experiences, worries and needs, and to a great extent just living everyday life in the community, proved sometimes more enlightening. On the other hand, however, interviews became more and more relevant to the research when they gradually started to build on the longevity of the relationships with my

interlocutors, giving me the chance to listen to their voices and reconsider my notes, memories, and interpretations while writing this thesis.

The research/2: people

In her important study on mental health carried out in Accra in the 1970s and published in 1984, anthropologist Leith Mullings describes the scenario of the available therapeutic resources through the identification of three macro-categories: 1) 'traditional healing' which, although 'directly affected by the dominance of capitalism' and able to perpetuate it (Mullings 1984: 187), defines illness and healing according to the local cosmological system; 2) 'spiritualist healing', which is instead based on the Christianity conveyed by the new 'spiritual' and Charismatic churches; and 3) Western and institutionalised psychiatry. Despite the chronological and spatial distance that separates Mulling's work from my research, the tripartition she described could still be useful to briefly present some of the key interlocutors and healing sites that have been at the centre of my research in Nzemaland. Thus, in order to trace a macroscopic description of the therapeutic resources available in the Nzema area and of the actors who embody them, we could use the same 'conventional' categories proposed by Mullings, provided that we acknowledge their constitutive fluidity and dynamism.

In Nzemaland, the category of 'traditional healing' is represented by two different therapeutic figures: the *ahɔmenle* (sing. *kɔmenle*), also referred to in English as 'fetish priests',[11] who are priest-healers possessed by the *awozonle* (sing. *bozonle*), the local deities; the *ninsinlima*

[11] On the missionary and colonial origin of this term and its erroneous association with the practice of 'witchcraft' – that was then borrowed and resignified in the antithetic, and yet complex, relationship of Pentecostal and Charismatic churches with 'tradition' and 'traditional religion' (see for instance Meyer 1998a; Piot 2010: 62) – see Vasconi 2017; cf. Chapter 2.

(sing. *ninsinli*), 'herbalists' that in some cases practise divination.[12] On the other hand, the category of 'spiritualist' healers could be used to describe the *asofo* (sing. *esofo*), prophets/prophetesses and pastors who treat patients in extremely heterogeneous Christian (Pentecostal, Charismatic, and Catholic) prayer camps.[13] A particular category of *asofo*, whose practices largely differ from those of pentecostal/charismatic healers and are situated at the crossroads between traditional healing practices and Christian-inspired ones,[14] is the one represented by the priests and priestesses of the Twelve Apostles Church, an independent church founded by the disciples of the Liberian prophet William Wadé Harris, after his preaching in Western Gold Coast in 1914.[15]

Both for 'traditional' and 'spiritual/spiritualist' healers, mental suffering and the necessary therapy are often linked to a supernatural dimension of existence. This dimension is inhabited by powerful entities that actively interfere in people's everyday life: for 'traditional healers', the *awozonle*, deities/spirits that can be both benign (*kpalɛ*) or evil (*ɛtane*) (Pavanello 2012: 34) and witches (*nyɛne*); and for 'spiritual/spiritualist healers', the Christian God (*Nyamenle*), the Devil (*Abɔnsam*) and his evil agents, often called *awozonle* themselves, and witchcraft (*ayɛne*), testifying the well known meaning conflation of witchcraft, occult powers, and 'traditional

[12] As argued by Pino Schirripa (2001), the *ninsinlima* have a relationship with the deities as well. However, what distinguishes them from the *ahɔmenle* is that their contact with the *awozonle* is not constant, but intermittent. As a *ninsinli* apprentice put it: 'we talk to them, but we don't work with them', where 'working with the *awozonle* ' is often used to refer to the *kɔmenle*'s activity (Interview with Ibrahim and Baba Mohammed, 14th January 2022). For a detailed description of these categories of traditional healers see Schirripa 2005 and Schirripa and Pavanello 2008.

[13] To this categories it should be added that of *mallams*, muslim healers who employ the Quran to heal their patients, which I did not have the chance to explore in the research.

[14] As reported by Alessandra Brivio (2015), because of their particular history which locates them at the crossroad of different healing traditions, Twelve Apostles Church *asofo* are often accused by Charismatic and Pentecostal pastors to work with 'bad spirits' and witchcraft, not differently from the *ahɔmenle*.

[15] The Twelve Apostles Church, also known as Harrist Church or Water Carriers Movement, was founded by John Nackabah – a 'fetish priest' converted by Harris – and Grace Tane. From the name of one of the two founders of the church, Twelve Apostle Church *asofo* are also referred to as *Nackabah asofo* or simply *Nackabah*. On the Twelve Apostles Church and Prophet Harris see, among others, Cerulli 1963, 1970; Walker 1983; Shank 1994; Brivio 2015.

religion' in Pentecostal and Charismatic cosmologies.[16] For this reason, in this thesis I sometimes refer to the practices of both 'traditional' and 'spiritual' healers in terms of 'spiritual healing', as their therapeutic activities and conceptualisations of illness are in any case closely linked with a supernatural dimension of life inhabited by spirits.

This supernatural dimension is apparently absent in the third category, that of psychiatry, which in the Nzema area is represented by two different kinds of biomedical mental health workers: the registered mental health officers (RMHO), who are psychiatric nurses normally based at psychiatric units, and the community mental health officers (CMHO), recently trained nurses who have the specific task of managing the relationship with local communities and patients outside of the hospital.[17] The distinction between the two roles, however, appeared perhaps more relevant at the beginning of my research, when the number of nurses was more limited, while in the last few years I have noticed that independently from their role, if funding allows, nurses working at the psychiatric unit organise among themselves in order to decide who goes 'on outreach' or 'home visiting' to take care of patients that for various reasons fail to visit the hospital (see Chapter 2). This was even more true in the case of the only psychiatric nurse I met who was not working at the psychiatric unit, Ernest. He was not a Community Mental Health Officer, but since he was only recently posted to a district health centre when I met him in 2020, he did not have any patients and realised that the only way to do his job was to visit the neighbouring communities and never stopped since then, favoured by the fact of having a motorbike he could use for this kind of activities.

My analysis of 'collaboration' at the crossroads of different conceptualisations of mental health and 'mental illness'/madness has taken the nurses' perspective as a point of departure and largely focused on their practices. This is not only due to the fact that collaboration is *de facto* promoted, both at a micro and macro level, by psychiatric institutions, or to the fact that the mental health unit has been my point of access to the research topic, but was also motivated by a deliberate intention to focus on psychiatric practitioners. Indeed, studies on mental health in

[16] Cf. note 11.

[17] This new professional figure of mental health worker was created in 2011 with the same reformative attitude that informed the process of formulation of the Mental Health Act (see Roberts et al. 2014).

Africa have long focused on traditional and religious healing, while contemporary psychiatric practice has rarely been addressed and is virtually absent in the mainstream popular imaginary about 'Africa', as it will emerge clearly from the media representations I will discuss in Chapter 4 (and as I learned myself very early on when I started talking about my research in general everyday interactions). During the research, however, as I hope it will emerge clearly in the thesis, I complexified this perspective by entangling it with other narratives, experiences, points of view capable of unveiling inner contradictions, inconsistencies, and rifts. This means – as it is perhaps easy to imagine – that during the research I did not only meet practitioners, but also patients, people deemed 'mad' and/or possessed by spirits, relatives and caregivers who took (and sometimes did not take) care of them. In most of the cases, I met them through their clinicians and healers, and then met them again at least a few times in order to establish a relationship, explain why I was interested in their stories, and ask them whether or not they wanted to share them with me within the framework of my research project. While it was generally easy to obtain 'consent' – as the ethics review committee jargon has it – from all kinds of interlocutors, throughout my fieldwork I tried to question the very idea of a consent given once and for all and to really be ready to put research aims 'on hold' when I felt it was appropriate. At the same time, as a first step in the direction of co-constructing knowledge – something that would require a lot more than an investigation carried out in order to write a doctoral dissertation – I always tried to clearly share with my interlocutors not only my interests and research aims, but also my points of view, hypotheses, and doubts.

The chapters

The *fil rouge* that binds together the chapters is the effort to dig into the multiple entanglements and contradictions that characterise the practice of 'collaboration' at the intersection of different conceptualisations of madness and mental illness, care and healing. This is reflected in the structure of the thesis which is organised around six binary oppositions: *madness vs. mental illness*, *psychopharmaceuticals vs. prayers*, *market vs. care*, *'belief' vs. science*, *chains vs. (affective) ties*, *collaboration vs. disagreement*. Binary oppositions that can easily

crumble if we look at them through the prism of the everyday experiences and narratives of the people I met during my research.

Starting from a reflection on the different ways in which people usually talk about mental distress in Ghana and Nzemaland, Chapter 1 deals with the first of the dichotomies the dissertation intends to unpack: the ambivalent relationship between the categories of 'madness' and 'mental illness'. Taking history and the process of institutionalisation of 'mental illness' in colonial Gold Coast as point of departure, the exploration of the thin line that separates/binds these two concepts in the collective imaginary can represent a valuable entry point to understand the multiple horizons of meaning navigated by 'mad/mentally ill' people and their caregivers. Talking of madness as something different from mental illness, especially in a context in which the experience of madness can *also* be indicative of a relationship with a deeper dimension of reality (i.e. that of spirits), obviously evokes Foucault's work on the *History of Madness* (2006 [1961]) and his influential account of the relationship between madness and modern reason in Europe. In the chapter, however, I try to analyse the dyad madness/mental illness in light of the particular meanings these words acquired in the context of the colony, highlighting, in line with classic and more recent studies in the history of madness in Africa, the specificities of colonial psychiatric theories and practices as compared to the ways in which they were elaborated and applied in Europe. This is not be a mere historical exercise or a flashback into the past: by retracing the multiple histories of psychiatry in Africa, and in Ghana more specifically, and putting them in relation with theories and ethnographic studies on madness/mental illness produced in those years, I suggest that many of the questions that keep *haunting* contemporary discussions in the politics of Global Mental Health (including the policy of collaboration with traditional and spiritual healers) have roots in that complex past; and, conversely, that past is crucial to understand the ways in which Ghanaian psychiatric institutions and practitioners conceive of madness, mental illness, and mental health care today.

Chapter 2 is dedicated to introducing the relational articulations of psychiatry and spiritual healing that this thesis aims to explore through the discussion of a crucial dyad: drugs and prayers. After having briefly retraced the recent history of the policy of collaboration between psychiatric institutions and non-biomedical healers currently proposed at the national level, I

will focus on the juxtaposition of pharmaceutical and spiritual therapies: *drugs+prayers* is the most common description of what 'collaboration' should look like in the perspective of psychiatric professionals. Yet, these two poles seem to constitute a neat antinomy and are sometimes evoked in contradictory ways in institutional discourses. As I try to show, as much as they could be perceived as two antithetical resources, drugs and prayers coexist in the lives of many patients and practitioners: in some cases, drugs even perform a crucial role of mediation between the reign of psychiatry and that of spiritual practices. Given their centrality, I propose to take the presence/absence of psychopharmaceuticals in Nzemaland (and in Ghana more broadly) and their (in)accessibility as a point of departure to understand what I provisionally call in this chapter 'experiments at collaboration'. Discussing some of the stories of the people I met and describing the everyday practices of psychiatric care provision that I had the chance to observe in light of the Mental Health Act and the recent neoliberal history of Ghanaian national healthcare, I propose to focus on the material implications of *drugs+prayers*. By doing so, the chapter invites a complexification of the weight generally attributed to spiritual interpretations of 'mental illness' and a reflection on the significance of scarcity, the commodification of care, and the inaccessibility of psychopharmacology in 'experiments at collaboration' and people's therapeutic trajectories more broadly.

Building on the discussion started in the previous section, Chapter 3 proposes a further analysis of the role of psychopharmaceuticals in the Ghanaian context: in the relationships established between psychiatric nurses and healers and in mental health care provision more broadly. By focussing on drugs and on the market dynamics developed around them, I suggest to provincialise the mostly western-centred discourse on the 'pharmaceuticalisation of the self' (Jenkins 2010) and to look at it from a peripheral perspective, from a place where pharmaceuticals are simultaneously 'hegemonic' and scarce, a context where they are conceived of as tools of care and can easily become means of exclusion. What impact does this paradox have on the ways in which mental health care is performed by nurses and experienced by patients and caregivers? I try to answer these questions by contextualising my ethnographic experience within the framework of the Global Mental Health discourse, which according to many critics draws heavily on a market-oriented understanding of mental health care mediated by drugs. As I anticipated, while this narrow understanding of care is currently at the centre of a crisis that is

increasingly shaking the foundations of contemporary psychiatry in the West, it seems to be largely ignored or overlooked in Global Mental Health policies and recommendations, as if Global South contexts (the real target of GMH interventions) were not part of the same 'world'. By analysing the entanglements of market and care in the practices and experiences of the people I met in Nzemaland, I also aim to destabilise and challenge this narrative.

After having highlighted the crucial importance of material conditions in the experiences of 'mentally ill' people and their caregivers, in Chapter 4 I finally go back to the argument of a supposed conceptual incompatibility between psychiatry and spiritual healing. This argument lurks in the Ghanaian institutional discourse aimed at promoting collaboration between biomedical and traditional/spiritual healers, which at a closer look appears utterly ambivalent. In the chapter, I propose to challenge this argument by using the concept that is most often evoked to support it and to ultimately discredit non-psychiatric conceptualisations of mental distress: *belief*. Belief is of course a problematic concept in anthropology and in the chapter, drawing especially on perspectives coming from medical anthropology and the anthropology of religion/religious studies, I briefly go through some of the key reasons why we should be wary of using it. On the other hand, however, in line with some recent scholarly attempts of 'rehabilitation', I find it interesting to explore its potentialities, especially because the issue of believing (or not) kept coming up in everyday conversations while I was in Ghana, even when I wanted to ignore it. Focussing in particular on the ways in which nurses talk about it, I suggest that the constant evocation of the category of 'belief' (attributed to patients and their relatives) reveals that the framing of 'collaboration' within the psychiatric discourse is inherently ambivalent. At the same time, however, belief itself can be ambivalent and is used to talk about spirits, God, and interestingly even 'science'. What if this ambivalence and the constitutive relationship that ties *belief* with one of its many opposites, *doubt*, could help us in understanding the ways in which people – patients, relatives, and practitioners – navigate healing options and constellations of meaning in dealing with 'mental illness'?

In Chapter 5, I address one of the topics most frequently discussed when talking about mental health in Africa and in Ghana more specifically: that of mechanical restraint. Together with belief, the chaining of patients in non-psychiatric facilities is one of the most common aspects evoked to suggest a potential incompatibility between biomedical and non-biomedical

therapeutic resources, but is actually largely tolerated. In this case too I find it important to explore this issue in relation to ongoing debates in the field of mental health and psychiatry even beyond the continent, in order to avoid the very tangible risks of adopting an African exceptionalist and/or sensationalist perspective. Discursively framed in terms of human rights violation and associated – especially in media and international NGO accounts – with prayer camps and traditional shrines, the practice of restraint actually transcends those spaces and often forces its way into family and affective networks, as well as in the therapeutic relationships that psychiatric nurses establish with their patients. Going back to some of the issues introduced in Chapter 2 and 3 with regards to the use of psychopharmaceuticals and processes of 'pharmaceuticalisation of the self', the chapter explores restraint as it is experienced, practised and narrated by different actors. By doing so, it proposes to thematise the blurring of boundaries between care and control, healing and violence in order to partially reframe the debate on coercion in Ghanaian prayer camps and shrines and, more broadly, to question contemporary meanings of 'mental health care' in the country and beyond.

In Chapter 6, I eventually go back to the fundamental keyword of this thesis: *collaboration*. Both as a hypothesis and a practice, collaboration has been at the heart of my research project and has oriented my fieldwork since its early days. Indeed, far from losing its popularity among scholars and policymakers working on mental health, since 2013 the aim to create collaborative relationships between psychiatric practitioners and traditional/spiritual healers is still a key element in contemporary debates across the Global South. In the last chapter, then, I suggest it is time to finally question the idea of collaboration itself: what do we really mean by it? Asking this question means complicating current paradigms of collaboration, by delving into the depths of multiple decisions, doubts, contradictions, and dilemmas that emerge in the everyday life of practitioners, caregivers and patients. What happens when patients and their relatives disagree with those who are supposed to take care of them? When there is dissent among practitioners? And how can we reframe our understanding of what collaboration is/can be on the basis of what these disagreements (Rancière 1999[1995]) may reveal? After having deconstructed the supposed incompatibility of psychiatric care with spiritual healing, in this final chapter I aim to clarify that this does not mean ignoring the multiple moments of friction that emerge at the crossroads of different conceptualisations of madness and healing. Focussing on disagreement,

instead, could be a valuable entry point to reflect on the limits of psychiatric care and the model of collaboration proposed in times of Global Mental Health, and to envision new, collective *possibilities* of care.

1. MADNESS | MENTAL ILLNESS

Questioning words, retracing histories

'What is your research about?' – I was obviously asked this question countless times, almost every time I introduced myself as a student, a PhD or 'somebody doing research', in Ghana as well as anywhere else. The answer should be easy, yet it never is. Depending on the context, the reply can sometimes become a formula, the real meaning(s) of which you almost forget. In my case, it often included a combination of keywords that will indeed be quite present in this work, such as *mental health*, *mental illness*, *madness*, *collaboration*, *psychiatry*, *traditional healing*, *spiritual healing*, *prayer camps*. In these occasional formulations, I often used *madness* and *mental* illness as synonyms. Once, after having presented one of these rushed formulas to a stranger, an Accra Uber driver I had just met on a cloudy afternoon in January 2020, I was asked a follow-up question: 'but what is the difference between madness and mental illness?'. The question was indeed a lot more complicated, and layered, than the previous one. During the trip, we talked about the meanings we respectively gave to these words: for him, madness referred to those people you could see begging in the streets, who looked completely 'lost'; 'mental illness' instead was the condition that affected one of his friends, who started 'seeing things' that were not there and had just started feeling better – 'he's still a bit talkative sometimes' – thanks to some drugs he was prescribed at the hospital. For me, the word madness pointed towards something that was simply larger than 'mental illness', perhaps a reminder that 'mental illness' itself can be larger than its biomedical definitions and labels.

Indeed, many of the people I met in Nzemaland shared the idea that the 'madness' of the people who 'roam around' in the streets – largely more copious and visible in a metropolis like Accra, as compared to the rural coastal towns where I carried out my research – is something different from a mere 'illness' that can be treated in hospitals and clinics. As a matter of fact, 'vagrancy' is the most powerful and pervasive representation of madness in West Africa, where

the figure of the 'mad vagrant' (Read 2012a: 55, Read 2020; cf. also Chapter 2) is a dominant depiction of mental suffering in cinema and visual media (Aina 2004; Ampadu 2012; Atilola and Olayiwola 2013).

As it is not difficult to imagine, talking in terms of madness is thus closely associated with stigma and avoided whenever possible, especially by psychiatric nurses. The Nzema word for madness, *ɛzɛlɛ*,[18] is commonly used as an insult, sometimes shouted, sometimes murmured when fights and arguments erupt. For most of the people I talked to in Nzemaland, including nurses, the word *ɛzɛlɛ* and its Twi equivalent *abɔ dam* can easily evoke the radical madness of the vagrant: someone either naked or dressed in filthy clothes, who roams around, abandoned by everyone. While some nurses refer to madness/*ɛzɛlɛ*/*dam* as simply a term for the 'lay people', a 'bad word', an expression that you can use for someone who is behaving *as if mad* 'just for a flash', others feel it is important to point out that

> mental illness has to do with your emotions, your thinking, your feelings [...] it's not about people going naked and those kinds of things [...] mental illness is broad [...] madness [refers to] those people on the streets, in tattered clothes, dirty and those kinds of things... it is part of mental illness, but mental illness is broad: someone can have depression and he is not mad, someone will be having suicidal ideation, stress... the person is not mad but is having mental illness.[19]

[18] In Nzema, the term *ɛzɛlɛ* is sometimes alternated to the synonym *ɛlane*, which is however less commonly used. The Twi translation of the word madness used by nurses who were not native of Nzema was *dam*, which was more frequently used in the adjective form *abɔ dam* (mad). In the second volume of his classic work on 'the Nzema people' (1978), Vinigi Grottanelli maintains that there is a difference between the category of *ɛlane* or *ɛlanebɔle* (also indicated by the term *bɔnavolɛ*) and the category of *ɛzɛlɛ*: according to him, the former refers to 'a sudden and inexplicable form of madness that occurs in until-then-normal adult people and can last for only a few months at a time' ('during the intervals – Grottanelli adds – the person is completely reasonable'); while the latter is used to identify 'a furious kind of madness, usually caused by a ghost or a god for serious reasons. The most common feature of this last type of madness is the unrestrained habit of walking around naked, something that does not make the person fit for being left alone in freedom' (Grottanelli 1978: 266, my translation). In my research, however, I could not identify a neat separation between the two categories described by Grottanelli. Indeed aspects of the two experiences he described could easily overlap in the narratives of many of the people I met.

[19] Interview with Ernest, 21st January 2021.

Worried about the risks of 'stigmatisation' – a keyword in contemporary vocabularies of Global Mental Health (White et al. 2017; Thornicroft and Sunkel 2020) – and the conceptual conflation of different forms of 'mental illness' and the haunting image of the mad vagrant, conceived of as the 'highest level of mental illness',[20] nurses prefer to use other expressions to talk about the people they take care of:

> [Madness and mental illness] are all the same, but when you use the word *mad* it looks like you are stigmatising the person. I think the right word that should be used is *mental illness*, for every mental illness [...] in Twi: *adwen* [mind] *mu yareɛ* [sickness].[21]

> We can't use the word mad [*ɛzɛlɛ*] for our clients. How can we use [it]? We all have a small mental illness in us: sometimes when you are angry, some of the things you can do... you see? So I don't accept the fact that we use the word mad for our clients, we must say *mentally challenged*, or *mentally handicapped*. You don't have to say that the person is *ɛzɛlɛ*, you can say that the person is not well, like *ɔnde kpɔkɛ* [he/she is not fine], just like when somebody is also suffering from malaria.[22]

The antinomy madness vs. mental illness, and more specifically the opposition between the repulsive image of 'madness as vagrancy' and the broader, more neutral macro-category of 'mental illness' can seem banal, but is indeed deeply meaningful. If on the one hand it obviously recalls the Foucauldian process of the medicalisation of madness, on the other it is also

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[20] Interview with Rosalinda, 17th January 2021.

[21] Interview with Juliet, 18th January 2021.

[22] Other Nzema expressions that are used by people to describe different forms of mental distress that nurses would generally describe in English as 'mental illness' include: *anwondole/ewule* (sickness, disease), *deɛ ne* (the thing), *ɔyɛ ɔtendɛ ngakyile* ([something that] makes the person talk differently), *ɔkpɔsa* (the person roams about), *ye adwenle* [mind] *ɛbɔ nuhua kpale* (the person's mind plays badly inside), *ɔmaa ɛti bɔ nuhua* ([something that] makes your head play inside), *yeyɛ ye adwenle sesaka* ([something that] makes the person's mind rough), *deɛ ne ɛyɛ ye adwenle ne* (the thing that makes/affects the person's mind).

reminiscent of the particular forms in which this process took place in colonial Africa. In this perspective, questioning these words could allow us to retrace histories that keep *haunting* contemporary constellations of mental health and experiences of suffering, as well as imaginaries of the past, the present, and the future.[23]

An exploration of mental health care practices in an African context today cannot totally overlook the history – or rather we should say *histories*[24] – of the concepts of *madness* and *mental illness* in the continent, the particular role played by psychiatry in the colonial framework, and ways in which this role did change (or not) in the postcolony. Starting from this assumption, in this chapter I propose to question the meanings of madness and mental illness by taking into account the historical trajectories that directly or indirectly informed and keep informing those meanings. First, I will briefly retrace the main theories and approaches produced within the framework of colonial psychiatry in Africa, with a particular focus on divergent ethnographic studies carried out in the then Gold Coast between the 1930s and the 1960s. In the second section, I will concentrate on the process of institutionalisation of madness in Ghana from the colonial to the decolonisation period, trying to bring out ruptures and continuities that could allow us to better understand mental health care policies carried out within the framework of Global Mental Health today, like the practice of collaboration this thesis aims to explore.

[23] The potentialities of *haunting* as an analytic category have been fruitfully explored in different recent works, both historical and anthropological, that identify in the histories of madness, healing practices, and 'nervous states' the power of disrupting established and unchallenged narratives of the past, sometimes ghostly permeating the present (Hunt 2016; Kilroy-Marac 2014a, 2019; Ng 2020; see also Good 2019).

[24] Indeed, as Nana Quarshie aptly put it 'What colonialism meant, in ideological and practical terms, varied widely even within the African territories of a single European power. *There is not one history to be undone, but divergent ones* (Quarshie 2022: 243, emphasis added).

'A foreign country': genealogies of 'mental illness' in colonial Africa

Colonial psychiatry: between the 'normal', the 'pathological', and the political

In his groundbreaking *History of Madness* (2006 [1961]), Michel Foucault analyses the relationship between modern reason and madness in Europe. He shows how, from the 17th century, reason dictated the terms of this relationship, by essentially defining itself *against* madness: while in the Renaissance madness was perceived as a particular kind of mystical knowledge or a wisdom that revealed the limits of reason, in the *classical age* (17th-18th century) reason drastically isolated madness from itself. It was, paradoxically, in that moment that, through the g*reat confinement* of mad people (together with all the unemployed), reason and madness became 'both bound and separated' (Foucault, 2006 [1961]: xxxiii). By making the mad an accessible object of scientific observation, the Great Confinement built the foundations of the modern concept of madness as *mental illness* (end of the 18th century): the lunatic asylums/psychiatric hospitals (also in their 19th century more progressive forms) were the product of the coercive and normative (*discursive*) power of modern reason, aimed at reducing madness – perceived as a threat, neutralised as a disorder – to silence.

Put simply, in Europe psychiatry had the role of defining and distancing the Other through the concept of 'mental illness'. But what about psychiatry outside of Europe? Or, as British historian Meghan Vaughan put it: 'If madness (...) is "a foreign country", what of madness in a colony?.'[25] In the colony the situation was evidently more complicated. As shown by Vaughan in her classic book on colonial medicine in Africa (1991), colonial psychiatry's primary preoccupation was to understand and describe the *normal* African. Therefore, the history of this discipline was somehow eccentric as compared to the history of biomedicine: both aimed at delimiting the boundaries between the *normal* and the *pathological*, but colonial psychiatry

[25] The quote comes from Vaughan 1991: 101 (cf. also Vaughan 1993). As indicated by Vaughan, the definition of madness as 'a foreign country', sometimes erroneously attributed to her, actually comes from the *Social History of Madness* (1987:9) written by British historian Roy Porter, whose pioneering work opened the way to an history of psychiatry 'from below' (Porter 1985; see also, among others, Bacopoulos-Viau and Fauvel 2016).

mostly focused on the 'healthy' African, which was perceived as dramatically *other*, as much as the mad in the European context. Thus:

> In colonial Africa the 'Other' already existed in the form of the colonial subject, the African. The category of the mad African, then, more often included the colonial subject who was insufficiently 'Other' – who spoke of being rich, of hearing voices through radio sets, of being powerful, who imitated the white man in dress and behaviour and who therefore threatened to disrupt the ordered non-communication between ruler and ruled (Vaughan, 1991: 101).

This idea of madness as a threat to colonial order, something that indirectly menaced to call into question the whole construction of African otherness is constitutive of colonial psychiatry. As a fundamental component of the medical discourse, psychiatry had a key role in informing the colonial encounter and, more generally, in shaping the imaginary about 'the African' in Europe. Interestingly, many of the theories of colonial psychiatrists tried to deal with the consequences of colonialism itself, framed in terms of 'social change', and particularly with the transformations triggered by urbanisation. Vaughan (1991: 12-14) talks about these theories in terms of 'politics of difference': a 'creation of difference' that shifted between the two poles of pathologisation and naturalisation.

From the very beginning, colonial medical discourse was involved in conceptualising and explaining the difference between colonisers and colonised. At first, the biological paradigm of race seemed adequate to the purpose, but when its efficacy started to weaken, medics had to formulate new differences: how to explain, for instance, the incidence of new illnesses linked to industrialisation in the span between the two world wars? Rather than being explained by the violence of the colonial encounter or a change in living conditions, these new mental illness cases were justified as an effect of a supposed 'maladaptation' of 'the African'. As a matter of fact, between the 1930s and the 1950s, colonial psychiatry started to register an increase in 'mental illnesses' and to associate this presumed increase with the supposed 'acculturation' or 'deculturation' conveyed by education. Thus, in combination with theories rooted in eugenics that explained the Other's 'normality' in terms of a biological-anatomic inferiority, promoted by

eminent psychiatrists such as Antoine Porot[26] and John Colin Dixon Carothers,[27] new theories of 'deculturation' and 'clash of cultures' were developed to explain the Other's 'pathology' in terms of cultural incompatibility, in line with long standing assumptions about 'the primitive man' (Mahone 2007).

According to 1930s-1950s psychiatrists, the most frequent cause of mental illness in Africa was the modernisation brought by colonialism: without that, Africans would certainly have been *inferior*, but essentially *healthier*. Doctors Horace M. Shelley and W.H. Watson's government-commissioned report on the incidence of mental illness in Nyasaland (Malawi) in 1935 is very interesting in this regard (Vaughan 1983, 1991: 100-128; Shelley and Watson 1936). According to them, it was possible to identify the causes of illnesses by the content of people's delusions and hallucinations: the most widespread, the ones that involved riches, power positions, prohibited sexual practices, employment of Western technologies, and relationships or comparisons with white people and their living conditions could be causally linked with

[26] Antoine Porot, French psychiatrist and founder of the Algiers School, described North African people as inferior, 'simple souls' naturally destined to a 'primitive' and instinctive life, without affectivity or preoccupations, incapable of any kind of abstraction, or assumption of responsibility proper to the adult individual (see for instance Porot 1918). Indeed, the mentioned article is a clear example of the ways in which colonial psychiatry oscillated between its two poles of interest: 'normality', on the one hand, and 'pathology' on the other, with the aim of describing the 'natives' in their totality. On the Algiers school, see, among others, Keller 2007; Faranda 2012, 2020; Studer 2015.

[27] John Colin Dixon Carothers, South African born British doctor and director of the Mathari Mental Hospital in Nairobi (1938-1950), author of two fundamental works in the history of Ethnopsychiatry (Carothers 1953, 1954), explained the 'otherness' of the 'African mind', combining physiological and environmental factors: according to him, the reason behind the radical difference between Africans and Europeans (read: African inferiority) – and especially their supposed lack of 'spontaneity, foresight, tenacity, judgement and humility' and their 'inaptness' for 'abstraction and for logic' (Carothers 1953: 87 cit. in McCulloch 1995: 61) – was the 'underdevelopment of frontal lobes' in African subjects. As retraced by McCulloch (1995), in his work Carothers combined racial determinism coming from eugenics and a 'cultural' lens, that regarded environmental aspects such as family structure and a non-repressive approach towards sex as causal factors. Carothers' theories – that brought him to draw the infamous comparison between the lobotomised European and 'the African' (Carothers 1951) – were strikingly well received in the anthropological *milieu*, where he was praised by critics of the stature of Margaret Mead (McCulloch 1995: 61-62). As it is well known, the 'paucity and absurdity' (Fanon 2004 [1961]: 228) of Porot's and Carothers' racist theorisations were powerfully lit up and blasted by Frantz Fanon in *The Wretched of the Earth* (2004 [1961]: 219-233), see. also Beneduce 2007: 57-113; 2011.

'acculturation' and 'modernisation'; while the others, the ones that concerned animals, conflictual family relationships, and witchcraft were a consequence of traditional society and its 'limits'.

As noted by Vaughan (1991), these kinds of studies raise two questions. First, if modernisation, industrialisation, education, and urbanisation had indeed such negative effects on local people, what happened to the concept of 'civilising mission', with which Europeans justified their colonial enterprise? Secondly, besides the effects on the mental health of local people, could the supposed dismantlement of 'tradition' and the acquisition of a new knowledge – mediated by education and new technologies – represent a threat for European social control?

With regard to the first question, it would of course be misleading to think about colonial discourse as the expression of a coherent and consistent system. Internal contradictions were indeed constitutive of colonial power: perhaps it was not by chance that studies conveying a new image of African 'noble savages' threatened by the advent of civilisation did never openly criticise the narrative of the 'civilising mission', neither were they capable of radically putting it into question.

Concerning the second issue, Vaughan argues that researches about 'social change' in colonial countries were precisely the expression of a colonial fear, which identified modernisation as a danger for European's undisputed exercise of power: particularly, the risk of undermining traditional political hierarchies upon which colonial rule (specifically British indirect rule) could count in order to contain the potential *disorder* deep-rooted in the violence of colonialism itself. Indeed – Franz Fanon would write a few years later – *disorder* was at the core of the decolonisation projects that arose in the continent in reaction to colonisation: 'Decolonization, which sets out to change the order of the world, is clearly *an agenda for total disorder*' (Fanon 2004 [1961]: 2, emphasis added). It is no accident that in 1954 the psychiatric expertise of Dr. John C.D. Carothers – one of the most prominent theorists of the 'African Mind' (see note 27) – was put at the service of the political need to understand and repress the Mau-Mau rebellion that broke out in 1952 against British authorities in colonial Kenya. In his report, Carothers described the local uprising as a psychopathological phenomenon to be attributed to Kikuyu 'forest mentality' and the stress engendered by the transition from 'traditional' to 'modern'

culture (Carothers 1954; see also McCulloch 1995: 64-76). Not differently from what happened a century earlier, when another physician, Samuel A. Cartwright, coined the terms *drapetomania* and *dysaesthesia aethiopica*[28] to pathologise black people's efforts to escape captivity and scientifically justify slavery, in Carothers' analysis of the Mau-Mau movement, the psychopathological diagnosis of an African liberation struggle was not only the product of racist thought, but also a tool aimed at maintaining white, colonial supremacy.

What was, then, madness in colonial Africa? In line with the inherently multiple and fractured nature of the concept, in the psychiatric perspective madness in the colony was, at the same time, African normality (i.e. 'inferiority'), the African threat to colonial order (i.e. in the form of 'modernisation'), but also the mental suffering of African people engendered by the violence of the colonial encounter (i.e. new incidence of 'mental illnesses'). How did all this translate into psychiatric practice in a colony like the Gold Coast, today's Ghana, where one of the first African 'lunatic asylums' was established in the late 19th century? In other words, how was madness medicalised into 'mental illness' in colonial Ghana? Before trying to answer these questions it could be fruitful to dwell on two more, somewhat entangled, aspects: the first is the colonial assumption about the low incidence of common forms of 'mental illness' in the West (e.g. depression) among African populations due to their 'less complex' mentality; the second is the role played by experiences that *looked like* madness, but were not necessarily perceived as such, and by the local ways of managing them – experiences and practices that would become particularly relevant in the quest for an 'African way' to psychiatry in late colonial and early post-colonial years. Remarkably, as I will try to show in the next two sections, some of the most interesting and rich explorations of these two aspects came precisely from the then Gold Coast.

[28] In his speech originally presented before the Medical Association of Louisiana in 1851, Cartwright respectively defined *drapetomania* as 'the disease causing Negroes to run away' from slave masters and *Dysaesthesia Aethiopica* as 'a disease peculiar to negroes, affecting both mind and body [that] prevails among free negroes [...] that have not got some white person to direct and to take care of them' (Cartwright 2008 [1851]).

Between the 1930s and the 1960s, colonial and then early post-colonial Ghana was the research site for studies that addressed the issue of psychopathology and social change: each in its own way, they offered dissonant perspectives on the topic in partial discontinuity with dominant narratives in colonial psychiatry, paying particular attention to the social dimensions of 'mental illness' and its management. The richer and most famous among them is undoubtedly Margaret J. Field's work: though Field is probably less well known than many of her contemporaries (especially among scholars who do not work in Ghana and/or West Africa), her book *Search for Security* (1960) is a classic in the history of transcultural psychiatry and medical anthropology.[29]

After having earned a degree in Chemistry in the United Kingdom, in 1929 M.J. Field went to Ghana and started teaching at the Prince of Wales College at Achimota (Accra). She later went back to the UK, where she studied Anthropology and returned to the Gold Coast in the Thirties as a government ethnologist charged with 'various assignments of ethnographic fieldwork' (Field 1960: 13): as she reveals herself in the preface of her book (*ibidem*), it was in this period that she was struck by what she could observe in the shrines that were mushrooming in the rural areas of the country, where a lot of people sought refuge from the fear, anxiety, and ill health that they associated with witchcraft. As it is also reflected in her earlier work (1937, 1940), Field saw the people who attended these shrines as obliviously – so to speak – 'mentally ill'. At the end of the Second World War, she went back to the UK, where she obtained a medical degree at the University of Edinburgh and some training in Clinical Psychiatry, before travelling back to Ghana in 1955: with this novel professional experience, she returned to her interest in the ways in which 'mental illness' materialised in shrines and non-urban communities more

[29] A few years ago, the book was included in the *Anthropology and Medicine* 'Canon' series, aimed at publishing 'reappraisal[s] of a past text of what may be considered (unfashionably) canonical, classical or at least of continuing interest in medical anthropology or cultural psychiatry' (Editorial note, Littlewood 2010): see Littlewood 2017.

generally.[30] At the core of her study, conducted in the Ashanti Region, there is a phenomenon – or rather a constellation of phenomena – with which colonial officers had long been trying to deal with throughout the continent: 'witchcraft', which was at the same time an epistemological, political, and juridical preoccupation. To the eyes of colonial administrators, witchcraft was a 'primitive', irrational, and unreal phenomenon. Yet the rationality[31] and 'mental health' of those who conceived of it as *real* could not easily be denied (e.g. in the form of 'legal insanity', see Waller 2003: 249). Yet this delusive 'belief' and the accusations and ordeals connected to it kept claiming victims. As many showed with regards to different contexts in the whole continent, British colonial law,[32] in order to contain the phenomenon, tended to punish those who considered themselves as the victims rather than the perpetrators (see, for instance, Melland 1935; Orde Browne 1935; Fields 1982; Gray 2001; Waller 2003; Vasconi 2017): generally, colonial acts prohibited ordeals and accusations, on the one hand, and, on the other hand, they targeted the whole complex of anti-witchcraft practices performed by healers and

[30] Aside from the pieces of biographical information provided by Field (1960: 13-15), see Osei et al. (2021: 21); Littlewood (2017: 236); and McCulloch (1995: 112).

[31] The most famous colonial analysis of the 'rationality' of witchcraft as a system of thought is of course Edward E. Evans-Pritchard's *Witchcraft, Oracles, and Magic among the Azande* (1937), which set a milestone in the history of the concept as an anthropological object. A classic topic in the discipline since the 1930s, witchcraft notoriously regained its popularity in the 1980s and 1990s through the work of scholars who defied the Weberian notion of the 'disenchantment of the world' as the core of modernity, by connecting witchcraft precisely to the latter (Comaroff and Comaroff 1993; Geschiere 1997; Meyer and Pels 2003; Moore and Sanders 2006).

[32] As pointed out by Vasconi (2017: 84 and ff.), all the laws issued in the different British colonies between 1912 and 1957 in order to criminalise 'witchcraft' – inspired by the 1736 Act that marked the end of the witch-hunt in Britain – were based on the definition provided by the Encyclopaedia of Laws of England (1907): 'Witchcraft maybe taken to include any claim of a power to produce effects by supernatural causes. By whatever name this alleged power might be called in any particular case, whether witchcraft, conjuration, sorcery, incantation, divination, or magic, the legal consequences attaching to its supposed exercise were usually the same [...] Sorcery is a convenient crime to fix upon those who had no other. [...] In the present state of the law pretended supernatural powers may be such as to bring those professing them under the criminal law, or to avoid an alienation of property caused in their belief in their existence [...]'.

'witch doctors' who were somehow guilty of making witchcraft 'real'. In this scenario, the Gold Coast initially represented an exception because until the early 1930s it was the only British colony where the practice of witchcraft itself was identified as a crime (Gray 2001). In 1930, however, the *Native Custom (Witch and Wizard finding) Order (N. 28)* imposed the same anti-witchcraft measures that were common in the rest of the colonies, thus criminalising witch-finding and witchcraft accusations and paradoxically encouraging the phenomenon of confession documented by Field (see also Brivio 2018). As suggested by Richard Waller about colonial anti-witchcraft legislation in Kenya, 'it was the question of "reason" that was at the heart of the difficulties in prosecuting witch killers' (Waller 2003: 249). In other words, similarly to what happened within the field of colonial psychiatry, in the conundrums of anti-witchcraft legislation it was once again the ambiguous category of 'African reason' to be called into question (cf. also Vaughan 1991).[33] In her research, Field dealt with both witchcraft and madness, but addressed them in a novel perspective.

Distancing herself from the key colonial preoccupation of defining the psyche of 'the African' against 'reason', Field (1960) presented almost one hundred and fifty clinical cases divided in thirteen chapters, each corresponding to a Western psychiatric category (including depression, anxiety, schizophrenia, paranoia, psychosis, obsessive-compulsive disorder): in most of them witchcraft is present and deeply entangled with different forms of mental suffering. The anthropologist-physician justified her choice of a psychiatric classification criterion, rather than an 'ethnological' one, as a means to avoid the risk of adopting 'hopelessly heterogenous'

[33] In this perspective, it is interesting to mention a 1930 petition by J.B. Danquah, lawyer of the head priest of Suhum (Eastern Region) Tongo shrine Kobina Assifu, very popular for his anti-witchcraft activities, to Governor Ransford Slater. In the text of the petition reported by Gray (2001), Danquah argued that, while respecting the new *Native Custom (Witch and Wizard finding) Order (N. 28)*, people who voluntary wanted to resort to the shrine in order to seek protection from witchcraft or get rid of unwanted powers should be allowed to do so. Adopting the language and to a certain extent the perspective of colonial administrators, the lawyer established a comparison between the witchdoctor and the psychoanalyst: according to him, the new anti-witchcraft legislation risked to 'result in people being put into fear of their lives as the influence that witches and wizards have upon them without having the right, under the Order in Council to consult a legitimate native doctor versed in the practices of witchcraft to analyze the cause of the person's troubles *by a process of psycho-analysis*, and to find remedies for the BELIEF, whether groundless, *hallucinatory* or not' (Gray 2001: 359, emphasis added).

categories: the heading 'witchcraft cases', for instance, would have embraced a very large number of different medical conditions (Field 1960: 148). Her choice, however, made more evident the challenge that her work posed to mainstream colonial psychiatric conceptions about the incidence of mental illnesses in Africa. Indeed, in the years in which Field carried out her research, it was widespread opinion that a pathology like depression could not be found in Africa, because of the supposed simplicity of the everyday life and mind of 'the African', as it was described by Carothers and his acolytes. This narrative, perhaps still present in Western stereotypes about 'life in Africa' implicitly or explicitly drawing on the myth of the 'noble savage', was contradicted by Field: according to her, not only did depression exist 'in Africa', but it was the 'commonest mental illness of Akan rural women' (Field 1960: 149). Hidden to the eyes of European psychiatrists who only saw patients in institutional settings, depression was not perceived by the women she met and the people around them as an 'illness' precisely because of the deep correlation that existed between their condition and witchcraft. The latter was, according to Field, an idiom that allowed patients to express their existential and everyday suffering: their condition had to do with ordinary problems and desires, but was also a historical product that could only be understood in light of the many changes that had invested the area. Far from proposing a 'culture clash' kind of reading – an interpretative framework that she overtly refused (1960: 52-54) – Field put social and economic change – e.g. the intensification and commercialisation of cocoa agriculture and the introduction of industrial mining – at the centre of her reflection, without describing it neither as a form of emancipation from 'primitive life' nor as a form of corruption of local culture, but focussing instead on the growing sense of precarity and insecurity attached to it.

Though Field's work could be – and has been – criticised for its excessively functionalist and medicalising approach towards witchcraft, it is important to point out how innovative it was in the milieu of colonial psychiatry: carried out outside of medical institutions, her research proposed a focus on non-institutionalised experiences of mental suffering that were generally ignored and/or considered absent from the continent. By doing so, not only did she challenge colonial assumptions about the inferiority of 'the African mind' and employed Western psychiatric nosology to describe the experiences of the patients she met at Ghanaian shrines, but she also refused to generalise the results of her ethnographic investigation carried out in 'a very

small corner of a continent racially and culturally heterogeneous' in terms of an 'us vs. them' perspective ('Do primitive people have the same mental illnesses as ourselves?') (Field 1960: 148): from this perspective, her work could be read as anticipating many of the conundrums and contradictions conveyed by the emergence of a universalist approach in global psychiatry as an attempt to overcome the racism of its colonial roots in times of decolonisation (Antić 2021a, 2022).

In the same period, another researcher's work in the Gold Coast would have come to challenge dominant assumptions in colonial psychiatry, especially those regarding the supposed low incidence of mental illness in Africa and the causal relation linking urbanisation/education to the rise of mental illness cases. According to Geoffrey Tooth, who in the 1940s studied the effects of sleeping sickness on Gold Coasters' mental health on behalf of the Colonial Office, no empirical data supported the thesis of an increased incidence of mental pathologies among 'westernised' Africans (Tooth 1950). Similarly to what Field would have later said about the depression-witchcraft nexus, Tooth seemed to suggest that the problem lay in the European gaze. Europeans tended to focus their attention on what they recognised as clear manifestations of mental illness, such as the markedly antisocial behaviours of people affected by schizophrenia in the city. 'Mentally ill' villagers, on the contrary, were consistently less visible, thanks to their embeddedness in communities that could effectively take care of them.

A decade later, in the 1960s, anthropologist Meyer Fortes and psychiatrist Doris Y. Mayer conducted a brief investigation on the relation between psychosis and social change among Tallensi communities in Northern Ghana, an area where Fortes had been carrying out fieldwork research since the 1930s. Fortes rejected the possibility of having overlooked, thirty years earlier, manifestations of mental illness comparable to those he observed in the 1960s ('since sufferers are never hidden to public knowledge', Mayer and Fortes 1966: 22). The anthropologist also denied that, due to difficult living conditions, psychotics were destined to a premature death and

therefore less visible ('food and shelter were always available to a madman even if he was so violent as to require putting "in log"', *ivi*: 23).[34] The author then, wrote:

> Alternatively, it might be that there were, in the past, as many people predisposed to psychosis as now, but that the traditional way of life and social organization, at that time hardly affected by the outside world, was either free of the stresses that precipitate psychosis nowadays or effectively cushioned them. Dr Mayer and I can give no conclusive answer to this question. (...) It is hardly to be doubted that there is a connection between the high incidence of psychosis among Tallensi to-day, as compared with a generation ago, and the changes that have taken place in their conditions of life during recent years (*ivi*: 23, emphasis added).

According to Fortes and Mayer, then, the increase of mental health cases was an indisputable fact, and its heightened incidence on people who experienced life in far away and urban contexts (southern Ghana) indicated that the social changes shaping the area had some kind of influence over pathologic phenomena. Not necessarily over their onset, but surely over their exacerbation.

Moving away from established colonial theorisations, though not in total discontinuity with them and sometimes with the risk of romanticising and essentialising 'traditional life' (as it is evident in Mayer and Fortes' words quoted above), these studies shifted the attention from the structure of the 'African mind' and its supposed incompatibility with 'European culture' and proposed a more layered and complex idea of social change that did not ignore the social dimension of mental suffering and the crucial role played by non-institutional and non-psychiatric forms of care at the community level. In a similarly dissonant, but also quite divergent and definitely more political perspective, the same issues were addressed in a movie shot in Accra in the 1950s, a movie that would have become one of the most watched and

[34] More than a decade later, observing the same phenomenon in the context of Nzemaland, but suggesting a slightly different conclusion, Vinigi Grottanelli, after having stated that *ɛzɛlɛ* is 'a furious kind of madness, usually caused by a ghost or a god for serious reasons. The most common feature of this last type of madness is the unrestrained habit of walking around naked, something that does not make the person fit for being left alone in freedom' (see note 1), incidentally adds that 'though it seldom happens that these persons commit crimes or create serious disorder, their relatives usually keep them locked up. For this reason, it is infrequent to meet a madman in the streets of the village or on the paths in the forest (Grottanelli 1978: 266, my translation).

discussed ethnographic documentaries of all time: *Les maîtres fous* by French anthropologist and filmmaker Jean Rouch.

The Hauka in front of the Accra Mental Hospital: mental illness and 'the mastery of madness'

> And looking at these smiling faces, learning that these men are perhaps the best labourers of the *Waterworks* team, comparing these faces with those horrible faces of the day before, we cannot help but ask ourselves whether these men of Africa know certain remedies that make it possible for them not to be abnormal, but to be perfectly integrated in their environment – some remedies that we ourselves do not yet know (Rouch 1955, *Les Les maîtres fous*, my translation).

Jean Rouch's haunting comment at the end of his famous film *Les maîtres fous* (*The Mad Masters)* powerfully sums up many of the ambiguities entailed by the concept of madness in the colony. The film, shot in 1954 – the same year in which Carothers proposed his psychopathological interpretation of the Mau-Mau rebellion – is about the annual celebration of a spirit possession ritual recorded among a group of Nigerien migrants residing in Accra: the ritual was an expression of the Hauka cult originated in Niger in the 1920s, in which people were possessed by the spirits of French colonial officers. Hauka practices were characterised by a pronounced violence and an evident embodiment of colonial aesthetics of power. In the last sequence of the film, Rouch shows to the audience the same individuals who had previously appeared possessed and distorted by Hauka spirits in their everyday life. They are smiling and working, like *normal* people: carrying loads at the market, conversing among themselves, playing cards, waiting for prey to rob. 'By an extraordinary chance' – Rouch's narrating voice points out – the Hauka *état-majeur* works in front of the Accra Mental Hospital. But they are *outside* of it: they looked mad (*anormaux*) when they were possessed by colonial spirits, but actually they are not, they are 'perfectly integrated in their environment' (Rouch 1955).

The film was highly controversial. As retraced by anthropologist James Ferguson (2002), *Les maîtres fous* was seen by many scholars (see, among others, Stoller 1994; Taussig 1993: 236-255) as the symbol of African *agency* and resistance to colonial power through imitation and irony – what Homi Bhabha called 'mimicry and mockery' (Bhabha 2004 [1994]: 123). However, when

the film was released not only was it contested and banned by the British government as threatening colonial authority, it was also severely criticised by African students who watched it in Paris in 1954 and accused Rouch of 'racist exoticism' (Ferguson 2002: 557). From this perspective, the film seemed to suggest that the only possibility for 'African modernity' was that grotesque and *mad* version of it: in an apparent collapse of the colonial categories of madness discussed above, the protagonists seemed both 'insufficiently Other' and 'insufficiently modern'.

Indeed, Rouch opened the film with the following written description: 'Come from the bush to the cities of black Africa, some young men collide with mechanical civilisation. Thus, conflicts and new religions arise. Thus, around 1927, the Hauka sect was formed. [...] no scene of it is forbidden or secret, but open to those who are willing to play the game. And this violent game is nothing but a reflection of our civilisation' (Rouch 1955, my translation). *Les maîtres fous* proposed a narrative of social change in the colony as entrenched with the experience of madness: not differently from the studies carried out in the Gold Coast explored above, the movie's narrative distanced itself from orthodox colonial representations of reason and madness, but at the same time could still echo the essentialism of colonial 'deculturation' and 'acculturation' theories – as some of the harsh reactions it sparked clearly reveal. To a closer reading (and viewing), however, it is difficult to deny that there is more to it: differently from those analyses that took the category of 'mental illness' as point of departure, Rouch's movie embraces the category of 'madness' as something different from its psychiatrised equivalent, as if there was an invisible boundary separating the two, the same boundary that separated the Hauka working *in front* of the psychiatric hospital and the people who were *inside* of it at the end of the documentary.

On the one hand, the employment of the category of madness instead of 'mental illness' is what allowed Rouch to offer an overtly political perspective on social change and the spirit possession ritual he had the chance to observe: the 'violent game' we are invited to watch as European spectators is a reflection of 'our civilisation', in other words colonialism *is* madness, as Frantz Fanon was suggesting in those same years (Fanon 2008 [1952]; see Vaughan 1993, 2007).[35] On the other hand, however, the concluding words quoted at the beginning of this

[35] For a divergent and provocative actualisation of the 'colonialism as madness' metaphor, see La Marr Jurelle Bruce's brief discussion of 'the madness of antiblackness' (2021: 27-29).

section shift the interpretative focus to the therapeutic dimension of the ritual and its capacity of successfully managing a form of suffering that is not only social, but also potentially individual. In this perspective, spirit possession could be described as an 'apparent madness' (*those horrible faces of the day before*) actually capable of 'mastering madness': an alternative to both 'mental illness' and psychiatry.

It is not easy to combine, nor to disentangle actually, a political reading of *Les maîtres fous* and a 'therapeutic' one and both may run the risk of being reductive (Colleyn 2019), as it happens more generally with regards to the phenomenon of spirit possession portrayed in the movie (Olivier de Sardan 1993, 1994). It is not possible, perhaps, to give a singular, univocal interpretation of Rouch's multilayered film, privileging one reading over the other and denying its implicit contradictions. Perhaps, we could accept that if, as suggested by Roberto Beneduce and Simona Taliani, 'spirit possession cults *do and say many things* at the same time by virtue of the structural many-sidedness of their dispositif' (Beneduce and Taliani 2001: 17, my translation, emphasis in the original), by immersing the viewer in a spirit possession ritual and its aftermath, *Les maîtres fous* does the same thing(s): it *does and says many things at the same time*. Exploring the multiple meanings of madness in the colony, the movie points our attention towards the violence of colonial (and neocolonial) power, the challenges to that power and its conceptual foundations, the possibility of mental suffering, and local forms of suffering management that play with the invisible and the corporal.

It is quite telling that, with its rapid appearance at the end of the film, the psychiatric hospital is on the backdrop of this complex representation: it is separate, but *at the same time* it is there.

The institutionalisation of madness in Ghana

From the Victoriaborg Lunatic Asylum to the Accra Psychiatric Hospital

While the influence of urban hygiene studies on the birth of 'public health' is direct and easily retraceable, the link between colonial theories of mental illness and the institution of asylums is not more oblique.

First of all, it is worth reminding that colonial asylums were mainly intended for detaining and restraining mentally ill people, rather than curing them. This detail may lead us to conclude that they represented a key instrument of political control, but in reality, despite the political influence exerted by Carothers's psychiatric theories on 'African inferiority' in the metropole, asylums turned out to be quite marginal in colonial policies: 'In other words, in Africa there was no Foucauldian "Great Confinement"' (Vaughan 1991: 120; see also Swartz 2010).

As highlighted by Vaughan (in line with the works by Field, Tooth, and Mayer and Fortes), colonial governments did not have any interest in directing precious resources toward psychiatric institutions when mentally ill people could simply stay with their families and communities, as long as they did not pose a threat to security (the 'criminally insane'). Colonial asylums, then, were mostly a public order tool used to contain 'extreme' situations.

As retraced by Nana Osei Quarshie (2011-2012; see also Osei et al. 2021: 32), the first asylum instituted in the Gold Coast was the Victoriaborg Lunatic Asylum (also known as Public Lunatic Asylum, see Quarshie 2011-2012: 192) established in 1887 on the grounds of the old High Court in Victoriaborg, central Accra. One year later, in 1888, the then acting governor William Brandford Griffith signed the *Lunatic Asylum Ordinance*,[36] which, in line with British legislation, legitimised the Victoriaborg asylum as a special institution aimed at 'providing for the custody of lunatics' and regulated the 'detention, examination, and "certification"' of people deemed as mentally ill (Read 2020: § 3.3., ebook). As a matter of fact, up to then, the juridical treatment of 'lunatics' – defined as a category of people 'including idiots and persons with unsound mind' – was regulated by the 'Prisons ordinance, 1876', which established that people defined as such should be arrested and confined in prison together with convicted criminals (Osei et al. 2021: 31).

[36] Due to the scarcity of studies on the history of psychiatry in the Gold Coast conducted on primary sources (especially when compared to other African countries), many, drawing exclusively on Forster (1962), wrongly attribute the institution of the asylum in Victoriaborg to the *Lunatic Asylum Ordinance* and consequently date it in 1888 (Quarshie 2011-2012: 191-196).

According to Edward Francis Bani Forster (1962a) – the first African psychiatrist[37] to be assigned, in 1951, to the Accra Mental Hospital[38] – by the early 1900s the Victoriaborg Lunatic Asylum had proved already inadequate to host the growing numbers of 'patients' who were de-facto 'inmates': they were not subjected to any type of therapeutic intervention and were forced to work to keep the institution going,[39] while staff duties were limited to supervising the feeding and physical health of inmates.

In other words, as argued by Quarshie (2011-2012), the kind of treatment the Victoriaborg Lunatic Asylum 'offered' to its patients was a form of 'moral treatment', that – as proved by its 'patients' death and discharge rates (considerably high the former and low the latter) – was completely inefficient in therapeutic terms, but allowed colonial institutions to benefit from the 'lunatics'' free labour.

The Accra Mental Hospital we see in the final scene of *Les maîtres fous* (later renamed Psychiatric Hospital) was built at the border between the Adabraka neighbourhood and what would later be known as Asylum Down in 1906, in order to overcome the chronic overcrowding of the Victoriaborg institution. The first patients arrived in 1907. The original structure consisted of four wards: a general one and a criminal one for each sex, with a total capacity of 200.[40] Like its predecessor, the hospital was mainly aimed at detaining people, so much that the visiting doctor was the same professional in charge of Accra's prisons. 'Patients' had to prepare their own meals and cultivated vegetables in the yard under the wardens' supervision. Those deemed as too violent were chained or put into isolation cells, while the others were subjected to

[37] Forster was born in Gambia, attended high school in Sierra Leone and went to Europe for his university degree. He earned his degree in Medicine from Trinity College, Dublin and specialised as a psychiatrist at London's Institute of Psychiatry (Osei et al. 2021: 41-43).

[38] How the institution would subsequently be renamed.

[39] As convincingly contended by Quarshie (2011-2012), the kind of labour the confined 'lunatics' were required and forced to do changed according to their gender: while men were employed in farming activities, women had to do the laundry.

[40] Starting from 1929, the colonial administration embarked on a series of structural works to face the constant overcrowding issue, expanding the total number of wards to twenty-five, with a total capacity of 600 patients (Kpobi et al. 2014; see also Osei et al. 2021).

an early form of treatment, that is the administration of 'chiefly arsenical' drugs (Forster 1962a: 26).[41]

'A bright future'? Psychiatry in times of decolonisation

In 1951, when Forster became director,[42] the hospital was gradually reconfigured into a site of care promising to absolve an eminently therapeutic function. During this new phase, psychotropic drugs and electro-convulsive therapy started to take on a central role, in accordance with the *Chlorpromazine*-fueled 'sedative revolution' of the early 1950s that (at least formally) swapped physical chains for chemical ones. At the time of Forster's arrival, the Accra Mental Hospital was still the only psychiatric institution in the country, but patients kept increasing every year. In 1960, President Kwame Nkrumah, the Pan-Africanist leader who three years earlier had led the country to independence, commissioned an asylum annex in Atimpoku (Eastern Region) in order to ease the pressure of chronically ill patients on the Accra Psychiatric Hospital. The two remaining psychiatric hospitals of Ghana, the Ankaful Psychiatric Hospital in Cape Coast (Central Region) and the Pantang Hospital in Accra, were only established in 1965 and 1975 respectively.[43] Meanwhile, in the wake of independence, Ghanaians had started going abroad to study psychiatry in the United Kingdom, the United States, and Canada (Forster 1962a; Read 2020). Very soon, the very same psychiatric infrastructure set up by the colonial government would be run by the elite of a growing local middle class.

During the same years, Forster organised and began directing the Department of Psychiatry, which would have joined the Medical School in 1962. In line with his double role as director,

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[41] Forster (*ibidem*) reports that this form of treatment was described at the time as 'exhibition of mind suiting drugs'.

[42] Among those who preceded him it is worth remembering Dr. F. Maclagan, a general practitioner who directed the Accra Mental Hospital from 1929 to 1942. He was the main architect of those internal reforms that 'chang[ed] the institution from an asylum to a hospital' (Kpobi et al. 2014: 5; Osei et al. 2021).

[43] When the Atimpoku annex closed down, its patients were transferred to Ankaful (Kpobi et al. 2014).

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Forster made the Accra Mental Hospital the home of the Department.[44] Though this was a period of great changes, psychiatry kept occupying a marginal position as compared to other areas of biomedicine within the general health sector. [45]

In the new 'imaginary' informed by the colonial experience, as well as by its eventual ending, postcolonial states reconfigured themselves as 'organizer[s] of public happiness' (Mbembe 2001: 31). Within that imaginary, the health system laid its foundation on the institutionalisation of health as a right of every citizen, and took a key role in defining the features of the modern African state: starting from the 1950s, in Ghana (as well in the rest of the continent), a series of measures and reforms were put in place in order to redefine health policies (Schirripa 2005; Vasconi 2020). It is worth reminding that those measures could only be understood against the backdrop of a global process spearheaded by international organisations such as the WHO and the World Bank, and in the following decades by NGOs and state-led decentralised cooperation.

Up until recently, however, psychiatry and mental health had been largely ignored by this renovation process: suffice it to say that the *Lunatic Asylum Ordinance*, the 19th century colonial law regulating all mental health matters, remained in effect until 1972.

'The future of psychiatry in Ghana is bright – wrote Forster in 1962 – because of the proposed improved facilities for the care and treatment of the mentally disturbed, but also

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[44] Forster remained in charge of the Accra Mental Hospital until 1971 (Osei et al. 2021: 45).

[45] For a colonial history of the affirmation of biomedicine and biomedical institutions in the Gold Coast see Addae 1997; Schirripa 2005; Vasconi 2012, 2020. As summarised by Vasconi (2012: 94 ff.), the history of biomedicine in the Gold Coast/Ghana could be divided into four different phases.
1) 1880-1919: foundation of the administrative machine and of medical services.
2) 1920-1930 (marked by the 1923 opening of the Gold Coast Hospital, or Korle Bu, which would become the most important medical institution and teaching hospital of the country): inauguration of a new policy and health discourse aimed at safeguarding the health (and the efficiency) of the local workforce, by extending access to public health to the whole population.
3) 1931-1959: slowdown of medical activities due to the 1930s economic depression and the establishment of rural of Health Centres managed by Native Authorities in order to contrast the inadequacy of existing structures (dispensaries and medical stores); building of new medical institutions during the 1940s and consolidation of their administration.
4) 1951-1960: start of a campaign aimed at raising awareness among the local population on themes such as hygiene and disease prevention; acquisition of the Medical Department by the Ministry of Health. Establishment of a new 'health system' paradigm; recruitment of local staff in medical institutions.

because among the population there is now an increasing awareness of the services that psychiatry offers' (Forster 1962a: 28).[46] But reality would have proven much more complicated than the Director of the Accra Mental Hospital had hoped.

In fact, beyond the optimism shown in his 'Survey of Psychiatric Practice in Ghana', Forster himself was fully aware of the complexity of the situation. In the same text, the author stated the mission of psychiatry and the obstacles it encountered in the Ghanaian context. If the discipline was meant to 're-educating people in the whole sphere of inter-personal relationships in such a way as to give them insight into their own behaviour and that of others' (*ibidem*) the task would be anything but easy. According to him, the main interferences that early 1960s psychiatry would have had to overcome were the following:

1) What Forster called 'extensive development programme and industrialization scheme' (*ibidem*), which represented the main cause behind the massive migration of workforce from rural to urban areas. According to him, moving to de-facto 'foreign' areas of the country was the main cause behind the rise of psychopathologies in Ghana, not only for the stress and tension that characterised city life, but also for the difficulties of adapting to a constantly changing environment.[47]

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[46] It is interesting to notice how the psychiatrist forecast – or wish, to better say– continues: 'It may also be expected that the all round improvement in the general health of the population by the provision of good housing, good water supply and adequate food, together with the intensification of agricultural production and the diversification of industry to minimise migration of wage labour, will contribute a great deal to modify stresses and tensions and thereby reduce the incidence of mental illness in Ghana' (*ivi*: 28-29). Firstly, Forster links the desired reduction of mental cases to a general improvement of health conditions, two parameters that until then had been kept separated. Secondly, the author builds on the interpretative trend inaugurated by Field, Tooth, and Fortes and Mayer, which connected the increase in mental pathologies to the stress and the insecurity generated by social changes, putting a particular stress on the element of migration as displacement from village to city.

[47] See previous note. It is worth reminding that Forster, while often pointing out the enormous difference between rural and urban life as one of the root causes of mental illness in Ghana, did not rely on an abstract theory of 'culture shock', nor did he oppose an alleged 'local' lifestyle to a 'westernised' one. If on one hand he highlighted the complexity of the cultural issue, stressing the existence of internal differences and rejecting any form of simplification, on the other hand he signalled the centrality of economic, social and political dimensions, and their dynamism.

2) The absence of structures capable of taking care of patients across all the national territory. In addition to the overcrowding issue, the fact that seeking psychiatric care often meant moving (again) to a completely new environment was seen by Forster as a major problem, one that required immediate attention. The psychiatrist suggested a plan to establish a number of minor hospitals (with a capacity of 250-300 patients) in every region of the country.

3) The shortage of psychiatrists and specialised staff, and the issue of their training.[48] Even though Forster was well aware of the centrality of the cultural dimension in relation to mental illness,[49] he did not think that African psychiatrists had to undergo a specific training ('with an African culture bias') differing from the Western/international one, partly because he challenged the homogenising idea of a singular 'African culture', partly because he found indesirable to be 'cut off from the rest of global psychiatry' (Forster 1962a: 28). Indeed, as argued by Read (2020: § 4.2, ebook), 'Forster saw his role as bringing scientific reason and humane treatment and rescuing persons with mental illness from the "charlatans" who punished patients considered to be "agents of the demons"' (Forster 1962a: 25, cit. *ibidem*). Nevertheless, the Director of the Accra Mental Hospital thought it was auspicable to integrate psychiatric training with the study of anthropology, social psychology, and transcultural psychiatry. He believed that psychiatrists, being Africans or non-Africans, would have benefitted from a six-month orientation course on the 'cultural structures and infrastructures' of the country where they were required to operate.

As highlighted by historian Ana Antić (2021b; cf. also Wu 2021), and as it partially emerges from Forster's opposition to a specific 'African-biassed' training for African psychiatrists, the decolonisation era was a key moment for the emergence of the 'global psyche' and the development of the universalist transcultural psychiatry now at the core of current formulations of global mental health (White et al. 2017; Lovell et al. 2019; Béhague and MacLeish 2020). Forster's work places itself within this framework, chasing an African way to psychiatry capable

[48] The paper ends with an appeal for psychiatrists to come and conduct even short periods of research in the country, given the scarce number of psychiatrists in the whole continent.

[49] 'The fact that certain neuroses which do not respond to Western therapeutic methods react rapidly and in a satisfactory manner to native psychotherapeutic measures, demonstrates the importance of social values in the domain of psychotherapy' (Forster 1962: 28).

of cutting the ties with the general racist assumptions about 'the African Mind' (Carothers 1953) that had informed colonial psychiatry until then and insisting at the same time on the universalist nature of the discipline (Read 2020; see also Antić 2021a). In other words, in times of decolonisation psychiatrists working in Africa and other non-western contexts were increasingly answering 'yes' to the question Margaret Field refused to reply to (i.e. *Do they have the same mental illnesses as ourselves?*).[50] On the other hand, Forster's position should be understood in the broader framework of a problematic relationship with local healing practices that in the postcolonial period could not be but complex and ambivalent, having to deal at the same time with contemporary ideals of 'modernisation' – declined for instance in a country like newly independent Ghana both in Pan-africanist and socialist terms –,[51] the heavy legacies of Christian missionary activities and colonialism – which had criminalised and denigrated under the same label of 'witchcraft' a multiplicity of practices associated with traditional healing and local epistemologies (see also Chapter 2) –, and the proud claim of traditional cosmologies that had long been discredited as 'primitive'. In Ghana for instance, President and Pan-Africanist leader Kwame Nkrumah maintained, as he wrote in his unfinished PhD thesis titled *Mind and thought in primitive society: a study in ethno-philosophy with special reference to the Akan People of the Gold Coast, West Africa*, that 'when the psychology of Fetishism comes to be written it will be found that it does not fall behind other religions of the world in philosophy and practice, and therefore the mind that created it cannot be inferior to any other mind' (cit. in Osseo-Asare 2016:83). In line with this worldview and within the broader scheme of his nation building project, Nkrumah actively promoted, long before traditional medicine recognition and professionalisation became a buzzword in World Health Organisation policy in the late 1970s, the creation of the Ghana Psychic and Traditional Healers Association (GPTHA), which aimed at emancipating healers from colonial biases by legitimising the role of both herbalists and

[50] Except for the designation of 'them' (African individuals) as 'primitive' (Field 1960: 148, see above), which could finally be rejected and written off.

[51] On the complex influences of Pan-Africanist and socialist thought on postcolonial conceptualisations of traditional medicine and its contradictory re-appreciation in Africa, see for instance Langwick 2010, 2011; Tilley 2021.

priests/diviners[52] (Osseo-Asare 2016, Twumasi and Warren 1998; on the legitimation process and the aftermaths of Nkrumah's initiative, see also Chapter 2).

The ambivalence towards traditional healing practices was very evident in the field of mental health, where after the independence – as suggested by Yolana Pringle expanding on a statement put forward by Alice Bullard on Senegal – in different parts of the African continent 'colonial psychiatry transformed into a diverse range of practices, ranging from collaborations with traditional healing to biomedical, pharmaceutical-based psychiatry' (Bullard 2007: 197 cit. in Pringle 2019: 9). Indeed, those were the years in which, in some African contexts at the dawn of decolonisation, radical experiments were being carried out with the same aim of Africanising psychiatry and attempting to dismantle its colonial foundations that animated Forster's practice, but with an approach quite different from his own. This was the case, for instance, of Nigerian psychiatrist Thomas Lambo in Nigeria (Heaton 2013) and French psychiatrist Henry Collomb in Senegal (Kilroy-Marac 2019), who both tried to combine psychiatry with local forms of knowledge and non-biomedical practices of healing (see also, among others, Beneduce 2012: 147-182; Antić 2021a). Become director of the Abeokuta Aro Hospital for Nervous Diseases in 1950, Lambo tried to incorporate local healers within the therapeutic practice of the hospital, proposing a model of 'village psychiatry', that instead of conceiving of the resource of community care as an alternative to psychiatric treatment – as it was the case also in innovative studies like the ones carried out by Tooth and Field, for instance – aimed at combining the two and avoiding the risk of atomising patients from their social context and horizon of meaning. Similarly, appointed director of the Fann Psychiatric Hospital in Dakar in 1959, Collomb proposed to embed local forms of healing and management of mental suffering within the hospital environment, actively collaborating with local practitioners as well as other non-biomedical professionals interested in exploring the cultural dimensions of madness (e.g.

[52] As stated by a healer of the time: 'It is a great honour for the herbalists, Priests and Priestesses that now Government has allow[ed] us to perform [our] practice, our work in public and to help the Nation.' (Osseo-Asare 2016: 84).

anthropologists, psychoanalysts, philosophers).[53] As it emerges clearly in the mentioned works dedicated to these 'experiments' and to the emerging field of transcultural psychiatry (in the multiplicity of its strands) more generally, the relationship with 'traditional' and non-western cosmologies and practices is marked by a constant tension between claims of universalism and cultural difference, with a lurking risk of reductionism in both directions (cf. Antić 2021b).[54]

A longer article published by Forster in the *American Journal of Psychotherapy* in 1962 in the newly inaugurated section 'Psychiatry in a changing world' – precisely aimed at collecting different perspectives on 'the adaptability of the popular, prevalent theories of etiology, psychodynamics, and psychotherapy to [...] specific culture[s]' (Lesse 1962) – is a clear example of these ambivalences and tensions. In a specific section dedicated to 'native doctors', the Gambian psychiatrist condemns traditional healers' inhumane practices and their ineffectiveness 'in dealing with the psychotic patient', but at the same time he recognises that as far as the psychoneurotic patients are concerned, those suffering from hysterical reactions, obsessions, and phobias,

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[53] Collomb's work at Fann was completely in line with President Léopold Sédhar Senghor's broader project of founding the newly independent state on its 'cultural' roots through the *Négritude* paradigm (Kilroy-Marac 2019).

[54] As retraced by Simona Taliani (2016), a profound ambivalence toward the cultural worlds of traditional healing can be found also in Frantz Fanon's work, which has been sometimes too easily blamed of cultural reductionism and essentialism and ungenerously likened to both colonial psychiatry and culturalist drifts in French postcolonial ethnopsychiatry. The place of 'traditional' culture was a key issue in the Martinican psychiatrist's reflection, it changed over time, and it emerged strongly as a problematic element in his fierce critique of Senghor's *Négritude* as an essentializing and depoliticizing ideology (Fanon 2004 [1961]). In his theoretical and pragmatic itinerary as a psychiatrist, an intellectual, and an activist, the unstable balance between universalism and cultural difference is further complexified by his political commitment to liberation and its urgence: in the last phase of his tragically short life, with the national liberation struggle becoming more violent, he started writing more explicitly of 'beliefs' and 'superstitions' as obstacles to liberation and healing for colonised people, *the wretched of the earth* (Taliani 2016). In her book and a more recent article published in *Africa is a Country* (2019, 2020), Katie Kilroy-Marac speculatively reflects on a letter that Fanon *supposedly* – because no one ever found it in archives or claimed to have seen it – sent to Senghor in 1953, asking for a job in Dakar: what would 'Fanon's Fann' have looked like if the future President of Senegal had answered positively? It would be interesting to entangle Kilroy-Marac's analysis of the potential of that unanswered letter for the future of Senegalese psychiatry *and* society with Taliani's reflections on the incoherences, contradictions, and changes in Fanon's approach towards 'culture' and non-biomedical forms of healing: what impact would that missed encounter have had on the transcultural psychiatry of the future?

and psychosomatic disorders can be relieved of their symptoms by the native doctors. In all this cases the fundamental belief in the effects of juju,[55] witchcraft, taboos, and performance of customary rites is effective [...] The native doctors have a definite place in the management of those emotional reactions which have a strong cultural overtone. It is possible that it is because of this that some psychiatrists advocate their continued existence (Lambo), and patronize their treatment (Tigani El Mahi)[56] (Forster 1962b: 43-44).

Quite interestingly, at the end of the section he reports the extract of a letter he received from a traditional healer, who claimed to be capable of curing people suffering from 'madness, insane or lunatic' and asked 'for employment as a native doctor in the Ghana asylum' (*ibidem*). Forster does not further comment on the received application and the reason why he included the letter in the section is not completely clear. It seems to stand there as a *possibility*, we don't know if it remained unanswered but it definitely did not convert in a stable employment relationship. Indeed – though Osei and colleagues (Osei et al. 2021: 43) report an interesting and apparently isolate episode in which a traditional priestess was invited by Forster to treat ten patients who were diagnosed as affected by schizophrenia at the Accra Psychiatric Hospital, leaving just a couple of weeks later – in Ghana psychiatry and non biomedical understandings of madness would have long remained formally separated.

The 1970s, the Mental Health Decree *, and therapeutic pluralism*

At the very beginning of the 1970s, before the passing of the new Mental Health Decree that tried for the first time since colonial times to reform mental health legislation in the country, American anthropologist Leith Mullings carried out an interesting research on 'mental healing' in Accra. The research, published more than a decade later in a book titled *Therapy, Ideology and Social Change. Mental Healing in Urban Ghana* (1984), was conducted in the Labadi area and

[55] The word juju, widespread in West Africa, can sometimes be used as a synonym of 'witchcraft', and normally indicates magic powers, acts, and/or objects.

[56] Tigani El Mahi (1911-1970) was a Sudanese psychiatrist trained in Sudan and the United Kingdom, renowned for his emphasis on socio-cultural aspects in psychiatric practice (Antić 2021b).

mainly focussed on comparing non-institutional healing resources, i.e. 'traditional' and 'spiritual' therapies. The scenario outlined in her work is particularly useful for a deeper understanding of the role played by biomedical institutions in those years. As already mentioned, Mullings described a dynamic multitude of therapeutic options, which she split in three macro-categories: biomedicine, 'Western and institutionalised'; traditional medicine, which defined illness and healing drawing on local cosmologies; and spiritual medicine, which instead defined illness and healing drawing on the new Christianity conveyed by Charismatic churches.[57] The author read this pluralism in a Marxist perspective and identified a fundamental link between therapeutic systems and relations of production: the emergence of the capitalist order was the cause of significant social changes, which directly informed healing systems and the ideologies upon which they were based.[58]

In the early 1970s, there were still only two mental health institutions – the Accra Psychiatric Hospital and the Ankaful Psychiatric Hospital in Cape Coast. The psychiatrists working in the country at the time were only two as well. In spite of the great changes that had invested national healthcare in those years and the optimism of Forster's words ten years before, Mullings described a scenario characterised by the extreme scarcity of facilities and resources, where the function of the two psychiatric hospitals remained 'primarily [...] custodial, with limited drug treatment' (Mullings 1984: 49). Psychiatric patients were different from general hospital patients, but what they had in common with them was the process of individualisation they were subjected to: once the facility started taking care of them – Mullings suggested – they fully became individuals, atomised from their family, which was not anymore responsible for their health or for the decisions concerning their condition.

Drawing also on the work carried out by Ghanaian sociologist Patrick Twumasi in those same years on medical pluralism in the country (1972, 1975, 1979), Mullings described psychiatric

[57] For a diachronic exploration of Accra's plural therapeutic environment and a different 'classification' of the medical resources available within the city from the 17th century to the present, see Roberts 2021.

[58] 'To note (...) – Mullings writes in the Introduction – that psychotherapy and, indeed all medical systems are cultural is only one step in the analysis. One must explain the occurrence of the "new values" and "new ideologies" – the ways in which cultural systems are linked to the social relations of the society' (Mullings 1984: 5).

institutions as extremely marginal, somehow a lot less reactive to social change than therapeutic resources that competed with them, like traditional and spiritual healing.

The new mental health law, the *NRC Decree 30* (known as *Mental Health Decree o Mental Health Act 1972*), passed in 1972 in substitution of the colonial *Lunatic Asylum Ordinance* by Ignatius Kutu Acheampong's government[59] did not change the scenario very much. Though it introduced a few important formal innovations concerning involuntary treatment (where for the first time the right to appeal was formally recognised), the training of specialised staff, and a broader recognition of the rights of people affected by 'mental illness', the law presented significant weaknesses: the rights of patients were not clearly defined, the decentralisation desired by Forster was not put in place, the funding of existing facilities was not clearly indicated.[60]

A few decades later, all these aspects would be at the centre of the debate that took place in the 2000s (especially around 2005-2006) about the need to reform mental policies in Ghana, a debate that culminated in 2012 with the passing of the Mental Health Act (846/2012) (see Chapter 2).

Aftermath(s) of colonial psychiatry: cracks, ruptures, and continuities

Even though histories of madness in Africa have largely focussed on the colonial period, that is the time in which *madness* was medicalised into *mental illness* (see for instance, Keller 2007; Mahone and Vaughan 2007; McCulloch 1995; Sadowsky 1999; Studer 2015; Vaughan 1991), there has recently been a growing interest in retracing the aftermaths of colonialism in the history of madness and psychiatry, as evidenced by the publications of books like *Black Skin, White Coats* by Matthew Heaton (2013) on Nigerian psychiatry in the early years of independence and *An Impossible Inheritance* by Katie Kilroy-Marac on the Fann Psychiatric clinic of Dakar (2019), together with Yolana Pringle's work (2019) on early post-colonial

[59] At the beginning of the year, Acheampong had led the coup that overthrew the previous government of anti-Nkrumahist leader Kofi Abrefa Busia.

[60] For a more detailed analysis of the decree in light of the 2005 WHO evaluation guidelines, see Ofori-Atta et al. 2010; Ofori-Atta et al. 2014.

psychiatry in Uganda (cf. Antić 2021a; see also Read 2015). Kilroy-Marac's work in particular explored the multiple, fragmented, and contradictory narratives and memories of Fann's past, both rooted in colonial and postcolonial times, in light of what Collomb's innovative decolonising project was *and could have been*, in a constant tension between tales of disruption and continuity. A similar perspective can be found in two recently published papers by anthropologist Ursula Read (2020) and historian and anthropologist Nana Quarshie (2022) that propose to reread colonial histories of psychiatry and madness in the Gold Coast in light of contemporary debates in Global Mental Health concerning community care, human rights, and deinstitutionalisation (see Chapter 2).

Read focuses on the controversial 'Operation Clear the Streets' launched in 2014 by the chief executive of the Ghanaian Mental Health Authority[61] Dr. Akwasi Osei in order to respond to 'numerous concerns expressed by the general public about the patients roaming the streets of Accra and other cities and towns' (Read 2020: §1.1, ebook). The 'operation' – later renamed 'Restoring Dignity' – was aimed at 'repatriating' the 'mad vagrants' to their communities and families after having admitted them to the hospital, 'cleaned them up', and treated them. The programme sparked harsh criticism among international organisations like Human Rights Watch that denounced the forced involuntary treatment of homeless people as a violation of 'mentally ill' people's rights. The programme, however, was attentively defended by its promoter, who used the same language of its detractors: that of human rights and Global Mental Health. He spoke of rehabilitation rather than confinement, of patients rather than lunatics, of the hospital as a 'place of safety' rather than an asylum. In other words, he advocated for the legitimacy of the 'operation' using the progressive language of 'mental illness': he pointed out that it was conceived in line with the newly approved Mental Health Act (2012, see Chapter 2), aimed at finally overcoming the longstanding inadequacy of previous legislation; and on the other hand, he also added that 'insisting that a vagrant psychotic, who lives in his own world, should give informed consent is standing logic on its head and does not show enough

[61] The *Mental Health Authority* is an organ established by the Mental Health Act passed in 2012 (see Chapter 2) to 'propose mental health policies to the Ministry of Health and thereafter implement same; to ensure the establishment of very high quality mental health care accessible to all, affordable and culturally sensitive', see: <https://mhaghana.com/message-from-the-chief-executive/>, last accessed 30 December 2022.

appreciation of the nature of mental illness' (Read 2020: § 1.2, ebook). Interweaving the analysis of the practices and rhetorics of 'Operation Clear the Streets' with a reconstruction of the history of psychiatry in the Gold Coast and its transitions into postcolonial Ghana, Read identifies the image of the 'mad vagrant' – the target of the operation *and* of colonial legislation and policy concerning 'lunatics' – as a 'ghostly presence' capable of revealing disturbing continuities between a colonial psychiatry mainly preoccupied with the social cleansing and confinement of 'the dangerously mad' and the project of a modern and progressive mental healthcare in a modern and progressive postcolonial state.

In his already mentioned 'Historical Survey of Psychiatric Practice in Ghana', Forster argued that 'psychiatry in Ghana is of recent origin. Prior to 1951 there were no psychiatrists in the country, except for a brief period in 1929' (Forster 1962a: 25). Commenting on this sentence, Quarshie (2011-2012: 194) convincingly shows that Forster actually provides 'two conflicting accounts of psychiatry's origins in Ghana'. As we have seen above, his article was up until very recently one of the few sources that told the 19th and early 20th century history of colonial psychiatry in the then Gold Coast: his account of that history started there, in 1888, with the *Lunatic Asylum Ordinance* and the legitimation of the Victoriaborg Lunatic Asylum as a facility aimed at confining those whose mind was 'unsound'. At the same time, however, Forster maintained that the origins of psychiatry in the country dated back to 1951 – the year in which he took up the direction of Accra Psychiatric Hospital. As suggested by Quarshie, the co-presence of these two possible histories within Forster's narrative might be due to the fact that for him colonial asylums were merely places of confinement, thus distinct from the therapeutic institution he concurred to establish as a psychiatric practitioner. However, as Read's analysis (2020) as well as Mullings' account of Accra psychiatric institutions in the 1970s (1984) show, it is difficult to ignore how these two histories are entangled in the aftermath of colonialism.

In a more recent article, Quarshie (2022) identifies another possible 'crack' in the univocal narrative of the transition from colonial psychiatry to progressive mental health care. Similarly to what Read does in her article, revealing how 'Operation Clear the Streets' is nothing but the 're-enactment of historical practice in the guise of innovation' (Read 2020: § 8, ebook), Quarshie challenges the common narrative according to which deinstitutionalisation policies

currently proposed within the Global Mental Health framework in formerly colonised countries like Ghana are decolonial measures. As we will see more in detail in Chapter 2, the *Mental Health Act* passed in Ghana in 2012 in order to replace the 1972 *NRC Decree 30* was aimed at promoting a decentralising, community-based mental health care and formally introduced the prospect of collaboration between psychiatric and non-biomedical healers that is at the core of this thesis. This policy was presented as thoroughly innovative and has been acknowledged internationally as one of the most 'advanced' mental health legislative instruments in the continent. Community-based care, both in terms of family care and traditional/spiritual healing, however, was in colonial times a relevant alternative to institutionalisation, as it clearly emerges, for instance, from the colonial ethnographic studies carried out at the time in the Gold Coast. As I have already pointed out drawing on Vaughan (1991), it was the presence of these local forms of care that allowed colonial administrations to contain their investments on asylums. In his article, Quarshie goes deeper in exploring these connections and retraces the antecedents of community-based mental health care policies in the colonial intuition of combining austerity measures and ethnopsychiatric healing practices. Indeed, as he shows through the analysis of historical and archival material, 'the first empire-wide deinstitutionalization policy emerged in the aftermath of a scandal in West Africa in 1935' (Quarshie 2022: 243). The scandal was initiated by the parliamentary question 'about the treatment of lunatics in Africa' posed by a British MP, Sir Arnold Wilson, at the House of Commons in the UK. His question drew attention to the widespread 'inhumane' practice of confining to prisons and asylums people who actually needed medical care. The controversy triggered by Wilson's parliamentary question eventually led Dr. Cunyngham-Brown, the former commissioner for the Medical Board of Control for Lunacy and Mental Deficiency for England and Wales, to carry out a government sponsored survey of colonial psychiatric care in West Africa, in order to assess the situation and prevent the spread of further scandal. Drawing on direct observation of family-based and traditional forms of care, in his report Cunyngham-Brown suggested that in West Africa there was a 'wide and deeply rooted system of [family] care' that was 'entirely in harmony with the officially encouraged strengthening of native administrations' (Cunyngham-Brown 1935, cit. in Quarshie 2022: 257). His proposal, that was positively embraced and ended up by informing empire-wide policy recommendations from West Africa to East Africa, from Malta to Hong

Kong, was to embed the reliance on family care for the treatment of 'mentally ill' people in the colonies within the broader framework of the indirect rule and the need to operate on 'shoestring budgets' in the inter-war period.

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The words madness and mental illness can be treated as synonyms, but at the same time the invisible semantic border that separates them can evoke a multiplicity of historical trajectories made of continuities and rifts, and a constellation of meanings that can go from colonial violence to care, from the intense experience of spirit possession to the universalist precision of diagnostic categories, from political rebellion to individual suffering, from 'stigma' (and the fight against it) to (physical and pharmaceutical) confinement.

The different ways in which these words were used by my interlocutors in Ghana, and psychiatric nurses in particular, is not only informed by the process of madness medicalisation initiated by the advent of psychiatry in colonial Africa, but also by the decolonial transition from an ideology of containment to an ideology of care and healing. At the same time, in their words, partially hidden behind the category of 'stigma', it is also possible to glimpse the 'ghost of the mad vagrant' – as Read (2020) evocatively describes it – capable of illuminating the continuities between colonial and postcolonial conceptualisations, policies, and practices of psychiatric care. If, in line with recent scholarly perspectives that invite us to destabilise established narratives of African psychiatry's colonial past and present (Kilroy-Marac 2019; Quarshie 2022; Read 2020), we look at (post)colonial continuities that keep *haunting* the present, we might ask: how are community care and collaboration with non-biomedical healers entangled with government budgetary restrictions and underfunding in the area of mental health care? What role do containment and restraint play in times of Global Mental Health? What kind of imaginary of traditional/spiritual healing is conveyed in the institutional discourse of collaboration? How is the subjectivity of 'mentally-ill patients' conceptualised in psychiatric practice? These are some of the lingering questions that permeate this work.

2. DRUGS | PRAYERS

Introducing 'collaboration' through the presence-absence of psychopharmaceuticals and the inaccessibility of psychiatric care

My first encounter with mental suffering in the Nzema area was a missed one. It was an afternoon in late October 2011, during my first stay in Ghana. I was on the beach, immersed in a crowd of people who had arrived in town from all directions to celebrate the annual *Kundum* festival.[62] While everyone was dancing and enjoying the rhythm of the drums, a young man was standing farther away on the seashore, almost immobile, alone. He was gazing at the sea, turning his back on the ritual festivities. He appeared to me to be in another dimension, separate from the life of the rest of the community. He was wearing worn, dirty clothes, and carried a pile of filthy papers and plastic bags on his head.[63]

I had met him often during my 2014 fieldwork: he spent most of his time where I had first seen him, at that precise spot on the beach. Sometimes he roamed along the main road that connects the coastal villages, stopping suddenly to drink from the gutter or to stare at something. Any attempt at waving at him on the road or the beach was a failure. When I returned to Ghana in June 2017, I learned that he had been found dead on the beach just a few months after my departure. They had to 'cut everything short' – his uncle Kofi explained to me – 'he was buried the following day', but predictably the funeral was not celebrated: 'nobody would have participated, so far as he was sick he didn't perform any duty in the community'.[64]

[62] The *Kundum* (or *Abisa*) is a crucial event in the social and political life of Nzema communities. Details can be found in the vast body of work cited in Pichillo 2012 (especially note 2: 145); see also Etikpah 2015; Lepore 2019.

[63] Dirt and proximity to rubbish are quite classic signs of madness in many African contexts. See Guitard 2012; cf. also Edgerton 1966.

[64] Interview with Kofi, 4 July 2017.

Kaku was a classic, harsh example of 'vagrancy', the most powerful and pervasive representation of 'mental illness' in West Africa at least since colonial times (see Chapter 1). For everybody, Kaku was *ɛzɛlɛ*, mad. His story echoes Ursula Read's reflections on the status of the 'mad vagrant', the 'ultimate Other' in Ghana. 'Only a stranger can with impunity be labelled *ɔbɔdamfo* [*madman* in Twi]', Read argues (Read 2012a: 55). In fact, Kaku was never described as a 'mentally ill' person or a person with 'mental problems' and nobody hesitated to describe him as somebody who was *ɛzɛlɛ* and couldn't 'come back from there', as his uncle Kofi put it.[65]

According to Kofi, many years ago, when he was a young boy working with his father in a coconut farm in another village, Kaku had been the victim of a curse (*amonle*) cast on him by a girl he had mistreated (or raped according to other, more disturbing accounts). In Kofi's opinion, the curse had to be broken, but since he did not know the girl it was impossible for him to break it, while Kaku's mother refused to become involved in the quest for a cure.[66] On another occasion, Kofi suggested that his nephew's condition was caused by a broken taboo: he suspected he had had intercourse with a girl – the same one who had cursed him, according to rumour. The intercourse had happened in the bush, at a place where a *bozonle,*[67] a spirit, lived. He had disturbed and offended the spirit, and *ɛzɛlɛ* was his punishment.[68]

At first glance, Kaku's story might seem to lie somewhat beyond the territory of 'mental illness', especially if one wants to discuss the relationships between 'drugs and prayers' as I aim to do in this chapter: in fact, Kofi and all the members of his community I spoke to agreed that

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[65] Conversation with Kofi, 6 October 2014.

[66] Mothers are usually expected to be the caregivers for their 'mad' children, see Read and Nyame 2019.

[67] The *awozonle* (s. *bozonle*), also referred to in English as 'spirits' or 'small gods', are local deities who coexist with human beings and can deeply influence their lives and wellbeing, either in a positive or negative way. As argued by Kofi, who was also a traditional herbalist (*ninsinli*) and prominent elder: 'they are like human beings [...] some of us are very very cruel, if you offend somebody and then [...] you beg, they will never listen to you... at times when you offend somebody [...] as soon as you tell them "oh, Papa or Maame, what I have done to you I have seen that it is wrong" [...] they will simply tell you: "Oh, it's ok". [...] but at times some of the human beings, they will not do it... the same thing applies to those gods in the bush' (Interview with Kofi, 4 July 2017). See also Pavanello 2017.

[68] On the punishments due to having offended the *awozonle* see Grottanelli 1978: 85 ff.

Kaku's radical *ɛzɛlɛ* was a 'spiritual' condition that had nothing to do with hospitals and 'mental illnesses'.[69] From a superficial standpoint, his story could even be used to support the discursive blaming of traditional/religious thought as 'ignorant belief' (see below). What is interesting, however, is that at the onset of his condition, before taking him to different traditional healers, Kaku's father had taken him to Ankaful Psychiatric Hospital in Cape Coast. Unlike Kaku's mother, his father *struggled* (Jenkins 2015: 261, see below) for his son to be healed until his death, spending – according to Kofi – an incredible amount of money. All his attempts proved unsuccessful, and after Kaku's father died, the family had to give up, 'because we can't spend the whole money in the family on one person', his uncle argued.

It is impossible to reconstruct, or even imagine, what really happened during Kaku and his father's quest for a cure from Kofi's words alone. What is striking, however, is that even in a case of radical *ɛzɛlɛ* – being radically other from what is considered 'normal' and 'ordinary' and representing 'the extreme' in local conceptualisations of the madness-mental illness spectrum (Cf. Chapter 1) – the spiritual and the psychiatric appear to be inextricably entangled. Even more interestingly, the story of Kaku and his father forces us to reconsider the stereotypical figure of the mad, abandoned vagrant. Crystallised in a timeless image of abandonment, the 'extraordinary condition' (Jenkins 2015) of vagrancy should actually be understood by taking account of the different temporalities of both the 'illness' and the struggle for a cure, in a *continuum* of conditions that also structure the experience of mental suffering through a relationship with the materiality of different therapeutic resources that may be (un)available or (un)affordable at any particular moment.

Kaku's story is similar to that of Rose and Emmanuel, two siblings I first met in their family compound in the summer of 2014 during a home visit with Francis, one of the nurses. At that time, Rose and Emmanuel were both patients at the local hospital, but Francis had not seen them for a while, and suspected they were not taking their antipsychotic medication. Emmanuel was tied up in his room: he had injured a family member with a cutlass some time earlier and had started roaming about in a neighbouring town; Rose was lying on the floor, staring into space, and did not react to Francis's questions. Their caregiver was a resolute but physically weak

[69] On the notion of 'spiritual condition', cf. Schirripa 2005: 51 ff., cf. also Chapter 4.

and tired old woman, their grandmother Nana. They lived not far from the hospital, but, as Nana explained to us, the family could not afford the monthly cost of antipsychotic drugs, and the investment was often not worthwhile, since Rose and Emmanuel frequently refused to take them.

When I returned to the hospital three years later, I asked about the two siblings: the last time I had visited their house, Rose had started to take medication and was feeling a little better, and I could not forget Nana's strenuous struggle to ensure a better life for her suffering grandchildren. The nurses' answer was uttered with sorrow, and was confirmed some days later by an older, weaker, and eventually defeated Nana who 'couldn't cook for them anymore':[70] the patients had both become vagrants, severing their ties with their loving grandmother, testifying to the failure of the nurses' attempts to take care of them, and ultimately risking dying alone like Kaku.

In these two convergent stories of mental distress ending up in vagrancy, the unaffordability of care – the usual situation of having to pay prohibitive sums for public mental health care – emerges as a common thread in the experiences of Kaku, Rose, and Emmanuel, tying their stories to those of many other people I have met during my research. In this chapter, I propose to take the presence/absence of psychotropic drugs, their (un)availability, as a point of departure to explore the intersections between the realm of psychopharmaceuticals and that of 'prayers' and spirits as two different, yet intertwined, set of resources that can be mobilised in order to deal with mental distress. As antithetical as they may seem, drugs, spiritual practices and prayers coexist in the daily lives of some practitioners and patients: as I will discuss below, in some cases medications actually play a key role of mediation in the complex relationships between psychiatry and spiritual healing. Looking at these intersections and relationships can be particularly interesting as it is also a way to address the issue of the global 'pharmaceuticalisation' of the self (Jenkins 2010) from a peripheral, non-Western perspective – an issue that I will further explore in the next chapter.

[70] Conversation with Nana and Auntie Theresa, 29 June 2017.

The Mental Health Act*: decentralisation and collaboration with 'unorthodox' practitioners*

Contextualising the new policy

In the Ghanaian context, characterised by a manifest multiplicity of therapeutic resources, the juxtaposition of psychopharmaceuticals and prayers is at the core of the current discourse on the necessity to promote a 'collaboration' between mental health professionals and non-biomedical practitioners. The emphasis on this topic – as well as the growing interest in mental health in Ghana in the last decade – must be understood within the larger process of genesis, passing, and implementation of the Mental Health Act (Act 846, 2012), the law enacted in 2012 in order to 'scale up' – to use the Global Mental Health idiom (Lancet Global Mental Health Group 2007) – psychiatric services (see, among others, Awenva et al. 2011; Doku et al. 2011; Doku, Wusu-Takyi and Awakame 2012; Roberts et al. 2013; Roberts et al. 2014; Kpobi et al. 2014).

In line with the aims of the WHO's mental health policies and the *Global Movement for Mental Health* in the 2000s, the law was aimed at promoting a renewal of the mental health care system, especially with regards to the respect of human rights and the fight against the stigma of mental illness, the decentralisation of services, and the collaboration with so-called 'unorthodox' practitioners. The term 'unorthodox' is used in the text of the law (Act 846, 2012: 7, 16) and aptly reveals a crucial asymmetry in the way 'collaboration' is envisioned in Ghanaian mental health policy and the Global Mental Health discourse more broadly.

Despite, as we have seen in Chapter 1, attempts of deinstitutionalisation can be traced back to the 1930s, when they were proposed by the colonial administration as a promising strategy that combined 'humanitarian' preoccupations and indirect rule with the financial need to operate 'on a shoestring budget' (Quarshie 2022), decentralisation and collaboration are relatively new in the specific sector of postcolonial mental health care. They have been, however, crucial factors in general health policies in Ghana – and across the continent – in the last decades, in accordance with the recommendations of the 1978 WHO Conference on primary health care held in Alma Ata.

The decentralisation project has informed the general structure of Ghanaian health services since the 1990s (Addae 1997), with the institution of relatively autonomous health districts in every region in 1996, and the implementation of the Community-based Health Planning and Services (CHPS)[71] in the early 2000s (Schirripa 2005; Vasconi 2011). In contrast with this process, however, mental health care remained highly centralised until the passage of the 2012 law. There were, and still are, only three psychiatric hospitals in the country, all of which are located in southern urban areas (the Accra Psychiatric Hospital and the Pantang Psychiatric Hospital in the capital and the Ankaful Psychiatric Hospital in Cape Coast). These notoriously inadequate and overcrowded hospitals have long been the main biomedical resource for 'mentally ill' people. Although the role of community psychiatric nurses was already established by 1976 and the first attempts to integrate mental health in primary care in some areas of the country date back to the 1990s, the distribution and availability of biomedical primary mental health care in rural areas was extremely poor, and almost non-existent, in most cases (Ofori-Atta et al. 2014). The aim of Act 846 was therefore to fill the gap between decentralised general health policy and mental health care, and the objective of collaboration with non-biomedical healers was instrumental to that goal, in line with current WHO orientations (Green and Colucci 2020).[72]

The roots of the Mental Health Act promoted 'collaboration with unorthodox practitioners' could also be traced back to the long history of traditional medicine recognition in the country. As a matter of fact, though the attempts of formally recognising 'alternative' medical traditions in the Global South were undoubtedly prompted by the Alma Ata Conference, in Ghana the process of traditional medicine recognition, which had its

[71] The *Community-based Health Planning and Service* take their name from the homonymous national programme aimed at decentralising healthcare that was put in place in 2005, with the institution of tiny clinics that depended directly from local health districts and were located in villages and towns from where it was difficult to reach local hospitals (Vasconi 2011).

[72] It is interesting to notice that coherently with these global trends, in the latest version of the *Diagnostic and Statistical Manual of Mental Disorders*, the DSM-V published by the American Psychiatric Association in 2013, 'traditional, alternative, and complementary forms of healing [are described as] cultural resources of [...] resilience' (Ecks 2022: 163).

turning point in 2000 with the passage of the Traditional Medicine Practice Act (No. 575), dates back to 1960, when the first recognised non-biomedical practitioners' organisation (the *Ghana Psychic and Traditional Healers Association*) was created at the behest of President Nkrumah.[73]

As observed by Elisa Vasconi and Stephen Owoahene-Acheampong (2010), the policy of traditional medicine recognition implemented in the last few decades in Ghana favoured its herbal components – which better fit in a scientific conceptualisation of medicine – at the expense of its spiritual dimensions.[74] The latter were not taken into account, resulting in a bureaucratisation of healing practices. In a more recent article (2017), Vasconi retraces the origin of this process in colonial times, when practices and practitioners that were locally perceived as different and even opposite to one another were all grouped together under the common label of 'witchcraft', as it was defined by the British anti-witchcraft legislation. As shown by archival evidence, similarly to what happened in many other African contexts, terms such as 'witch doctor', 'witchcraft', 'fetish priest', 'fetish dance', 'fetish religion', 'occult' and 'supernatural' were constantly used by colonial officers as synonyms. In fact, many of these terms were used to designate healers and therapeutic practices, but the expression 'traditional medicine' – which had a positive meaning – was exclusively used in documents about local herbal remedies (Vasconi 2017: 88). Making direct reference to the Traditional Medicine Practice Act (No. 575) and the predominant role it attributed to 'herbal' remedies, the author highlights that the colonial conceptual and semantic overlapping of witchcraft, religion and medicine has had very palpable effects in the postcolonial era: not only are many of the terms mentioned still used in the same fashion in the contemporary discourse, but the criminalisation of a certain kind of healing practices, the ones equated to witchcraft, and the concurrent reduction of the category of 'traditional

[73] On the recognition and professionalisation of 'traditional medicine' in Ghana see, among others: Kpobi and Swartz 2019; Osseo-Asare 2016; Schirripa 2005; Twumasi and Warren 1988; Vasconi and Owoahene-Acheampong 2010; Ventevogel 1996.

[74] For an interesting discussion of this phenomenon in the context of Tanzania and beyond, cf. Langwick 2015.

medicine' to its mere 'empirical' dimension have shaped the national health policies of independent Ghana until the present.

The ambivalent history of traditional medicine recognition in Ghana is particularly relevant to the field of mental health, where the spiritual is deeply embedded in the way illness and healing are experienced and conceptualised. Reflecting on such a history could also be useful to understand the conflicting ways in which 'collaboration' between different practitioners is currently imagined, promoted, and discussed.

Collaboration and 'prayers'

Compared to colonial times, the picture is perhaps even more complex today, as the popularity of 'traditional medicine' has been increasingly challenged by the emergence of prayer camps, healing sites where people who are willing to distance (and protect) themselves from the realms of witchcraft and traditional deities can turn to a prophet or pastor to solve their health and life problems with the help of the Holy Spirit, mainly through prayer, fasting, and deliverance (among others, Fancello 2008, Larbi 2001, van Dijk 1997). These therapeutic sites are generally embedded in churches pertaining to what Allan Anderson (2004: 10) called 'range of Pentecostalism', an heterogeneous constellation of institutions alternatively labelled as '(neo)Pentecostal', '(neo)Charismatic', and 'spiritual'.[75] Rooted in early 20th century North American Christian movements and nowadays widespread throughout the African continent, these churches are linked by the common thread of the emphasis they put on 'the workings of the Spirit, both on phenomenological and on theological grounds' (Anderson 2004: 13).

As many scholars convincingly retraced, the pentecostalisation of Ghanaian society was an all-encompassing process not limited to the health and healing field that started intensifying in the 1990s, following media liberalisation in the country and the massive emergence of

[75] The term 'charismatic' is usually linked to the experience of independent African churches', while 'Pentecostal' should be used to describe those churches whose history is explicitly linked to North-American Pentecostalism. However, in literature the two terms are often used as synonyms, since their histories are strongly entangled and the differences between churches are seldom ascribable to a fixed model of 'Pentecostalism' or 'Charismatism' (Schirripa 2012).

Christian TV channels and radio stations (among others, De Witte 2004, Gifford 2004: 30-39, Meyer 2004). It is interesting to note that in spite of their competing relationships, in the *Mental Health Act* prayer camps and traditional shrines – and the extremely diverse healing practices that might be respectively grouped under such definitions – are classified together under the label of 'providers of unorthodox mental health care' (Mental Health Act 2012: 7) and identified as key places where to develop a decisive yet controversial 'collaboration' aimed at improving the experience of people affected by mental conditions. The hyper-visibility of Pentecostal Christianity in the Ghanaian public sphere, however, is probably one of the reasons why, in media outlets as well as in the multidisciplinary scholarly literature produced in the last decade, prayer camps have so often been considered as central sites to investigate the possibility of developing cooperative relationships between psychiatric institutions and 'alternative' sources of care (see for instance, Arias et al. 2016, Benya 2022, Goldstone 2017, Ofori-Atta 2017, Ofori-Atta et al. 2018, Osafo 2016, Taylor 2017). 'Prayers' and 'prayer camps' were also quite central in my conversations with psychiatric nurses about 'alternative' conceptualisations of mental affliction and how to deal with them. Indeed, 'prayers' were often used as a synecdoche to refer to everything that is not psychiatric:

> Even the Mental Health Authority, in a way is saying 'you might not believe it, but you need to accept it', in a way. And that is why now they are asking us to work hand in hand with the traditional [healers], prayer camps, and all that. Because people still believe that. They tried to ignore it [saying]: 'No, it's not a spiritual thing'. But they realised it's not working, so they decided: 'Why don't we work hand in hand? *You come for your medication, then you can go for your prayers*'.[76]

> When I was doing my service, we used to go to this traditional-based... whatever, we go there and we give them the medication and they are fine. So, to me, I believe that if you think a spirit is cursing, *come and take your medication and still pray, God is there to help*

[76] Interview with Francis, January 11th 2022.

> *all of us*. So we can help by giving them the medication, 'cause the *asofo* [prophets] will do the spiritual aspect, but we have to do the physical aspect too.[77]

This reduction of everything that is non-psychiatric and non-biomedical to 'prayers' is interesting as it seems to be the other side of the coin to what formally happened to traditional medicine during its recognition process. Indeed the synecdoche of 'prayers' well mirrors the idea, often expressed by nurses, that the relationship with traditional healers tends to be more complex. According to some of them, this is mainly because it can be very dangerous for patients to combine the herbal concoctions generally administered by traditionalists with 'orthodox' psychopharmaceuticals. It is important to highlight, however, that herbal substances are not an exclusive prerogative of non-Christian healers, and the boundaries between traditional and Christian practices can be very blurred. On the other hand, it is also important to notice that a potential 'interference' with the effect of psychotropic drugs lies also in Christian prayer camp everyday practices, where fasting is commonly associated with prayers. In fact, psychiatric nurses ask the prophets with whom they aim to 'collaborate' to exempt their patients from fasting while they are taking psychotropic medicines.

Collaboration as an ambivalent discourse: cultural alibis and social abandonment

In the numerous publications that have focused on the issue of collaboration with prayer camps, often framed in potential terms, as a key, yet controversial, strategy for overcoming the inadequacies of the public system (among others, Arias et al. 2016, Goldstone 2017, Ofori-Atta 2017, Osafo 2016), two problematic and widely-discussed aspects seem to emerge most prominently: the differences in practitioners' 'beliefs' regarding 'mental illness' and the human rights conundrums associated with the chaining and shackling that are often practised at prayer camps. As we will see in more detail in Chapter 5, discussions on the latter have been amplified in recent years by the resonance in the media of the humanitarian

[77] Interview with Juliet, January 18th 2022. The theme of 'belief' that emerges from Juliet's and Francis' words will be further explored in Chapter 4, see also below.

discourse endorsed by international organisations such as Human Rights Watch, which have publicly exposed not only the chaining and fasting practices, but also the many reported cases of violent abuses of prayer camp patients (Osafo 2016, Read 2019). Albeit with differences in intensity, most of the literature seems to project the image of an unstable balance: on the one hand, the sharing of a dual 'spiritual-biomedical lens' (Arias et al. 2016: 13) – that is, the fact that for different practitioners, as well as patients, mental suffering can be experienced both in a spiritual and biomedical perspective; and on the other, the occasionally harsh rejection both by nurses who condemn mechanical restraint and religious healers who perceive psychiatric care as a threat to their authority to endorse treatment practices that differ from their own (Read 2019).

In line with media and scholarly debates, human rights and the issue of 'beliefs' have also been crucial elements in the discourse of Ghanaian psychiatric institutions. Their attitude towards prayer camps is, in fact, utterly ambivalent. A declared intention to collaborate is often accompanied by a strong denunciation of incompatibility, a marked difference that is usually expressed in terms of an opposition between 'modernity/science/knowledge' and 'superstition/belief/lack of understanding' (Read 2017: 172-173; see also Goldstone 2017). As Dr. Akwasi Osei, pre-eminent Ghanaian psychiatrist and head of the newly established Mental Health Authority who was also for many years the director of the Accra Psychiatric Hospital, put it on the occasion of a public speech he gave for the 2014 World Mental Health Day:

> Schizophrenia is very common in Ghana but the problem is that many people don't recognise it, and even if they do, [they] decide to send [those ill with schizophrenia] to inappropriate places [...] traditional healing centres and prayer camps, where [patients] are put in chains, starved, locked, sexually abused or used for forced labour. [...] Interestingly, schizophrenia has very effective treatment, unfortunately [...] by falling on superstition many persons with schizophrenia, just as other mental patients, are considered to be victims of witchcraft, the Devil, or themselves may be the Devil or witches.[78]

[78] Dr. Akwasi Osei, Public speech, 15 October 2014, Accra (personal recording).

On a similar note, John, a psychiatric nurse working in the Nzema area, maintained:

> Here in Ghana the one problem is [that people] believe that when someone has [a] psychiatric condition, they think it is caused by a curse so the only way is to remove that curse or to fight against it: that is, to see the traditionalist or the priest for that cure. But it is time for them to understand that although in our society we have those spirits [...] psychiatric conditions are not caused by those evil spirits. That is the problem we have here.[79]

Along with the clear assertion of the existence of a polarity, in both cases 'traditional'/religious thought is represented as 'the problem', the main obstacle to 'very effective treatment' and recovery. As I suggested early on after my first fieldwork experiences (Draicchio 2018, 2019), this representation may end up by turning 'culture' into an 'alibi' (Farmer 2003: 49; that is, in this case, 'superstition', or 'ignorance') to justify people's suffering instead of looking at the structural inequalities that inform their experience. Indeed, although they are often only evoked in very general terms – if not completely overlooked – inequality and scarcity emerge as being central to the everyday lives of people dealing with mental suffering as well as to the articulations between psychiatric institutions and prayer camps, leading to forms of exclusion and 'social abandonment' (Biehl 2005).

Even though it is sometimes criticised for its distant and determinist perspective and for its occasionally unconditional and oversimplifying use of the notion of 'medicalisation' (cf. Rose 2007; Béhague and K. MacLeish 2020; see also Good 2010), critical medical anthropology has effectively shown the massive impact of neoliberal policies, structural inequalities, and their normalisation on illness and healing processes. In the field of mental health, notions of 'abandonment' and 'social abandonment' are often used to describe these processes. Coined by João Biehl in the context of his ethnography of *Vita*, an informal asylum in Northern Brazil, and his encounter with Catarina, a woman who had been determined to be mad and left there by her family, the notion of 'social abandonment' addresses the phenomena of marginalisation and the

[79] John, group interview with psychiatric nurses, 7 November 2013.

production of 'public death' generated by the neoliberal turn in public health. *Vita* is a 'zone of social abandonment' because it is 'a dump site of human beings' (Biehl 2005: 1-2) produced by the state and medical institutions, a place where marginalised people are directed through ordinary processes of social exclusion. Later reformulated by Elizabeth Povinelli (2013), this notion of abandonment has been criticised for producing an over-determined, passive image of family and close relatives – those who *also* abandon – without leaving them any form of agency (Han 2013, Das 2015: 18). Keeping in mind this critique, we may combine Biehl's notion of *social abandonment* with Jenkins's idea of *struggle* for health of 'mentally ill' people and their close ones in what she defines as the 'interactive process' of mental suffering (Jenkins 2015: 254). 'Struggle – she argues – is not just *against* an illness and its symptoms but also *for* a normal life, *to* make sense of a confusing and disorienting circumstance, *with* intimate others, and *in* a world characterized by stigma' (*ivi*: 261).

Imagining it as an 'interactive' condition, we may speak of an *interpersonal social abandonment* that encompasses the 'mentally ill' and those who *struggle* with them. If we go back to the stories of Kaku, Rose, and Emmanuel, we can observe that far from being a permanent condition, abandonment emerges as both a (micro)historical result of 'extraordinary' conditions of scarcity and a paradoxically interpersonal experience. It is not something that is deterministically produced by their family as a whole; instead, it is something Kaku, Rose, and Emmanuel shared with their defeated caregivers. Understood in these terms, 'social abandonment' appears as a key element in their stories, especially for what concerns the accessibility and affordability of mental health care in rural Ghana. These issues are crucial to the psychiatric-religious forms of collaboration mediated by drugs that I will explore in the next section.

Drugs as mediators: pharmaceutical articulations of psychiatry and religion

A 'hospital within the hospital': dealing with scarcity

As I have mentioned previously, some of the interactions between psychiatric and non-biomedical practitioners I had the chance to observe in Nzemaland since 2013 could be framed in terms of an already existing collaboration rather than an hypothesis, a potentiality, or a project still being discussed at a national level. Here I will refer to these interactions as partial and imperfect *experiments at collaboration*, suspending for now a discussion of the term collaboration itself – something that I will pick up again at the end of this work (see Chapter 6). With a few administrative changes, these experiments at collaboration have been totally self-organised by the local psychiatric unit since 2013. When I first met them, Mary, Francis, Michael, and John, the four nurses (three Registered Mental Health Officers and one Community Mental Health Officer) who worked in it at the time, had a detailed programme of community outreaches, and among their crucial destinations there were numerous local prayer camps.

Outreaches were described as a concrete effort to decentralise mental health care and take care of people who would not normally visit the hospital because they lived too far away and could not afford TNT (public transport fares), or were not aware that the hospital might be a useful resource for 'mental illness'. Most of the time, however, the nurses were not able to keep up their schedule, as they themselves often did not have enough funds to invest in TNT. Since mental health care is *supposedly* free of charge (Act 846. The Mental Health Act, 2012: 35) and not covered by health insurance, the unit did not 'generate anything for the hospital in terms of

income', making it unprofitable for the management to support it economically.[80] As the nurses put it, the unit was a 'hospital within the hospital': it had to provide community-based mental health care by itself, collecting small sums of money to finance its outreach activity.[81]

Interestingly, as suggested by David Mensah in a recent study carried out with psychiatric nurses from Ankaful Psychiatric Hospital (2021), the administrative and financial neglect of the mental health sector within hospital settings as 'not generating anything' or 'not producing to the government' – to use the strikingly similar expression of one of his interlocutors – is closely related to the neoliberal turn that invested not only Ghanaian public health (see below), but also broader ideas about people's role within society and has a lot to do with the 'stigma' of mental illness. According to Mensah, the stigmatisation of psychiatric nurses goes beyond 'merely' being called *abɔdam* (mad, in Twi) like their patients – something that my nurse friends in Nzemaland often complained about – and extends to the idea of being 'seen as not contributing anything to the country's development because they take care of people who are perceived to be 'useless' in society and to the country' (2021: 66). Indeed, the blame projected onto them is something similar to what Kofi said about his nephew Kaku's uncelebrated funeral ('so far as he was sick he didn't perform any duty in the community').[82]

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[80] During an interview, Ernest, a psychiatric nurse working in a different context (a sub-district health centre), commented in a similar way: "Mental health in this country has been someway, let me put it this way, neglected for so long, even when you come to the district the attention given to mental health…there is not even attention given to mental health (…) if I should go to work and I don't go to work, it seems like nobody cares, there is no…nobody cares [because] *you don't generate any money for the facility* […] even at the end of the year, and they don't get reports, they don't even ask for [them] " (21st January 2022, emphasis added).

[81] Group interview with psychiatric nurses, 10 July 2017.

[82] It is also interesting to notice that to counter this kind of argument some of Mensah's interlocutors invoke another version of the same neoliberal logic: 'The nurses believe that the neglect towards mental healthcare is in a way a shortage of human resource for the country's development because these people are ill and cannot work, but if the government is to take care of them, they will be useful to the country.' (Mensah 2021: 67). As it is well known, this argument is at the core of the tricky Global Mental Health motto 'no wealth without mental health' first proposed by Thomas Insel in 2014 (Ecks 2022: 201 ff.).

To react to its (stigmatising?) marginalisation within the healthcare system, the unit acted as a 'hospital within the hospital' also in another way, as I learned during my 2014 fieldwork. Since psychotropics were only delivered to the hospital sporadically, frequently becoming unavailable to patients,[83] the nurses had started to buy drugs on their own initiative, often by giving prescriptions to people who were travelling to major cities like Accra, Kumasi, or Takoradi and asking them to bring back what they could find. This 'informal' initiative ultimately made drugs available at the unit, but they were unaffordable in the long term to many patients who were entitled to get them free, like Rose, Emmanuel, and many others. The nurses were aware of this, but it was the best they could come up with to provide at least some kind of care: an 'emergency' measure under 'extraordinary' conditions of scarcity.

In June 2017, I learned from a document hanging on the unit wall that this informal mechanism had somehow been formalised at a national level by the Mental Health Authority (MHA) some months earlier. This document, which had been issued by the MHA, suggested to Regional Directors of the national executive agency Ghana Health Service that, 'given the longstanding shortage of psychotropic drugs', they should 'buy and sell' medication to patients, who were optimistically described as 'prepared to buy if available' (Mental Health Authority 2016). Though, as I will highlight below, there were a number of important changes in the last few years, this informal – and yet formally recognised – trading system has remained almost unaltered: in January 2022, when I last visited the unit, the MHA document was a bit faded, but still hanging on the wall.

This (in)formal economy, as well as the discourse on mental health care 'not generating income for the hospital', are evident effects of neoliberal processes of privatisation. These processes have been a feature of the Ghanaian public health system in recent decades, with the introduction in 1985 of user charges – the 'cash & carry' system – that resulted in substantially reduced access to health services for the poorer sections of the population (Asenso-Okyere et al. 1998). The introduction of a voluntary prepayment financing mechanism alongside 'cash &

[83] On the unavailability of psychopharmaceuticals in Ghanaian mental health services cf. Oppong et al. 2016; see also Mensah 2021. To contextualise the (in)accessibility of psychotropic drugs within the broader framework of the circulation of (traditional and non traditional) medications in the Ghanaian context see, among others, Schirripa 2015; Senah 1997; Libanora 1999.

carry' – the National Health Insurance Scheme (NHIS) – which was approved in 2003 and put in place in 2005, was aimed at overcoming this failure and achieving universal health coverage. Prices of enrolment and the ineffectiveness of the exemption criteria and processes, however, continue to be major factors in preventing poor people from accessing public health (Kwarteng et al. 2020; Dixon et al. 2011). Interestingly, even though mental health care should be an exception in this scenario, being technically 'free to everyone' – to the point where it is not even covered by the NHIS – it appears to be profoundly informed by the general *commodification of care* (Farmer 2003: 152 ff.), as illustrated by the emergence of the (in)formal economy I have described.

At the hospital where I carried out my research, the relationship between the nominal free-access to psychiatric care and NHIS registration has become even more complex in the last few years, following a new measure put in place by the newly installed management in 2018. This leadership change, according to both the nurses and the director, was beneficial to the psychiatric unit: compared to the past, it was granted greater access to funding and generally more consideration and support. Perhaps as a form of institutional 'inclusion', that is as a way to let the unit 'generate something' for the hospital, the rules of access to the unit were changed: in order to be assessed and treated, patients now had to either be insured on the NHIS or pay a user-fee of 15 Ghanaian cedis that added up to the 5 cedis the unit requested for the purchase of a personal 'appointment card' (a booklet where the dates of follow-up visits were noted) and the potential costs of drugs. Presented by the nurses as a way to encourage NHIS registration among the local population, this new policy seemed sometimes to turn away people who were not registered or at least to make their access more difficult.[84] Again, there is a tension between things as they are and things as they should be. As a matter of fact it is not only psychotropic drugs that should be free of charge for people 'with mental illness', NHIS too should be free for this category of citizens that formally belong to the larger 'exempt group'. This group includes children under 18, people in need of ante-natal, delivery and post-natal healthcare services,

[84] During an interview, Pamela, one of the unit nurses, observed: 'If the person is not having health insurance, it means you are denying the person her service, the person has to stay home, which is very bad'. Interview with Pamela, 20th January 2022.

persons classified as indigent or disabled by the Minister responsible for Social Welfare, pensioners of or contributors to the Social Security and National Insurance Trust, and individuals older than 70 years.[85] As highlighted in the study conducted by Kwarteng and colleagues (2020) in the Upper East Region of Northern Ghana, and as I realised myself when in 2021 I escorted a friend of mine to register at the district NHIS office, it is incredibly difficult to formally identify as members of the exempt group, at least in the case of an 'indigent'[86] and 'a person with mental disorders' (Act 852, National Health Insurance Act, 2012: 19): people in need of health insurance end up by just paying the premium - which is set from 7,20 to 48 cedis - when they can, or by renouncing it. This was the case of Comfort, a young woman that I met in September 2021 during a unit outreach to the garden of a *kɔmenle*, Maame Afiba, in a small town not far from the hospital. I went there with Pamela, a psychiatric nurse that started working at the unit in 2019: she had not visited the garden before and neither had her colleagues, they had only recently heard about it from a patient of the healer who attended the unit as well. They were informed by a patient and the man who accompanied him, who happened to be the *kɔmenle*'s son, that there were other people – other 'cases' in the unit jargon – at the garden, and since the place was not too far in terms of TNT they decided to 'go and check'. Comfort, a woman in her twenties, was one of the healer's patients. After talking to her and Maame Afiba, Pamela diagnosed her as suffering from epileptic psychosis and prescribed her *Olanzapine*, an antipsychotic medication, and *Carbamazepine*, an anticonvulsant, that at the time were both available at the hospital pharmacy at the cost of a few cedis, as they were provided by the government. Comfort, however, did not have NHIS, so she had to pay the full price: 30 cedis. She did not have any money or family member that could sponsor her at the shrine, and after a time of negotiation that I will go back to in the next chapter, the *kɔmenle* accepted to pay for her (and another patient), demanding a partial discount. Before leaving, Pamela insisted on 'educating' (cf. Chapter 6) Comfort on the need to register to NHIS: 'if only she had done it! She could have got her medicine almost for free!' The patient complained,

[85] See NHIS website: <https://www.nhis.gov.gh/membership>, last accessed 30 December 2022; See also Act 852, National Health Insurance Act, 2012.

[86] On the difficulties of identifying as 'indigent' in order to get free NHIS, see also Akweongo et al. 2022.

however, that she did not have TNT money to go to the district NHIS office, let alone to pay for registration. In the past, I had witnessed a lot of people complaining because they had their health insurance card, they had paid for it, and still they had to spend money for their treatment at the psychiatric unit. The new policy, however, added yet another possibility of inaccessibility in this scarcity scenario. NHIS officers did not easily grant exemptions, even to people like Comfort who were entitled to it. Many patients had denounced this kind of unfair treatment to the unit – Pamela told me when we were going back to the hospital – and to try to address it she and her colleagues were developing another informal strategy: since one of the nurses' husband worked at the NHIS office, they were compiling a list of psychiatric patients who still did not have health insurance, hoping that with his mediation they would be granted their due exemption. When I last visited her in January 2022, Comfort was still not insured on the NHIS though.

The complex informal economy sketched in this section profoundly shapes the everyday experiences of people dealing with mental suffering, as well as the ways in which the psychiatric unit 'collaborates' with local prayer camps.

Spiritual nosologies, medications, and the unaffordability of care

Despite the initial lack of support and the major shortage of resources that still defines their institution, in the last decade the unit has been able to establish a fairly solid, albeit intermittent, collaborative relationship with a number of prayer camps: among them, there are two healing sites that I have come to know quite well during in the past few years: Esofo Christ's and Maame Akuba's.

The former is part of the local branch of a well-known Pentecostal church and was founded by the *esofo* more than twenty five years ago, while the latter, which is interestingly embedded in

a Catholic church,[87] was established by the prophetess over thirty years ago. Daughter of a *kɔmenle*, Maame Akuba had to fight hard – helped by Catholic nuns who had established a church and a hospital nearby – to defend her faith from attacks from her relatives and the *awozonle*, the spirits her mother worked with. Both prayer camps are relatively modest, but they host dozens of people; the number of 'mentally ill' patients included among them varies, but they are usually less than ten. Both healers view the 'mental illness' they are able to treat as possession by evil spirits and/or the effect of *ayɛne* (witchcraft), which sometimes – or often, according to Esofo Christ – can be the result of a responsibility incurred or an offence committed by the 'ill' person. The two practitioners claim to have healed – '*ɛnee bɛ nye zo ɛtete*', 'today their eyes are open'[88] – hundreds of people through prayer. Esofo Christ also employs fasting as a therapeutic tool to starve and weaken evil spirits when they possess the person. The two *esofo* chain 'mentally ill' patients up in their camps, although not always, and not for the entire duration of their stay, but rather when 'necessary', including for long periods: neither of the two referred to shackles and chains in terms of 'therapy', but as a necessary measure to restrain patients when they are 'aggressive' and to avoid having them run off into the bush.[89] Neither *asofo* charges their patients, but at least one relative has to take care of them during their stay – which can last for days, months, and sometimes even years – and provide them with food.

[87] Though relatively 'invisible' (Mayblin et al. 2017a: 2 ff.) in scholarly literature, especially when compared to the incredibly wealthy body of literature produced around (neo)Pentecostalism and (neo)Charismatic churches – particularly in a continent like Africa, and in a country like Ghana – Catholic churches are still very relevant in the global religious scenario (Mayblin et al. 2017b). Raised as a Catholic in Italy, I myself was quite surprised at first to see a 'Catholic prayer camp' that revolved around the presence of a woman who had healing powers and performed deliverance. In fact, its very existence is a reminder of the global impact of charismatic dynamics even on so-called 'mainline Christianity' (see, for instance, Thomas Csordas's work on the Catholic Charismatic Renewal: 2007; see also Csordas 1997, 2002; in Africa, see for instance, Wilkens 2011), on the one hand, and of the multiple risks of taking for granted the traditional opposition between Protestantism and Catholicism and the values associated with these two poles in religious studies and the anthropology of religion, on the other hand (cf. Meyer 2017). On Catholicism in Ghana, see for instance: Adoboli 2018; Niedźwiedź 2012; Boi-Nai and Kirby 1998; Obeng 1996.

[88] Interview with Maame Akuba, 11 July 2017.

[89] On chaining practices in prayer camps and elsewhere see Chapter 5.

However, at the end of the therapeutic process, once the person is healed, the *asofo* do accept 'something from the patients' hearts' in the form of monetary donations and gifts.

Ideally once a month (but more realistically when the unit can afford it), one of the nurses, normally the CMHO, goes to the prayer camps on outreach. The nurses are allowed by the pastors to carry out assessments and follow-ups, fill prescriptions, and sell drugs. Occasionally, the *asofo* themselves call the nurses or refer patients to them when they think their intervention might be useful. They do so when they consider that the condition is not (or not only) 'spiritual', or when they think it would be appropriate for certain camp patients to take psychotropic drugs to contain their 'aggressiveness'. In other words, in these cases drugs can help 'manage' the illness, while prayers and other spiritual practices are aimed at directly 'healing' patients (cf. Arias et al. 2016: 11; Read 2019: 626 ff.). During one of our conversations, in order to explain to me why he allowed hospital nurses to visit the camp and his 'children' (patients) to take 'their' medications, Esofo Christ quoted directly from the Bible:

> Give doctors the honour they deserve, for the Lord gave them their work to do. Their skill came from the Most High, and kings reward them for it. Their knowledge gives them a position of importance, and powerful people hold them in high regard. The Lord created medicines from the earth, and a sensible person will not hesitate to use them. Didn't a tree once make bitter water fit to drink, so that the Lord's power might be known? He gave medical knowledge to human beings, so that we would praise him for the miracles he performs. The chemist mixes these medicines, and the doctor will use them to cure diseases and ease pain. There is no end to the activities of the Lord, who gives health to the people of the world. My child, when you feel ill, don't ignore it. *Pray to the Lord, and he will make you well.* Confess all your sins and determine that in the future you will live a righteous life. Offer incense and a grain offering, as fine as you can afford. *Then call the doctor — for the Lord created him — and keep him at your side; you need him*.

However, he added:

> if evil spirits possess somebody – many girls are here now that are possessed by evil spirits – in such a case, if you use medications for one hundred years and over, they will not be

> healed. Instead prayer! Through prayer, the power of the Spirit and then the fire of God goes onto them and if they [the spirits] are not able to stand, they quit, they go away and leave the person free...but in such a case, you cannot use medications *to heal*.[90]

While for the nurses prayers can be a form of support to medical treatment, in the *esofo*'s perspective, psychiatric drugs can, in some possession cases, be *kept at one's side*, and *put alongside* prayers: 'Sometimes *when I treat them in prayer*, I order them to go there [to the hospital] for medications'.[91] Drugs cannot heal, but they can 'help' in the healing process.

On particular occasions, however, the nurses themselves also see the point of seeking help from pastors or traditional healers. To be honest, when I told the nurses that both Esofo Christ and Maame Akuba mentioned that the unit occasionally 'referred' patients to them, making their supposedly asymmetric relationship reciprocal, not only did they deny it, saying that they only referred patients within the institutional hierarchy (to Ankaful Psychiatric Hospital, for instance), but they also started laughing, and joked about assigning referrals to the famous 'traditional/fetish priest' Nana Kwaku Bonsam.[92] Nevertheless, when I continued to ask them if they ever considered a 'spiritual side' to 'mental illness', presenting hypotheses based on events that had taken place at the unit during my previous fieldwork, John described two 'case studies' in which he acknowledged that the 'spiritual aspect' had to be taken into account.[93] The first referred to a woman who claimed to have been 'used by some *awozonle* for their work' (possessed). She said she just needed to perform a ritual and would be fine. When he looked at her, John did not see 'anything abnormal': he knew that even though 'when it comes to science you don't buy it [...] what she was saying was somehow true'. 'Sometimes you get stuck', he

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[90] See Sirach (Ecclesiasticus) 38: 1-15; Interview with Esofo Christ, 10 November 2014.

[91] Interview with Esofo Christ, 10 November 2014.

[92] Nana Kwaku Bonsam is an 'International Traditional Priest', as he self-defines on social media (see his Facebook page: <https://www.facebook.com/nanakwakubonsampowers/>, last accessed 30 December 2022), very well known in Ghana and the diaspora. On his figure and his popularity, see for instance: Meyer 2012a, Grossi 2017.

[93] Group interview with psychiatric nurses, 10 July 2017.

commented. On that occasion he decided to let her go, somehow endorsing her spiritual therapeutic pathway, and asked her to return after the ritual. She did not, but when he met her again some time later she was perfectly fine.

The second 'case' he recalled was about witchcraft: the subject was a girl who was 'crying in a sad mood' and did not calm down even after she had been given *diazepam.*[94] Her relatives thought the condition was coming from one of her aunts, who did not want her to prosper: every time she moved somewhere to work, first to Accra and then to another town in Nzemaland, she experienced the same condition. John gave her family a referral letter to a hospital near her home town, and some time later he asked some colleagues who worked there about her, but neither the girl nor her family had shown up. The referral letter was like a concession: 'I believe that now that she is back home, she is OK.' 'For us, we can put the spiritual aspect there, even though it is not in our books', Francis added, effectively summarising his and his colleagues' position.

As asymmetric and partial as they may be, the experimental collaborative relations between the psychiatric unit and the two prayer camps, as well as the nurses' ambivalent acknowledgment of a 'spiritual' dimension to 'mental illness' (cf. Ceriana Mayneri 2009-2010), illustrate something that is at the centre of this thesis and is indeed quite obvious: the absence of any supposed antinomy between religion and psychiatry, even in caregiving.[95] What is striking, however, is the key role played by psychopharmaceuticals in these articulations: in fact, the everyday relationships between prayer camps and mental health workers are essentially *mediated by* and *based on* psychotropic drugs.

For nurses, selling or 'advertising' medications to patients or their relatives in prayer camps becomes crucial for them to be able to take care of people, to do their job. Hence, on outreach occasions, biomedical mental health care becomes available mainly in the form of tablets, drug sachets, injections, and the like. However, as was recounted to me in many of the stories I have

[94] An anxiolytic that is often used as an anticonvulsant. For more details on the range of psychotropic drugs available at the unit see chapter 3.

[95] For a further discussion of the idea of a conceptual incompatibility between religion and psychiatry, see Chapter 4.

listened to in Nzema prayer camps and households, 'it's all about money': for most patients and their relatives, mental health care remains 'unaffordable'.

In patients' therapeutic paths, prayer camps are not only places to go to be 'completely' healed (Read 2012b) by God, but they also offer a shelter, a 'chance', when biomedical care is unaffordable (cf. Goldstone 2017). This does not mean, as Read convincingly showed in her influential paper on the perceptions of antipsychotic medications and their effects in Ghana, that if they were affordable drugs would always be preferred to spiritual healing, prayers, and the miraculous possibility of being freed from suffering forever. Indeed, the sometimes deceptive power of psychotropic drugs – that can be 'too strong' (cf. Read 2012b: 444), thus not compatible with daily work and what is perceived to be a healthy life, and at the same time too evanescent, thus not conclusive in terms of healing – can be troubling not only for patients and their family members, but also for healers who open their prayer camps to pharmaceutical treatment. During an outreach visit with Ernest, a psychiatric nurse that works alone at a local health centre, Maame Akuba complained to him: sometimes God told her that people needed only prayers, other times he directed her towards hospital drugs, and she always followed the instructions she received. But sometimes she was very puzzled: 'why do those people who must be treated with medications become fine and then, after a while, they fall sick again? I don't understand'. Ernest 'explained' to her that for some illnesses it is necessary to take drugs continuously: you have to continue living *with* the drugs. Maame Akuba nodded, but remained dubious. During my meetings with Maame Akuba, we spent a lot of time talking about the miracles God was able to perform through her, through prayers: like the time God removed a shard of glass from one of her children's belly, or the time God restored the sight of another one by extracting a tiny hook – one that even doctors were not able to take out – from his eye. These compelling experiences, that she always described in vivid detail and narrated during the testimony sessions of prayer programs held at the camp, presented a counterpoint to the transient effects of psychotropic drugs.

Any reflection on the elusive power of psychopharmaceuticals (and prayers), however, must be combined with a consideration of the (in)accessibility of psychiatric care and biomedical care more generally. As a matter of fact, this is relevant not only in 'mental illness cases': it is not uncommon for people who cannot sustain the cost of expensive operations or long journeys to

specialist hospitals to decide to seek help from prayer camps. From this perspective, prayer camps might be conceived of as 'zones of social abandonment' (Biehl 2005), places where medical institutions do not (usually) intervene directly, but to which people are sent through processes of social exclusion and abandonment that are carried out by these same institutions. They are definitely much more than that, however. Unlike Biehl and Catarina's *Vita*, Esofo Christ's and Maame Akuba's prayer camps are not sites of abandonment *per se*: patients are usually taken there by a caring relative who is required to stay with them during the healing process, and they are encompassed within a form of social life that revolves around church activities, such as joint prayers, services, daily tasks within the prayer camp and sometimes even outside of it. Nevertheless, they are also places where the social exclusion produced by the inaccessibility of public health services becomes visible. Paradoxically, what happens when institutional mental health care enters prayer camps to reach excluded people – the 'mentally ill' *and* their caregivers – is to a large extent a reproduction of this social exclusion. In fact, outreaches are conceptualised by nurses as a means of making contact with people who fail to attend the psychiatric unit because they are far away (and TNT is an obstacle or deterrent for them), or because they are 'ignorant' of its existence and/or its therapeutic role (they are 'superstitious'). Although it can work for some, on most of the occasions when nurses assess patients in prayer camps and suggest that they or their caregivers should buy medication, unaffordability emerges as a major problem that tends to engender a (forced) refusal. As I will discuss in the next chapter, this has a notable impact on the ways in which psychiatric caregiving is performed and understood.

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This analysis of the complex processes of the provision of mental health care should not lead us to attribute extensive recourse to prayer camps or adhesion to their demonic interpretations of 'mental illness' entirely to economic precariousness and the unaffordability of medication. Prayer camp experiences need to be understood in the context of the broader pentecostalisation

of society and the public sphere that has affected Ghana in past decades, as well as in the narrower singularities of people's stories, which should always be investigated on a case-by-case basis.

This chapter, however, invites a reconsideration of the weight of spiritual interpretations of 'mental illness' in the debate around mental health and collaboration in Ghana. As we will see more in detail in Chapter 4, the horizon of these interpretations, whether they be linked to (the entangled dimensions of) witchcraft, demonic possession, taboo, or offences against the *awozonle*, is usually shared by biomedical practitioners, and does not seem to be the main obstacle to accessing psychiatric health care, as is sometimes claimed in institutional discourses like the ones quoted at the beginning of the chapter.

Partially building on a process of marginalisation of traditional religions and medicines in the Ghanaian public sphere, the main form taken by collaboration in discourses (Read 2019) and practices alike is a juxtaposition of the biomedical and the spiritual in the form of *drugs+prayers*. Nurses suggest a collaboration to pastors that is mediated by drugs to be set alongside prayer, with the former being presented as useful tools for 'managing' the illness. This raises a number of crucial questions with regard to the form of therapy psychiatry offers to patients in these instances: it seems to be closer to the idea of control than to a concept of healing or care (cf. Read 2019, see also Goldstone 2017). The unstable relationship between care and control (Basaglia 2005; see also Schepher Hughes and Lovell 1987) will be further explored in this work, in this chapter, however, I have tried to take a step back, and to question the material and pragmatic implications of these ideas of collaboration: what happens when pastors agree to collaborate in this way?

In the Nzema area, collaborative experiments occur under, and are informed by, 'extraordinary conditions' of scarcity, as witnessed by the story of Rose and Emmanuel, former patients of the psychiatric unit who became 'vagrants'. They take place in prayer camps, which are zones of 'interpersonal social abandonment' that nevertheless provide a social service for patients and their caregivers – those who 'struggle with' them – filling the gap left by neoliberal

health institutions.[96] Finally, they are embedded in an (in)formal economy of trade in psychotropic drugs that, while framed as an emergency measure, normalises the social exclusion and abandonment of those who cannot afford them. In a rural context such as the one where I carried out my research, the socio-economic and political conditions that allow people to suffer, and possibly even die, through processes of social abandonment are undeniably 'ordinary': they mark people's everyday lives. Here, however, playing with Jenis Jenkins's powerful definition of 'extraordinary conditions' (2015), I have often framed them as 'extraordinary' in an attempt to reveal the danger of their normalisation and to stress their crucial entanglement with the 'struggle' of 'mental illness' itself, for sick people and their caregivers alike. According to Jenkins 'the anthropological study of mental illness is necessarily a study of *extraordinary conditions*' (2015: 259, emphasis added), a term that for her

> carries double meanings. In the first place, it refers to conditions—illnesses, disorders, syndromes—that are culturally defined as mental illness. However, [it also refers to] conditions — warfare and political violence, domestic violence and abuse, or scarcity and neglect of basic human needs — constituted by social situations and forces of adversity (*Ivi*: 1)

Inspired by Jenkins's effort to conceptualise the intersection between 'the nonordinary and spectacular qualities of mental illness in experience and representation' (*ibidem*) and the often dreadful socio-economic and political conditions that inform the 'interactive process' of mental suffering (ivi: 254), in this work I constantly try to find a balance between the significance of meanings, interpretations, and subjective experiences attributed to madness, mental illness, and mental health and the many, complicated practical ways of dealing with it, highlighting the

[96] As already observed by Jean Comaroff more than ten years ago (2009: 20-21), 'At a time when, under the sway of neo-liberal policies, many states have relinquished significant responsibility for schooling, health, and welfare - in short, for the social reproduction of their citizens - religious organizations have willingly reclaimed this role. [...] It is not merely that faith-based initiatives are expanding, that their culture of revelation is having a major impact on ordinary understandings of self, identity, politics, and history. These movements are assuming a widening array of civic responsibilities, especially where state sovereignty has been compromised for one reason or another'.

necessity of paying attention to their most material implications. What is the impact of scarcity, the commodification of health, and the unaffordability of drugs on the ways in which 'mental illness' and mental health care are experienced and practised?

Even in the context of potentially beneficial relationships between biomedical practitioners and prayer camps, these conditions radically inform the trajectories of people living with mental illness and, at the same time, complicate the practice of caregiving. Indeed, mental health workers seem to walk on a tightrope stretched between market and care - as I further explore in the next chapter.

3. MARKET | CARE

Provincialising pharmaceuticalisation, localising Global Mental Health

In the previous chapter, through the exploration of the antinomy prayers vs. drugs – an antinomy that actually turned out to be a powerful dyad in the discourse of collaboration – a third, often neglected element strongly emerged: money. If it is true that psychotropic drugs operate as mediators in experiences of collaboration between psychiatry and spiritual healing, it is also true that they often do so within the framework of an economic exchange in a scenario marked by severe scarcity. What can this nexus tell us about the role of psychopharmaceuticals and their impact on mental healthcare in a country like Ghana?

Investigating the role of psychotropic drugs across the world today means addressing a crucial theoretical issue, both on a phenomenological and socio-political level. It means looking at how psychotropic drugs represent increasingly widespread 'technologies of the self' (Foucault 1988) capable of moulding subjectivities and experiences and, at the same time, how these tools – which can also act as 'technologies of power' (*ivi*: 18)[97] – articulate with multi-layered inequalities and their social (re)production.

Exploring these entanglements between the experiential and the political is particularly intriguing in the so called Global South, where common assumptions about the hegemonic role of psychiatry and psychopharmaceuticals are often called into question by the general unavailability and unaffordability of such resources and their coexistence with other popular forms of traditional, religious, and spiritual care.

[97] A particularly powerful example of drugs as technologies of power can be found in migrant detention centres in Italy (CPR - Centri di Permanenza per i Rimpatri) where the abuse of psychopharmaceutical prescription and administration as a means to control 'inmates' – a practice that should be understood at the intersection of political processes of migrant medicalisation (Beneduce 2015) and illegalisation (De Genova and Peutz 2010) – has been recently documented (Borlizzi and Santoro 2021). On the carceral use of psychotropic drugs as 'technocorrections' in a different context (the United States) see Hatch 2019.

As suggested by Byron Good with reference to the Indonesian and Chinese cases, looking at the role of psychotropic medications in contexts strongly marked by the scarcity of resources and the difficulty of access to biomedical mental health care forces us to reframe the analysis of 'pharmaceutical hegemonies' (Good 2010: 117). Moreover, he adds, we should ask ourselves 'how might our roles as researchers and advocates for improved mental health services influence how we address these issues?' (*ibidem*).

Interrogating the role of psychotropic drugs in Global South contexts may have extremely relevant implications also on the ways in which we conceive of our own positionality in the field as critical medical anthropologists and scholars of mental health more generally. It is mainly for these reasons that in this chapter I propose to re-examine the key issue of the contemporary pharmaceuticalisation of our selves and imaginaries as outlined by Janice Jenkins (2010b) from the peripheral point of view of Nzemaland.

Pharmaceutical selves and (critical) Global Mental Health

Between self and imaginary

In an edited book dedicated to analysing the global proliferation of psychopharmaceutical use from an anthropological angle, Janis Jenkins introduces two complementary concepts: *pharmaceutical self*, that is the increasingly widespread 'subjective experience of psychopharmaceuticals' and *pharmaceutical imaginary*, which she uses to identify the 'global shaping of consumption' (Jenkins 2010b: 6).

If I think about my own experience in European contexts (Italy, the UK, Spain), it is not difficult for me to acknowledge that psychotropic medications have become an inherent part of intimate experiences and everyday practices, as well as discussions: they are prescribed, sold, bought, taken, abused, stopped, 'discontinued', criticised, sanctified, demonised.

One of Jenkins' main theses is that the pervasiveness of psychopharmaceuticals in shaping human subjectivities and imaginaries goes well beyond the specific cases of particular national contexts – i.e. the US, where she has conducted her research – or conditions – i.e. psychosis, the

treatment of which she has long studied. According to her, 'the extent to which we are *all* pharmaceutical selves has yet to be fully appreciated' (Jenkins 2010c: 17, emphasis in the original). It is precisely the entanglement of the concept of *self* with the concept of *imaginary* that leads her to make this statement. Interestingly, she suggests that the idea of a 'pharmaceutical self' applies not only to people 'on medication', but also to those cases in which people *do not take drugs* because of a free choice or lack of access. 'The point – she argues quoting psychological anthropologist Steven Parish – is that the existence of pharmaceuticals for ingestion on a regular if not routine basis is culturally understood as a means for constituting a "possible self"' (Jenkins 2010c: 38), where the 'possible self' is understood as 'a venture into life, a way of endowing life with purpose and direction, the form that the human effort to live takes' (Parish 2008: ix).

Conceiving of the *pharmaceutical self* – understood as a reality and/or a 'possibility' – as pervasive entails two different questions. First, does this represent 'a problem' in a critical perspective? And second, to what extent is this idea of a global process of *pharmaceuticalisation* Western-centric?

As retraced by Byron Good, there is an extensive anthropological scholarship that analyses the crucial role of psychopharmaceuticals in contemporary societies within the framework of the 'medicalisation hypothesis' (Good 2010). These perspectives highlight how complex social and psychological issues have been increasingly reduced to their merely (neuro)biological dimension. This bio-conceptualisation of mental suffering – which has notoriously become hegemonic in psychiatry – met the interests of an expanding pharmaceutical industry that aimed at marketing 'magic bullets'[98] all over the world. Indeed, as anthropologist Stefan Ecks has recently stressed (2022: 105), medicalisation and pharmaceuticalisation can be complementary, but they are not the same thing: medicalisation increases the professional power of doctors, while

[98] The expression (in German *Zauberkugel)* was coined by German Nobel Laureate Paul Ehrlich to conceptualise the function of antibiotics, that is the pharmaceutical capacity to target the cause of the disease in the body without harming the rest of it. This principle was used to describe arsphenamine, the first effective antisyphilitic medication introduced in the first decade of the 20th century. The 'magic bullet' pharmaceutical theory was translated to the field of psychiatry in the 1950s, though its validity in the realm of psychopharmacology is increasingly contested and called into question (Ecks 2013: 190).

pharmaceuticalisation – understood as a 'reduction of human problems to medical prescribing' (Nichter and Nichter 1996, quoted in Ecks *ibidem*) – boosts the profits of private companies.[99]

An unresolved hegemony?

According to many critics, a narrow and often market-oriented understanding of mental health is at the core of the *Global Mental Health* discourse (see for instance Fernando 2014, Mills 2014, Summerfield 2013). The expression *Global Mental Health* (GMH) was introduced for the first time in the public debate in 2001 by US Surgeon General David Satcher (Satcher 2001). The terminological shift from 'world mental health' – the expression previously used in policy and scholarly literature (see for instance Desjarlais et al. 1995, Cohen et al. 2002) – to 'global mental health' anticipated by Satcher's piece in *JAMA* marked a clear political shift: while both expressions invoked a worldwide approach that paradoxically focused only on low- and middle-income countries, the second one explicitly put the emphasis on the need to include mental health care in the Global Health agenda (Ecks 2022: 195).

Since the early 2000s, and especially after the publication of the influential article 'No Health Without Mental Health' (Prince et al. 2007) and a series of related papers in the *Lancet* in 2007 and the foundation of *The Movement for Global Mental Health*[100] in 2008, GMH emerged as a strong paradigm in public health policies, with the aim of overcoming the inadequacy of mental health care in low and middle income settings and filling the so-called 'treatment gap' (Patel et al. 2010). The 'treatment gap' – a notion first introduced by the 2001 WHO World Health Report (World Health Organization 2001) dedicated to mental health

[99] Drawing on Abraham (2010), in his reflection on pharmaceuticalisation Ecks stresses also the absence of a mutually constitutive relationship with medicalisation, as the marketing of drugs can increasingly progress without the transformation of a general 'problem' into a 'medical one' (Ecks 2022: 105).

[100] The Movement for Global Mental Health self-defines as 'a network of individuals and organisations that aim to improve services for people living with mental health problems and psychosocial disabilities worldwide, especially in low- and middle-income countries where effective services are often scarce. Two principles are fundamental to the Movement: scientific evidence and human rights'. See: <https://www.globalmentalhealth.org/pages/about>, last accessed 30 December 2022.

(Lovell et al. 2019: 524) – is 'the gap between the numbers of people assumed to be suffering from mental illness and the numbers receiving treatment' (White et al. 2017: 12), where treatment – it is crucial to stress it – is to a large extent understood as pharmaceutical.

As shown by Anne Lovell, Ursula Read, and Claudia Lang in a recent special issue of *Culture, Medicine, and Psychiatry* (Lovell et al. 2019; see also Bemme and Kirmayer 2020; Rose 2019), *Global Mental Health* is today an 'assemblage', a heterogenous constellation of different perspectives and practices that keeps changing. In this perspective, it is important to highlight that some of its leading advocates have recently acknowledged the limits of a 'biomedical definition of mental disorders' (Patel et al. 2018). Nevertheless, it is undeniable that today GMH is still eminently based on psychiatric reason and its universalistic understanding of 'mental illness', currently characterised by 'evidence-based' and pharmaceutical interventions (Beneduce 2019; see also Sax and Lang 2021a; Cosgrove et al. 2020). This makes still very relevant the criticisms advanced by scholars and activists who have proposed to read Global Mental Health as a (neo)colonial project aimed at achieving a 'psychiatrization of the majority of the world' (Mills 2014), through the introduction of Western nosologies and the lucrative expansion of related pharmaceutical markets (among others, Fernando 2014; Mills and Fernando 2014; Summerfield 2013).

On the other hand, however, with its own existence, the Global Mental Health discourse seems to suggest that the process of pharmaceuticalisation is less hegemonic than what we may think, at least outside the psychiatric environment. In fact, even though it is true that psychotropic drugs increasingly circulate formally and informally in many non-Western contexts,[101] it is also true that the 'treatment gap' identified within the *Global Mental Health* discourse goes along with the scarcity that characterises many countries in the Global South. If one is familiar with one or more of such contexts, it is very difficult not to agree, at least partially, with Byron Good when he states that

[101] See, for instance, Ecks 2013, 2017, 2022; Ecks and Basu 2009, 2014; Biehl 2010; Good 2010; Tran et al. 2020.

> [P]ut simply, [in resource-poor settings] the logic suggests too few drugs rather than too many (...); too little understanding of the potential benefits of medications rather than too great expectations; too little access to the full range of antipsychotics, which allows for alternative medications to be prescribed for 'treatment resistant' conditions; too few community resources for mental health care; and too little support for psychiatrists and mental health workers who practice in the absence of broader social, cultural, and financial support (Good 2010: 122).

In this perspective, the discourse of Global Mental Health – which plays a key role in informing public debates and policies on mental health in countries like Ghana – could be understood as simultaneously an expression of psychiatric/pharmaceutical hegemony and of its failure in the Global South, where the unaffordability of biomedical care – together with the plurality of therapeutic resources – is often a constant element, as in the stories of Kaku, Rose, Emmanuel (Chapter 2) and many others among my interlocutors. Calling into question the (unresolved?) hegemony of psychopharmaceuticals and exploring the entanglement of market dynamics and Global Mental Health is particularly interesting at the present moment, as according to many Western psychiatry is going through a deep crisis (see, among others, Ecks 2022, Harrington 2019, Scull 2022). This is not unprecedented: as suggested by historian Anne Harrington, the diachronic trajectory of psychiatry could actually be retold as a chain of perceived/announced revolutions and crises that recursively dealt with the mirage of a univocally biological understanding of 'mental illness'. Thus, perhaps not surprisingly, the current crunch is the expression of the decline of the most recent 'biological enthusiasms'[102] (Harrington 2019) and the concurrent disinvestment in psychopharmacology. As a matter of fact, though it would be difficult to infer it if we only

[102] In an emblematic, often quoted declaration, Thomas Insel, the former director of National Institute of Mental Health (NIMH) – the lead institution for research on mental health in the United States – stated: 'I spent 13 years at NIMH really pushing on the neuroscience and genetics of mental disorders, and when I look back on that I realize that while I think I succeeded in getting lots of really cool papers published by cool scientists at fairly large cost—I think $20 billion—I don't think we moved the needle in reducing suicide, reducing hospitalizations, improving recovery for the tens of millions of people who have mental illness' (Rogers 2017).

looked at prescription and sale rates worldwide (Ecks 2022: 224; see also Brauer et al. 2021; Oldani et al. 2014),[103] the efficacy of psychotropic medications and the validity of pharmaceutical theories (e.g. the influential 'chemical imbalance' argument) have been increasingly challenged in the last few years, often provoking debates, strong reactions, and confusion in the public sphere (see for instance a recent article published by Joanna Moncrieff and colleagues [2022] on the serotonin theory of depression and its subsequent reverberations: Moncrieff 2022a, Moncrieff 2022b). Simultaneously, after having invested in producing drugs aimed at keeping patients in chronic treatment and in developing almost exact replicas of already existing substances in order to maximise profits, in the last decade the private pharmaceutical companies that funded most of the research on psychotropic medications have started defunding research in this field as no longer cost effective (Dumit 2018).

There is no crisis (?)

In a poignant review essay of *Mind Fixers* (Harrington 2019) and *Desperate Remedies* (Scull 2022) published in the *Boston Review*, the historian of medicine and psychiatrist Marco Ramos suggested that 'while both Harrington and Scull point to a "crisis" in the profession today, the scarier truth is that many in the academy are proceeding with business as usual. The real crisis in academic psychiatry, in other words, is that there is no crisis' (Ramos 2022: § 50). Something similar could be said about *Global Mental Health*. According to Ecks (2022: 210), some oblique allusions to the 'growing doubts about the efficacy of medications' might be identified in recent policy documents like the WHO *Mental Health Action Plan 2013-2020* (World Health Organization 2013). However, the recently published WHO *World Mental Health Report* (2022), while reaffirming in theory the importance of psychosocial approaches coherently with previous publications (WHO 2022: 139), continues to hold as key features in the discourse both the 'treatment gap' and psychopharmaceuticals, which are often mentioned especially – and interestingly so – in the lived experience

[103] If we look at such figures it is evident that the 'prescription' and 'psychiatric drug epidemic' observed by some authors (see, among others, Davies 2017, Moncrieff 2017) is still ongoing.

narratives that punctuate the document. In many ways, the GMH discourse seems often to be detached from debates and developments that are currently shaking Western psychiatry as a profession. Put another way, while affirming a universal order in which every place in the world belongs to the same global health space, GMH risks to relegate low and middle income countries – the *local* sites where *global* mental health is intended to be enacted – to an allochronic present where the ongoing crises in psychiatry and psychopharmacology have not yet occurred, where a *pharmaceuticalisation of the self* is yet to be achieved. A way to challenge this narrative, I suggest, is to follow Jenkins' invitation to conceptualise *pharmaceuticalisation* and the *pharmaceutical self* as a reality *and* a 'possibility', at the intersection of subjective experience and consumption. Another way to challenge this narrative, as it happens with the rhetorics of global health more generally (Biehl and Petryna 2017), is to dive into ethnography. I will try to do both in the next pages, by looking more closely at the entanglements of market and care and their material and ethical implications on the ways in which mental health care is performed in Nzemaland.

'C'est l'argent qui parle': money and medicines

'Money talks', Ama talks back

Without any intention of fetishising it, we could say that ethnographic research, being essentially nothing else than a dimension of everyday life, is also made of epiphanies, moments in which we suddenly seem to see something we had not seen before. I had for the first time this kind of feeling during one of the outreach activities I described in the previous chapter. It was the first time I visited Esofo Christ's prayer camp, in October 2014. I was with Michael, one of the nurses of the unit, who, knowing about my interest in the unit's relationship with local healers, had invited me to accompany him. The camp is a vast outdoor space that includes the *esofo*'s house, an aisleless church, and a modest building with some rooms for the residents. Many of them, patients and family members who were required to stay with them throughout the healing process, were sitting and lying outdoors in the shade of a tree or under a raffia

canopy, where some women were cutting and peeling cassava, and cooking soup for lunch. After having introduced himself to a woman and having learned that the prophet was not home, Michael started identifying potential 'mentally ill' patients, partly on his own and partly with the help of the woman. Apparently there were seven, three of them chained to trees. Sitting in the shadow of a tree in the centre of the camp there was George, a young man that Michael immediately recognised as a unit patient who had discontinued his treatment, and then sitting next to each other, their ankles tied to two different trunks, Kouao, an Ivorian man in his late forties, and Ama, an Ivorian woman in her twenties. Similarly to what happens in national debates about mental health, the topic of mechanical restraint was recurrent in my conversations with psychiatric nurses, especially when we discussed the risks and potential incompatibilities entailed in their attempts to collaborate with prophets and prophetesses (Read 2019; see chapter 5). In that case, however, Michael preferred to adopt a pragmatic approach: he avoided focussing on this aspect and immediately started talking to the presumed 'mentally ill' residents and their relatives in order to assess the patients and prescribe them the appropriate medication(s). Observing one of these consultations before her turn came, Ama shook her head and cracked a sardonic smile: 'C'est l'argent qui parle!' – she commented.

Ama had been at the camp since the beginning of May. The day her husband decided to bring her there, she had gone to look for her father in one of the big coastal towns in the area, because – she recalled – somebody in her father's sister's town, where she was living at the time, had told her that he was not dead as she believed, but was now based there. She asked around, and she realised her father was not there. From then on, she did not remember anything, except that her husband put her in a car and brought her to Esofo Christ's prayer camp. She spent four days there, from Sunday to Wednesday. On Thursday she tried to escape: at first she tried to stop a car just outside of the camp,[104] but her mother – who was staying with her – sent the driver away. So she waited a bit and went to town, where she joined another car to go back to the place where her father was supposed to live. But they brought her back. Eleven days later, she was put

[104] Shared taxis, simply called cars (in Nzema *kale*) or commercial cars, and motos (generally identified by the Nigerian term *okada*) that pick up passengers on a fixed route are the main means of transport for people in the area. Esofo Christ's prayer camp is located at the outskirts of the town, but close to a road normally covered by shared taxis.

in chains because she refused to bath,[105] and probably because they were afraid that she would have tried to run away again. She did not understand why she had to stay there, why her mother wanted her to stay. Before coming to Esofo Christ's place – her mother told me – they brought her to the hospital, because she had a high fever and had started having these 'mental problems':[106] 'her father had died a long time ago, why was she convinced that he was still alive?'. Her mother did not understand what happened to her, she did not know, only the *esofo* could know. At the hospital she was prescribed some psychotropic drugs, but after a while she refused to take them: she did not feel 'normal' after swallowing them, she slept too much. According to Esofo Christ, whom I talked to a few weeks later, when Ama was not in chains anymore and she was finally 'very very sound',[107] there were two events behind her condition: some time after the death of her father she had gotten married in the absence of his successor, who was not pleased about it and 'this also caused that trouble', and secondly – she 'confessed' to him – she had stolen gold from her husband.

I learned these scattered details about Ama's life – her conflicts with her father's family, with her husband, and probably also with her deceased father, who did not allow her to marry her first child's father when she was sixteen – in subsequent visits to the prayer camp, because when I first met her with Michael during the outreach, we barely stopped by 'her' tree to talk to her after her mother had made clear that she was not interested in buying any drug, as her daughter refused to ingest them.

It is not my intention here to fall in the cliché of the 'mad who reveals the truth', but after having talked to her and her mother it was clear to me that when she made her ironic comment, Ama was speaking from a position of detachment from both the prayer camp solution – from which she had tried to escape – and the solution proposed by the psychiatric nurse visiting the camp – whose drugs she refused to take. Talking back from that position, she was able to enlighten something deeper than the mere prayer camp-hospital opposition evoked in institutional and scholarly debates that was so central in my own conceptualisation of mental

[105] On dirt as a worrying sign of madness, see Chapter 2, note 2.

[106] Interview with Ama and her mother, 24th October 2014.

[107] Interview with Esofo Christ, 10th November 2014.

health care in Ghana at the time. Indeed, the provocative power of her challenging assertion pushed me to appreciate the almost exclusive pharmaceutical nature of psychiatric nursing – to the point where, since she refused to take drugs and her mother was not opposing her decision, it seemed there was no need for Michael to assess her – and the complexities of the money-drug nexus in the ways in which mental health practitioners were able to provide care in the area.

How do you treat 'mental illnesses'? The 'hegemony' of drugs at the unit

If the unaffordability of psychopharmaceuticals described so far may lead us to call into question the idea of a global pharmaceutical hegemony in line with Good's reflections (2010), it is difficult to deny that drugs are quite 'hegemonic' among the psychiatric nurses I carried out my research with: throughout the years, their provision has always been a key preoccupation for them, they are the first form of treatment nurses think of when they describe their job, and it is very rare for them not to prescribe any psychotropic medication to people they identify as affected by a 'mental condition', like schizophrenia, bipolar disorder, or depression. At the unit, psychotherapy, family therapy and counselling are often evoked as important and potentially healing practices, but they are rarely practised and – not differently from 'prayers' (cf. Chapter 2) – they are frequently conceptualised as a supplementary resource to pharmacotherapy, or something functional to it. For instance, as Rama, a mental health nurse working at the unit since 2017, put it:

> With them [people with schizophrenia] it's a bit huge, it is something that is serious sometimes, because some with schizo, they show signs of depression and mania at times, so it depends on the signs and symptoms, because with them, their mood and stuff, maybe the treatment you would give, it's not all that [easy], *so it's medication, education... With medication, education you are good to go*. But sometimes we involve the family 'cause sometimes the lifestyle of the person doesn't help with the treatment so we talk to the family about the condition (...) so that you'll know how to manage the person, with the drugs too.[108]

[108] Interview with Rama, 11th January 2022, emphasis added.

As it is often the case, in Rama's words counselling and 'family therapy' are blended together under the idea of 'education' about the condition and its (pharmaceutical) management (cf. Chapter 6).

It would be reductive and ultimately unfair, however, to say that psychiatric nurses in Nzemaland exclusively promote a narrow biological and pharmaceutical-oriented understanding of mental distress. When I directly asked her how 'mental illnesses' could be treated, for example, Juliet started from drugs and ended by stressing their limits, and the need to take into account the social dimensions of mental suffering when dealing with patients:

> We do treat mental illness firstly by identifying them: you go round, you have to identify the patients. (...) we have 'assessment': that is how you know that this person is suffering from depression, this person is suffering from schizophrenia, because the signs and symptoms will show (...). After the assessment, you have to diagnose. And after diagnosis you have to treat, *by giving them the medication*: somebody is suffering from schizophrenia, you have to give '*Ola*',[109] sometimes you have to give *Largactil*,[110] when the person is aggressive, sometimes you have to give *Chlorpromazine*[111] to the client, somebody suffering from depression you have to give... sometimes there is psychosis in depression so that one too you have to give *Olanzapine* to the client. Sometimes you have to also counsel, it is not all, that you have to give medication: you need counselling. It could be that the person is suffering some problems in the house, but we are not aware, so when you are identifying the client, you have to talk to them, you have to find out. So you will find it during assessment. During assessment you will know that this person has this problem and that is why you have to counsel. So I could say that it's not always medication. The ones that need medication you have to give them, but sometimes they will need counselling (...) Sometimes they would just even need work! 'Cause somebody is not having work, it has become a

[109] Abbreviation frequently used at the unit for *Olanzapine*, an atypical (second generation) antipsychotic drug.

[110] Trade name of Chlorpromazine, typical (first generation) antipsychotic medication.

[111] See previous note.

> headache to the person, the person is not sleeping and the person is having migraine because of that, you see! Migraine: you have to give medication, but you still have to talk to the person.[112]

Olanzapine and *chlorpromazine* (Largactil) are among the most prescribed drugs at the hospital,[113] which during the time of my research has been intermittently equipped with a limited range of antipsychotics (*chlorpromazine*, *olanzapine*, *clozapine*, *fluphenazine*, *haloperidol*, *risperidone*), antidepressants (*fluoxetine*, *amitriptyline*), anxiolytics (*lorazepam*, *diazepam*), and anticonvulsants/mood stabilisers (*phenobarbitone*, *carbamazepine*) – as well as medications used to limit some of the side-effects of antipsychotics (*benzexhol*, *benztropine*) – mostly produced in Ghana and India. As anticipated, their availability at the unit depends on irregular supplies from central administration and self-organised provision attempts drawing on individual and collective informal networks, which means that it is not common for the mentioned drugs to be at nurses' (and patients') disposal all at once. In the last few years, especially since 2018, there have been a few positive changes: shortage episodes increasingly reduced and second generation drugs like *olanzapine* and *risperidone*, known to have considerably less side-effects as compared to first-generation drugs (e.g. *chlorpromazine, clozapine, fluphenazine, haloperidol, amitriptyline*) started to be supplied by the central administration, while in the past their availability at the unit exclusively depended on informal provision. However, today psychopharmaceutical supply still remains highly 'erratic' – to adopt the expression used by a supply manager working at Regional Medical Stores in Takoradi to describe the main challenges in psychotropic drugs provision – making continuous

[112] Interview with Juliet, 18th January 2022.

[113] This is related to the fact that schizophrenia is by far one of the most diagnosed conditions at the unit, generally second only to with epilepsy (which despite being a neurological disorder falls under the umbrella of psychiatry as it is often the case in countries classified as 'low income' in Global Mental Health literature, cf. Lovell and Diagne 2019: 669).

pharmaceutical therapy at the unit highly problematic.[114] Together with their unpredictable availability, another issue that has continued to be relevant in my conversations with many of the nurses and in discussions among them is the narrowness of the range of medications they are able to prescribe to their patients.

After coming back from his study leave with a fresh degree in 'Mental Health Nursing' from the University of Cape Coast[115] and becoming the new unit 'in charge' (or 'IC', as it is common to say in the hospital jargon), in November 2021 Francis, one of the veterans of the unit, started preparing a list of psychopharmaceuticals to request to the hospital pharmacy staff for them to 'hunt' them in the 'open market' and – if prices allowed – buy them in order to extend the variety of drugs available at the hospital: this would have made it easier to look for alternatives for patients who are 'treatment resistant' or suffer unbearable side-effect of prescribed medications. Needless to say: patients who could pay.

On the other hand, Francis was perhaps the strongest critic of an indiscriminate use of psychopharmaceuticals as the main form of treatment at the unit. When asked a similar question to the one I posed to Juliet, he answered:

> Biologically, psychologically, socially: these are the main ways in which you can treat mental illness. Biological: we are talking about a medical approach, giving medication... and doing some lab tests to see if there is infection and all that. And you give medication: general medication and antipsychotics. You are managing biologically. Then, psychologically, maybe you come for counselling, psychotherapy, individual psychotherapy, and all that. Then there is the social, related to other people: family therapy, (...), group therapy, some counselling, and all that. So if you just

[114] Conversation with Mr. Adjey, 12th January 2022. According to the supply manager, the 'erratic' nature of psychotropic drug provision is to be attributed to the full dependency from donors' funding and supply for this kind of medications (cf. Raja et al. 2010; see also the recent document issued within the framework of the UK Aid funded Ghana Somubi Dwumadie Programme: <https://options.co.uk/sites/default/files/ghana_investment_case_mar_2021.pdf>, last accessed 30 December 2022). Essentially, this does not allow Regional Medical Stores to be entirely in charge of pharmaceutical provision to regional and district hospitals.

[115] The University of Cape Coast was the first academic institution to inaugurate a degree programme in Mental Health Nursing in Ghana in 2014/2015.

> come and *they just give the person medication, medication... you are not doing this.* Assuming that my illness has something to do with the fact that I've lost my husband, I'm depressed, and I always come for medication, medication... you need to work on that, that thinking. (...) If you come, I give you medication, and you go... I'm not working on the thought. (...) *If you come and I give medication, and you go, and go, and go, I don't work on your psyche, and the person will keep on coming for medication,* I know that along the line there might be a few relapses, but if you are able to work on the psyche and the social aspect the person can be fine.[116]

'But that, let's say psychotherapy, it's difficult to do it here' – I commented, thinking of the daily routine at the unit. 'It's difficult, it is – Francis agreed – but we want to make a few changes here'. Indeed, after the issue first emerged during a few staff meetings in 2021, the nurses decided to ask some funding to the hospital management with the aim of creating a separate space within the unit – more private and comfortable – to carry out proper counselling away from the eyes and ears of the other patients that usually wait for their assessment/medication(s) sitting on the unit's bench.

'And also' – Francis added

> I've told my colleagues that we need to review our home visits and all that, because (...) it won't be sufficient: 'How are you?' 'I'm fine', 'We came to look at you, if you are doing well, okay, that's all, bye bye', no! We need to do more! You know, before I go for home visits: *what is the need of the client?* Is that there is no family, having issues with family, having issues with the mother or the father, having issues with the husband? You need to find out. So before you go there you have your facts. So maybe [you call them]: 'Hello, I will visit you today. Can I come? (...) When I come I would like to meet you and your husband, can I talk to your husband so that they make the time for me? Okay (...)'. Then you go, and you have the family therapy. There is a procedure for family therapy, you go and have it with them. If you go – he grumbled –: *'How are you?' 'I'm fine'. 'Do you have your medication?' 'I brought medication, will you buy?' 'I won't buy', 'Okay' 'I don't have money.' 'Okay' 'Thank you' 'Thank you'. Then you go! We need to improve on that one.*[117]

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[116] Interview with Francis, 11th January 2022, emphasis added.

[117] Interview with Francis, 11th January 2022, emphasis added.

The overwhelming centrality of drugs in the nurses' practice and the complex therapeutic, moral, and professional conundrums it entails are all in this telling, frustrated, but forward-looking, self-critical reflection.

'I'm not taking anything from them': moral monies?

When right after the visit to the prayer camp, triggered by Ama's provocative remark, 'It is money talking', I asked Michael to explain to me how the informal trading of psychotropic drugs worked – something I had not really looked into before – he started by saying: 'They have to pay but I'm not taking anything from them'. Michael's words echo in a certain way what the Dutch anthropologist Eva Krah was told by some of the traditional healers she worked with in Northern Ghana: '*I don't charge*. Even if they wake me up in the night [to treat them]. By daybreak, if they give me one or two cedi I will take it. ... If they want to give us anything afterwards, we will take it' (Krah 2019: 65, emphasis added).[118]

According to Krah, in the Mamprusi area where she carried out her research, there is a shared idea that traditional healers' 'professional authority is intrinsically bound to the absence of

[118] Another among her interlocutors similarly told her: '*I don't charge*. But what is due to the medicine, I let you pay it. If it is a fowl, you pay for that, if it is four cedi, five cedi, I will tell you that. *But I don't charge*' (*Ivi*: 68, emphasis added).

money' (Krah 2019: 57): charging money is unacceptable for a respectable practitioner.[119] She maintains that local medicine is based on a gift economy where traditional treatments cannot be paid because they are 'imbued with the intrinsic and ineffable identities of their owners' (Krah 2019: 57).[120] It is a knowledge that healers inherited from their ancestors, who received it for their part from a supernatural entity (a deity or a spirit) according to the principle of 'keeping while giving' (Weiner 1992).[121] According to the anthropologist, however, there is an apparent contradiction: many of the healers she met firmly refused the idea of charging money, stating precisely that it is impossible for them to sell anything as the owners of the medicine were their forefathers and not themselves. Yet, they actually received money from patients at the end of their healing process. This money, however, is not understood as a form of payment because it does not correspond to a fixed price and, most importantly, it is not given when the patient receives the treatment, but at a different moment: it looks like a fully-fledged 'counter gift' in

[119] Krah's work is in close dialogue with the ethnography carried out in the 1990s in the neighbouring Dagomba area by Bernhard Bierlich (2007). Reflecting like her predecessor on the relationship between money and therapeutic practices, she gives a different interpretation of *'money spoils the medicine'*, a common expression in Northern Ghana already explored by Bierlich. Even though it seems to evoke the Western *topos* of the devilish nature of money (Parry and Bloch 1989) and the ambivalent ideas about the (im)morality of money conveyed by Christian churches and popular culture in many contemporary African contexts (Meyer 1995, 1998b; van der Geest 1997; Comaroff and Comaroff 1999), they both propose to read the corruptive power of money as not related to 'money as such', but rather to its impact on relationships (cf. Bierlich 2007: 154). For Bierlich the adage has to do with the relationship between men and women: it conveys 'the anxiety experienced by men and elders considering the possibility of the collapse of male authority' (Bierlich 2007: 177) following the 'commodification of medicine' (Farmer 2003: 152 ff.; Dekker and van Dijk 2010) that took place between the 1980s and the 1990s and made it possible for women and young people to buy drugs privately and thus to pursue their healing without recurring to traditional practitioners (normally male and old). For Krah, instead, the conviction that money corrupts curing is common to men and women and does not necessarily express a male preoccupation, but it rather has to do with the relationship between humans and non-humans that is at the core of local traditional medicine.

[120] This conceptualisation explicitly draws on the notion of 'inalienability' as it was formulated by Annette Weiner (1992) and Maurice Godelier (1996).

[121] As it is well known, Weiner's reflection on the 'paradox of keeping while giving' was formulated in relation to the Oceanian context and in dialogue with Marcel Mauss' analysis of *hau*, cf. Aria 2016: 59-65.

Pierre Bourdieu's terms (Bourdieu 2013 [1977]), so as to be often described as 'kola',[122] the gift *par excellence* in Mamprusi culture. Krah proposes to look at the money patients give to their healers as a form of *moral monies*: 'special kinds of monetary (counter)gifts [that serve] as instruments to reunite contemporary monetary needs with the sociocultural, moral, and historical roots of a cultural economy of healing' (Krah 2019: 70).

While Krah, in contrast to those medical anthropological analyses that focus on the impact of neoliberalism on African medical systems,[123] debatably chooses to link this moral dimension of treatment 'payment/gift' exclusively to the realm of traditional medicine – risking to crystallise its image, by reinforcing an artificial polarity (culture/gift/traditional medicine *vs.* neoliberalism/market/biomedicine) and ultimately overlooking how traditional medicine is actually entangled with other economies and practices in everyday life and therapeutic itineraries – it is interesting to reflect on the similarity between the explanation Michael gave to me after the outreach and the *moral monies* invoked by Krah's interlocutors.

Despite evident differences in context and meaning, there is indeed an affinity between the idea of letting patients pay 'without taking anything from them' expressed by Michael and that of letting patients pay 'without charging' suggested by Krah's interlocutors, which is indeed very similar to what happens at Maame Akuba's and Esofo Christ's prayer camps – something quite paradoxical especially if we think of the connections established by scholarly literature between pentecostal-charismatic churches and neoliberal economies. In all these cases, a moral distinction seems to be traced between the specific kind of transaction in which the practitioners are involved and the classic functioning of the market, that entails an earning and a price. During

[122] Widespread in West Africa, kola nuts are fruits of the *cola nitida* and *cola acuminata* trees and have a fascinating history of global circulation. Very rich in caffeine, they are used in ceremonial and ritual occasions, as well as in recreational and therapeutic settings (Abaka 2000, 2018 [1995]; Lovejoy 1980; Osseo-Asare 2018).

[123] 'The idea that century-old systems of health care in Africa – she polemically states – have simply fallen 'victim' to 'the market' doesn't do justice to the complexity of local-global encounters in which, for instance, agentive powers are manifest. Rather than to draw public health transformations into a structure/agency discussion or a social inequality debate, I argue there is the need to re-emphasize and theorize 'culture' in the context of socioeconomic transformations [...] In particular the concept of the gift sheds light on the robustness of culture in the context of an expanding global neoliberal market' (Krah 2019: 56).

our conversation, Michael, as many of his colleagues, was determined to highlight that the money he had asked for in the prayer camp were in a certain way *moral monies*, as Krah would call them. Yet, in line with Ama's comment on the nurse's economic interest, during that morning at the camp, the nurse had declared multiple times his enthusiasm for the number of potential patients-buyers – 'There are many cases here, it's good for us!' – somehow evoking, with his briefcase full of medications, the morally ambivalent image of a pharmaceutical salesman. Every patient assessment ended with a pharmaceutical prescription, with the cost of each medication oscillating between the considerable amount of 15 and 40 cedis, since at the time most of the drugs available at the unit were autonomously supplied by the staff. Though sometimes there can be a profit margin for the nurses who are directly involved in the trade of pharmaceuticals, Michael's enthusiasm – together with Ama's comment – can mainly be understood within the framework of the necessity to cover the unit's expenses to buy the drugs in the first place. On the other hand, however, as discussed in the previous chapter, during outreaches like the one described here, psychiatric healthcare enters prayer camps as a pharmaceutical commodity to be bought: the exclusion of patients who cannot afford it emerges as a key element.[124] As Veronica, a woman I had first met at her house in September 2014, clearly told me when I encountered her with her sick daughter Grace at Esofo Christ's prayer camp, three years later: '[The hospital people], they come here, but when they come they take money. Some time ago, [a nurse] came here and said that I should pay. I said I don't have money so I don't take [any medicine]'.[125] It is striking how the words she used to describe their experience echo the bitterly mocking way in which Francis portrayed a typical exchange between patient and nurse, critically reflecting on the limits of the money-drug nexus in his professional experience.

[124] On psychotropic drugs as tools that should embody ideas of inclusion, accessibility and participation, but end up by reproducing forms of exclusion from care in community psychiatry, cf. Jain and Jadhav 2009.

[125] Interview with Veronica, 18th July 2017.

Grace and 'the pill': meeting (exclusion from) psychiatric care in *the prayer camp*

The first time I met Grace, her mother Veronica, and her father Jeremy was at their house. Akwasi, a general nurse doing his national service at their home town's health centre, invited me to visit them with him after a friend of his, living in their same compound, had informed him about Grace's probable mental condition. As most of the people I met during my research, when they were trying to explain to us what happened to their daughter, they hesitated, they were not sure, they had contemplated a number of possible theories, and a number of possible solutions.

Three years earlier – they told me – while she was at her grandmother's place, she started behaving awkwardly, she would undress herself, talk too much, roam about, and act 'aggressively' towards people around her. Grace's grandmother was a *kɔmenle*, a spiritual healer possessed by local *awozonle*, so a possible explanation of the girl's condition – the one they were most convinced about at the time – had to do with the daunting power of local deities: they wanted to possess her, making a healer out of her, but she opposed resistance to them, committing a serious offence. It was the gods' anger, according to this first aetiology, the reason why she had lost her mind:[126] '*zɔhane dokoɛ ne ɔsɛkye menli o'*, 'that thing destroys a lot of people!' – her mother commented a few years later.[127] Some time later, however, they visited an *esofo* in a town nearby their place and he told them that the cause behind her condition was a different one: her great-grandmother – her mother's grandmother – was a witch and she had attacked her to prevent her from prospering. It was for this reason that they had chosen to bring her to Esofo Christ's prayer camp: to seek refuge from the evil power of witchcraft, in God and prayers. This, however, was not their first attempt at healing. Since Grace fell sick, her parents had been with her to many *ahɔmenle*'s gardens and prayer camps as well as to the closest general hospital, to which they decided to recur after she had behaved in a particularly aggressive way, threatening

[126] For a different example of how the fragile relationship between a possessed person and the deities that choose him/her for their work can lead to madness in Nzema cosmology, see Schirripa 2001. On the dreadful consequences that may occur after offending a *bozonle*, see also Grottanelli 1978: 85 ff.

[127] Interview with Veronica, 18th July 2017.

the safety of her family members. At the hospital, which was not equipped with a psychiatric unit and specialised staff, they prescribed Grace some drugs, probably anxiolytics and/or antipsychotics that they happened to have at the pharmacy for 'non-psychiatric patients'. Nonetheless, they promptly suggested they go to Ankaful Psychiatric Hospital in Cape Coast. Being both farmers with very limited financial resources, however, Veronica and Jeremy could not afford the transportation and medical expenses of bringing their daughter to Ankaful. For the same reason, Veronica and Grace had to leave the first prayer camp they had resorted to, where differently to Esofo Christ's prayer camp's 'policy', they were asked to contribute money for the healing to be performed: 'as for this place it is only the food [we have to provide for]' – she told me with some kind of relief when I met them there in 2017.[128]

It is interesting to note that being financially unable to go to Ankaful as it was recommended to them a few years earlier, Grace's family's first point of contact with psychiatric health care was the prayer camp. As soon as they were touched (*out-reached*) by it, in the form of 'the pill' (Jain and Jadhav 2009), however, they realised that they were excluded from it. At least for the time being.[129]

'Critical situations': exclusion and the (pharmaceutical) gift of care

Evident in Grace and her family's experience, the exclusion generated by the *de facto* privatisation of mental health care is a crucial aspect, but it is of course only one side of the coin. When patients, or more often their family members, are able to decide whether or not to buy the drugs prescribed by the nurses, the exchange of money and pharmaceuticals seals an act of trust and the beginning of a possible relationship.

As nurses often repeat to patients and relatives, consistency is crucial for the success of the pharmaceutical treatment: the first drug purchase produces a potentially durable relationship

[128] *Ivi*.

[129] 'I haven't been to the hospital, but I have made up my mind: if I get money, I will send her to Ankaful' (*Ivi).* The last time I met Grace and her mother Veronica in 2022, however, they were back home, but they were still struggling with financial issues.

made of phone calls, follow-up visits in prayer camps, home-visits, hospital appointments, drug and dose adjustments, help and favour requests, and even pharmaceutical gifts on behalf of nurses when habitual patients are experiencing economic difficulties.

In fact, in conversations with nurses and in their practices, it clearly emerges a *continuum* between economic interest and caregiving, where the awareness of the contradictions that characterise their work and their role in mental health economies is anything but absent. This is evident, for instance, in what Francis told me in 2017, during one of the worst phases in the history of government pharmaceutical provision to the hospital:

> What I'm saying is that the drugs are not forthcoming [from the central administration] as it used to be and we need to make sure that the unit also is running. We can't close it down. So we should also find a way to make sure that the unit stays and then our clients too are also ok....the drugs, unlike other physical drugs, which are sold at the drugstores...these drugs, you can't get them everywhere unless you go to the big pharmacies...the distance so far as travel fares are concerned [is too much]... so we try to look for the less expensive and keep it here for our clients, those who are ready to buy [...] in case the government buys the drugs we give them to them [without charging any money] and... I hope you saw [that] critical situation.[130]

With the expression 'critical situation' Francis alluded to what had happened some hours earlier, when he decided to give for free some unit procured pharmaceuticals to a schoolgirl who was not able to pay for them that day. In a context in which autonomously supplying drugs and selling them is almost the only way to take care of patients, the practice of gift also arises as a possibility. It is an occasional practice, rather than a continuing one, whose recipients can be habitual patients with whom the nurses have already established a therapeutic relationship – as the schoolgirl Francis was referring to – but not necessarily.

In February 2020, during another prayer camp outreach, this time with Ernest, the psychiatric nurse working at the CHPS (see Chapter 2), I could observe a reverse dynamic compared to the prayer camp visit I described earlier. In fact, after having assessed the potential

[130] Group interview with psychiatric nurses, 10 July 2017.

patients at the camp, Ernest decided not to charge a patient for the antipsychotic medications he had prescribed to him, as his mother could not afford them. 'This is my job, what else should I do?', he told me some days later, commenting on the episode and adding that it was not the first time he invested his own money in similar circumstances, even though he admitted that he could not always afford it and that could never become a continuing practice for him. His choice was mainly motivated by two factors: the severity of the patient's condition – a case of acute psychosis according to his diagnosis – and the profound anxiety of his mother, whom her son had physically threatened multiple times as he held her responsible for his troubled mental state. Ernest, firmly convinced that antipsychotics could be an effective solution to cool off the conflict and improve the patient's condition, did not have the nerve to deprive them of that opportunity 'because of money'. He gave his number to the woman, asking her to update him about further developments. She thanked him and promised that she would have tried to reimburse him at least partially, reframing Ernest's gift in an indefinite kind of debt.[131]

More broadly, as we have seen in the previous chapter in the case of Comfort – the young woman I met with the nurse Pamela at a *kɔmenle*'s garden – drawing heavily on private, sometimes individual, pharmaceutical provision, the informal economy of mental health care leaves room for negotiation, at the intersection of economic evaluations and ethical dilemmas. After realising that Comfort was not insured on the NHIS and could not afford to pay for the drugs she had prescribed to her, Pamela, who was in charge of the outreach to the traditional healing site, looked at me, clearly struggling in deciding how to handle the situation: 'What should I do?'. After the *kɔmenle* told her that she would have paid for Comfort and another patient's[132] drugs, but only up to 30 cedis for the two of them (the total amount for the two patients, both non-insured, was 45 cedis), Pamela decided to call Michael, who was the unit's 'In

[131] Though for the purposes of this chapter I only focus on these aspects here, the narrated episode is a lot more complex than that and will be explored more in detail in chapter 5 as it elicits many other crucial topics like the role of family members in 'mentally ill' people's healing processes, the right to auto-determination, coercion, and the ethics dilemmas posed by such issues in the practice of community psychiatry.

[132] The other patient was a woman in her sixties, who was diagnosed by Pamela as suffering from psychosis and thus prescribed *Olanzapine*.

Charge' at the time. She briefly described the circumstances to him, and, after making sure that she was indeed a new client,[133] he agreed on selling the drugs at a reduced price.

The elusive practices of gift and debt, and economic concessions more broadly, are frequent phenomena, yet often neglected and concealed in institutional contexts like public health services. Actions like the ones performed by Ernest and Pamela can generate complex relationships that oscillate between gratitude and dependency towards the nurse, but at the same time they can also produce some kind of professional expectation in the practitioner: that of having 'acquired' a patient/client of whom he or she will need/have the opportunity to keep taking care. In this sense, the 'pharmaceutical gift' can also be framed, to a certain extent, as a kind of economic *and* professional investment, in line with Michael Oldani's reflections on the centrality of 'the gift' in pharmaceutical sales practices (Oldani 2004).[134]

In the described episodes, we can observe a 'commodified' pharmaceuticalisation that is a lot more than that. On the one hand, the possibility of pharmaceutical trade encourages the development of potential collaborative relationships between the apparently separate domains of psychiatric care and religious healing; on the other hand, in the daily practices of psychiatric nurses, the boundaries between market and care, economic interest and gift, in all of their ambivalence appear blurred, revealing connections and contradictions (Cf. Zelizer 2005; Biehl 2012).

A similar process of 'informal commodification of mental healthcare' is analysed by Katie Kilroy-Marac within the context of the famous Fann Psychiatric Clinic in Dakar (Kilroy Marac

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[133] The use of the term 'client' instead of 'patient', very common at the unit (see for instance the group interview quoted above) as well as in many similar contexts in anglophone countries, is of course a sign of the conflation of market and care that characterises healthcare in neoliberal times and has repeatedly prompted terminological debates among practitioners (see for instance Lancet 2000). At the unit, the term 'patient' is sometimes used as a synonym to 'client', though some of the staff tend to use it to distinguish outpatients coming for their medication – identified as 'clients' – from inpatients who are admitted to the general ward under the supervision of the psychiatric unit – identified as 'patients'.

[134] 'The actual everyday pharmaceutical economy – he argues analysing through the lens of autoethnography his pluriannual experience as a pharmaceutical sales representative for a big multinational drug company – is based on social relationships that are forged and strengthened through repetitive and calculated acts of giving' (Oldani 2004: 332).

2014b; cf. Chapter 1). In her article, she reflects specifically on the transformation of the paradigmatic figure of the *accompagnant*, the person required to stay with inpatients during their hospitalisation: the role of *accompagnant* used to pertain exclusively to family members, but has become today an informal paid occupation (*accompagnant mercenaire*). Looking at this radical shift, it would be instinctive to infer 'that a purely moral economy of family caretaking has been supplanted by purely amoral set of market transactions via the *accompagnant mercenaire*' (Kilroy Marac 2014b: 441). However, as Kilroy-Marac shows in her work, as soon as we look at what people do, the relationships they create, the solutions they invent, and the choices they make, it appears clear that 'the assumption that commodified care relations are necessarily amoral, mechanistic, cold, or void of "true" care' (Kilroy Marac 2014: 429-430) definitely needs to be complicated.

'It's about taking care of people': 'charismatic nursing' between entrepreneurship and care

> Initially I didn't really like it, but after the first year I developed some kind of love for the nursing job. When you come to our house, it's a family something... my grandmom is someone who really loves people, even in the house you can find so many people there that have nothing to do [with us], they are not related [to us], but she would accommodate everybody there, feed everybody, same as my mom (...) taking care of people it has been something with us...because sometimes it's like *I found myself in the job*: taking care of people, taking care of people. So... nursing is about taking care of people.[135]

Like many of his colleagues, Ernest chose his nursing career mainly because he thought that after completing the programme it would have been quite straightforward for him to find a job. He chose specifically mental health nursing because according to his sister, who lived in the United States and had secured for herself a very good occupation there, that specialisation would have 'paid' particularly well. 'Somebody would say – he told me while explaining how he ended up being a nurse – that we all work for the papers'. After the first year of training, however, it was

[135] Interview with Ernest, 21st January 2022.

surprising for him to discover some parts of himself and his family's attitude *in the job* he was learning about. Rooted in pragmatic considerations about what was financially advisable for his future, Ernest's professional experience slowly developed – in his own description — in something like a 'calling' that ultimately 'enlightened' parts of himself.

The nurses' narratives about how they ended up doing what they do vary greatly. Some started feeling a 'calling' since they were young – like Juliet, who first asked herself 'Can I be a nurse?' when she was just fifteen, after her father was severely ill and received very poor care at the hospital where he was admitted.[136] Some other embraced the profession totally by chance – like Pamela, who thought she had 'bought the forms'[137] for general nursing and wound up in an interview for mental health nursing ('I don't know whether it's a miracle or what! Maybe God wanted me to be there...').[138] In any case, the tension between an initial preoccupation of just wanting to find a good job and the conviction of mental health nursing not being 'a job like any other' came up in most of the nurses' stories.

This tension between pragmatic needs and the 'calling' of the job is relevant not only in stories and narratives, but also in nurses' everyday life as for many of them their chosen profession turned out to be not as 'good' as they expected it to be, especially in terms of income. In line with what happens at the national level – where strikes to demand better working conditions have been repeatedly organised and there is an increasing phenomenon of nurse 'brain drain to greener pastures' (Western countries, and the United Kingdom more

[136] Interview with Juliet, 18th January 2022.

[137] 'Buying forms' is the expression used to indicate the process of making a formal application upon payment (i.e. for University degrees, public sector jobs, etc.).

[138] Interview with Pamela, 10th January 2022.

specifically)[139] – all the nurses I met in Nzemaland complained, at least to a certain degree, about their meagre remuneration, the fact that they did not receive any risk allowance, and the generally resource-deprived conditions in which they were forced to work, unable to apply what they studied in school. Fuelled by their dissatisfaction and often also by pressing expenses and very concrete family needs and expectations, many of the nurses are involved in a number of different entrepreneurial projects to supplement their average 2000 cedis monthly income, with minum or larger amounts of money: some own small shops managed by family members, some cook food in their free time and sell it to colleagues and 'clients' at the hospital, some buy commodities in bulk online on websites like *Alibaba.com* and market them through informal networks, some invest in hopes of developing a parallel career as musicians or Youtubers, some other save money with the final aim of buying a plantation.

The same entrepreneurial initiative and creativity nurses put in their personal 'side projects', as I have tried to show so far, is also a strategic asset in their main job, *taking care of people*. To a large extent, we could say that psychiatric service provision in Nzemaland is based on the already described informal economy of pharmaceutical care – that is, the drug buying and selling – as much as it is rooted, more deeply, in the personal dynamism of the medical practitioners who animate it. The energy and inventiveness they put in their daily activities, trying to deal with the material and ethical conundrums that trouble their job, exerts a powerful influence on the kind of relationships, often ambivalent yet intimate, they are able to establish with patients, especially in 'critical situations' like the ones illustrated above. In this perspective, we could say that some sort of 'charisma' is crucial in the delivery of mental health care not only, as it is obvious, in the context of prayer camps, but also – in its broader, non-theological meaning – in the context of institutional psychiatric services. I find it interesting to think with this 'charismatic' dimension of nursing because it forces us to appreciate more deeply the existence of multiple grey zones in the

[139] See for instance: Ghana Business News 2022; Boakye 2022; Nyabor 2022. Talking about the unfavourable financial conditions in which psychiatric nurses work, and especially about the disregard towards psychiatric nurses at the hospital where the research took place (cf. also Chapter 2), Sarah said: 'They don't value psychiatric nursing, they see you like someone else, so we are all travelling [laughs] when you go to Ankaful [Psychiatric] hospital almost all nurses are travelling. They are going to London, they write IELTS and leave, but me, I want to finish with my degree before going' (Interview with Sarah, 17th January 2022).

economy of mental health care, and even to identify unexpected affinities between institutional practitioners and religious healers. This is particularly relevant in the way nurses conceive of themselves, forced to 'constantly defend and reinvent their roles'[140] in the face of evident contradictions between their 'calling' to take care of people and the material conditions in which they find themselves operating.

This 'charismatic' dimension of nursing can be found in the individual efforts clinicians put in the organisation of outreaches and home visits, in the procurement of drugs, and in their attempts to 'ethically' distribute them, but most of all in the personal relationships they establish with patients and family members. 'Are you also a priest?' – Ernest was once asked by his patient Egya Solomon, who had just met him a few minutes earlier in the context of a home visit in November 2021. This was one of the rare cases in which, albeit hesitating, the nurse decided not to prescribe any drug to the new patient, who was complaining of feeling some kind of pressure inside his head. The feeling, he explained, was particularly disturbing when he went to bed, making him unable to sleep and think clearly for a whole week. He looked exhausted and was confused about how to interpret what was happening to him: was it something 'spiritual'? Was it because he had recently started intensively studying the Bible ('When I read the Bible. I feel courage', he said)? Was some evil spirit, or the Devil himself, trying to prevent him from being closer to God? Was it something physical that was happening to his brain instead? Ernest listened to him carefully, trying to understand what his habits and daily preoccupations were. Since Egya Solomon told him that he dedicated most of his evenings and nights to the study of the Bible and other books, Ernest advised him: 'You should try and sleep more, it's very very important... I might not... prescribe you anything now, keep monitoring these episodes, keep me updated, and we will see what to do'. They exchanged their mobile numbers. 'Sometimes – Egya Solomon added when Ernest was almost ready to leave – I start thinking about all my failures. They are so many... Sometimes I can't help but think about it'. Ernest sat down again. Egya Solomon was in his sixties, he was in the United States when the Covid-19 outbreak hit in 2020 and he decided to

[140] Here I paraphrase Paul Brodwin's description of the everyday ethics conundrums that constantly arose from 'the inevitable conflicts between [clinician's] agenda and clients' own desires' at the North American community psychiatry clinic where he carried out his research (Brodwin 2013: 5).

go back to Ghana, but now he felt he had lost everything, he was old, and he had just made too many mistakes. 'You shouldn't do that – Ernest told him – you should try to think about the beautiful things in your life'. Illustrating the thesis of the world-famous motivational book 'The Secret' by Australian author Rhonda Byrne (2006), the nurse strongly recommended Egya Solomon to follow 'the law of attraction' and focus on positive things, because focusing on things that went wrong, and failures can only 'attract' more negative things. That is when Egya Solomon asked him if he was 'also a priest', intrigued and captivated by the emphasis Ernest was putting on the need to transform his attitude towards life in order to improve his condition. On the way to the next home visit, Ernest commented that he could not be sure that what the man was going through was only 'psychological', but he definitely needed psychotherapy, 'serious psychotherapy' he added with a dash of bitterness in his voice. He enjoyed the conversation with Egya Solomon and he had the impression that it could be the start of a meaningful therapeutic relationship, but he complained about the short time he had to dedicate to him and patients like him: he was the only psychiatric nurse working at the health centre and it was not easy for him to make time for those kind of encounters, juggling between the necessity to be available at the centre unit for prescriptions, to survey local prayer camps and traditional healing sites and visit them for outreach activities, and to follow up with patients in the whole sub-district.

This peculiar dimension of nursing that I have decided here to call 'charismatic' can be crucial in creating bonds of trust in relationships with patients and their families, to the point of establishing a particular reputation for a particular nurse, even more so when these relationships are mediated by effective drugs. This was the case of Michael, for instance, who proudly told me the story of 'Borga Man', a man living in a town not far from the hospital who had been severely sick for more than thirty years, until Michael assessed him during one of his outreach activities, prescribed him the right antipsychotic medication, and kept monitoring his progress until he started recovering: 'he is fine now'. One day in October 2021, while I was at the unit, Michael received the visit of a couple coming from Takoradi: the man was a wealthy businessman and his wife, who kept silent for the whole time, had started behaving strangely, sometimes being aggressive towards her sister and family members. Something – they thought – was wrong with her. He had some relatives in 'Borga Man''s home town and he heard about the 'miraculous'

work Michael had done with him, so he wanted him to take care of his wife too. Among the nurses at the unit, the circumstance was defined in terms of a 'trust issue': there was a big regional hospital in Takoradi, with a well equipped psychiatric unit, and probably there was a broader range of available drugs there as compared to what they could offer, but, similarly to what could happen with a pastor or a healer, the man – who made clear he 'had the means' to pay whatever was due – was putting his hopes in that particular place because of Michael's presence and his previous, famous experience with 'Borga Man'.[141] This was probably the most striking case, but it was not uncommon for some of the nurses' patients to show devotion and gratitude to some particular nurse, sometimes even bringing gifts to the unit, in the context of trust relationships that continued well beyond working hours, with phone calls and urgent requests for help.

By briefly recounting these two episodes, I would like to convey the perhaps prosaic but still decisive fact that in a mental health care system marked by scarcity – and especially by the scarcity of a particular commodity, psychotropic medication, which is regarded as the main therapeutic tool – so much depends on the personal entrepreneurship of individuals, who are often forced to 'market' their care.

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In conclusion, what does 'pharmaceuticalisation' look like in Nzemaland? Does it exist? Is it 'failing' as Good ironically suggests for other Global South contexts (Good 2010: 122)?

As I have tried to show, psychotropic drugs in Nzemaland are a crucial element in the mental health arena. They are scarce, they are not regularly available, but they are totally hegemonic within the psychiatric field, where they represent the main expression of care. Moreover, as we have seen in the previous chapter, even though we may tend to think of pharmaceuticals as

[141] After an initial attempt to take the patient into care at the unit, even admitting her at the VIP general ward for observation, the unit's in charge, in accordance with Michael, convinced the woman's husband to seek care from their city's regional hospital and wrote a referral letter for her.

antithetical to non-biomedical forms of healing, they are actually the main tool used to develop relationships across different therapeutic traditions.

In Nzemaland, I argue, pharmaceuticalisation – both as a reality and a 'possibility' for the self – exists and it is able to make visible, more than in other contexts, some of the key contradictions of this process: namely, the conflation of market and care that informs it, the mechanisms of exclusion that derive from it, and the frequent use of psychopharmaceuticals as other-directed means to 'control', 'manage', 'contain' subjectivity (cf. Chapter 5) as opposed to psychotherapy options that are contemplated but are still very rarely put in place. At the same time, pharmaceuticalisation in Nzemaland also indicates that the coexistence between pharmaceutical psychiatry and other, more holistic, ways of understanding illness and cure in people's therapeutic paths is more than possible: it is already happening.

Acknowledging this means also bringing back a 'remote' area potentially beneficiary of Global Mental Health policies like Nzemaland to its coevalness with the rest of the world. In particular, the entanglement of market and care, which is at the core of the current psychopharmacology crisis in Western psychiatry (Dumit 2018), is very much relevant and revealing also in the micro-processes of pharmaceuticalisation that I had the chance to observe in the Global South context where I carried out my research.

Perhaps in order to define our own positionality as critical researchers in the field of mental health (i.e. put simple, should we advocate for 'less drugs' or 'more drugs'? Are we 'for-or-against' Global Mental Health? Cf. Cooper 2016a: 356), we have to dig into the contradictions and ethical dilemmas that emerge in 'remotely global' sites, we have to look at the complex ways in which Global Mental Health is performed and experienced by patients, caregivers, and caretakers in these contexts. By doing so, it will be easier to realise how the challenges experienced by people in the Global South – those people who are still considered to be the main target of GMH policies – actually resonate with what is happening in the mental health arena in 'the rest of the world'.

4. BELIEF | SCIENCE

Dismissing the 'incompatibility' argument through an old-fashioned concept

'For me, I don't believe this [Corona]virus will get to me or anybody here. My belief is not about this disease'. In March 2020, just a few days before interrupting my fieldwork because of Covid-19, I found myself in the middle of a heated discussion about *believing or not* in Coronavirus. Just a few weeks earlier I had submitted an abstract for a medical anthropology conference, in which I proposed to explore the intersections between psychiatry and spiritual healing at the core of my research through the prism of 'belief': a somewhat obsolete anthropological concept that always made me raise an eyebrow when I read it scholarly texts, but kept coming up in my everyday conversations and interactions in Ghana. I was sitting at a drinking spot in the coastal village where I was based when the argument between my friend and occasional interpreter Kodwo, the one who uttered the opening sentence above, Stephen, a primary school teacher, and a couple of other people started, and immediately caught my attention. Interestingly, not only was the virus described in terms of *belief*,[142] but the whole dispute revolved around the meaning of *belief* itself. 'There is a difference between believing and knowing — Stephen maintained — to know you have to see first. I heard that this thing is coming, I have not seen it, but I believe it. So I will protect myself.' Kodwo did not agree at all: 'But how can you believe if you don't see?'. He stated he only believed himself and the community *bozonle,* whom he claimed he saw when he was a child, triggering a few perhaps sceptical or simply amused laughs among the bystanders. This did not necessarily mean, as Kodwo explained to me that day and in subsequent discussions, that he was not going to

[142] It is important to point out that similar discussions about '*believing or not* in the virus' have been recurrent in multiple forms also in non-African contexts like the Italian one from which I am writing right now.

preventively 'protect' himself from the alleged threat of the virus, but only that he strongly refused the idea of *believing* in it without having any proof.

This chapter is not yet another anthropological discussion of Covid-19. However, I have decided to begin with a brief reference to this discussion for two main reasons: first, it introduces the concept of *belief* that I would like to address here in all its paradoxical duplicity as something that always evokes (at least) an opposite (not believing/not seeing); second, it reminds us the quite obvious yet crucial fact that even in 'ethnographic' contexts there is a multiplicity of opinions and worldviews, and ultimately a multiplicity of disagreements. This is particularly relevant here as the concept of 'belief' has often been used, in anthropological scholarship and beyond, to homogenise and exoticise the African 'other', alternatively portrayed as 'heathen', 'superstitious', or 'animist'.[143]

Since the early days of anthropology as a discipline – when the concept held a prominent theoretical position – *belief* has been repeatedly subject to close scrutiny, and rightly so. In particular, both in the sub-fields of medical anthropology and the anthropology of religion/religious studies, eminent scholars have warned us against the use of the term, highlighting the many limits and pitfalls it entails. Stemming from a problematic clear-cut distinction between what is knowledge/science and what is not (Good 1994) and/or from an equally problematic secular idea of religion as something necessarily 'interiorised and private' (Houtman and Meyer 2013; see also Asad 1993), the term 'belief' has nevertheless been a keyword in the history of anthropology and continues to be used, sometimes uncritically, in formal and informal ethnographic accounts, as well as in everyday discussions like the one mentioned above. Indeed, belief is still – it seems – a 'good [concept] to think "against"' (Lindquist and Coleman 2008: 2).

As I have anticipated in Chapter 2, people's *beliefs* on 'mental illness' are often evoked in discussions about mental health care in Ghana among policymakers and psychiatric practitioners. While in the previous chapter I have tried to call into question the weight attributed to non-biomedical interpretations of mental distress as obstacles to care, highlighting

[143] For a critique of the Western conceptualisation of 'animism', see for instance Samuel Imbo's review of Okot p'Bitek's work (Imbo 2004).

the stigmatisation of people's beliefs as a 'cultural alibi' (Farmer 2003: 49) that diverts attention from material conditions and structural inequalities orienting patients' experiences of psychiatric care, in this chapter I would like to go back to the ways in which the category of *belief* is mobilised in the Ghanaian mental health arena. By taking *belief* seriously, in line with recent attempts of 'rehabilitation' (see, for instance, Luhrmann 2010, Mair 2013, Aulino 2022, Eves 2022), I would also like to outline a reflection on the theoretical role that this opaque concept may have in understanding the articulations and relationships between the psychiatric and spiritual dimensions of mental health care. Can we still consider it as a viable category? And if yes, in what sense and with what caveats?

In order to answer these questions, I will try to unpack — without any ambition of being exhaustive — the concept of *belief* in light of some relevant theoretical reflections coming from medical anthropology and the anthropology of religion/religious studies. I will then analyse the role that the category of *belief* has in discussions about mental healthcare in Ghana, and among psychiatric practitioners in particular. Finally, relying on its ambivalences, I will try to show how this term, despite being often used to directly or indirectly suggest the idea of an 'incompatibility' between the horizons of meaning of psychiatry and spiritual healing, might actually be employed to better grasp their intersections.

Unpacking 'belief'

'The problem of belief' /1: a concept to deconstruct

As constantly highlighted in historical reviews and encyclopaedic articles (see, among others, Lindquist and Coleman 2008, Good and McDowell 2015, Coleman 2018, Day 2018, Streeter 2020), *belief* has been a fundamental concept in anthropology since the very beginning of the discipline, when Edward Burnett Tylor put the term in the list of elements that constituted what

he defined as 'culture'.[144] As observed by Abby Day (2018), from the mid-nineteenth to the mid-twentieth century, the concept was mainly used to represent a counterpart ('other', 'primitive', see below) to western 'rationality': 'to mention belief now in the course of an inquiry presents epistemological problems heavy with the weight of embarrassment and guilt from an unsavory disciplinary past' (Day 2018: 2). While the burden of this history started to emerge in a clearer way in more recent years, in line with a broader – ongoing and far from completed – process of deconstruction of anthropology's colonial genealogies and legacies, revisions and critical admonitions against the use of the concept started to appear early on in the second half of the twentieth century. The work that inaugurated this thorough critical review within the discipline is Rodney Needham's seminal book *Belief, Language, and Experience* (1972), in which the British anthropologist pointed towards the heuristic limits of *belief* from an empiricist point of view.

Two decades later, in the first chapter of his famous *Medicine, Rationality, and Experience* (1994),[145] Byron Good presented a detailed analysis of the 'problem of belief' in the historical development of anthropology. Good acknowledged Needham's by then classic examination,[146] but went in a different direction, with the aim of re-reading the concept in light of its place in the sub-field of medical anthropology. Drawing on the work of the historian of religion and theologian Wilfred Cantwell Smith (1977, 1979), the American medical anthropologist (Good

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[144] As the famous definition – learned by heart by generations of aspirant anthropologists – has it, 'culture' is in Tylor's words 'that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society' (Tylor 1871: 1).

[145] The book draws on the four Lewis Henry Morgan Lectures Good gave in March 1990 at the University of Rochester: <https://urresearch.rochester.edu/institutionalPublicationPublicView.action?institutionalItemId=27067&versionNumber=1>, last accessed 30 December 2022.

[146] Generally recognised as a benchmark in the literature on belief, Needham's book has been repeatedly criticised. According to Tanya Luhrmann (1989: 430) and more recently Joseph Streeter (2020), the main issue with Needham's analysis of belief and his consequent invitation to put the concept to rest once and for all was the fact that it was grounded in a wrong interpretation of Ludwig Wittgenstein's take on the term or, as Streeter puts it, in 'a missed encounter' (Streeter 2020: 134) with the work of the Austrian philosopher. For an early critique of the relationship between *Belief, Language, and Experience* and Wittgenstein's work see also Gardner 1979.

1994: 14-17) retraced how in the last three centuries the meaning of the term shifted from the idea of 'pledging allegiance to' and 'giving your heart to' (i.e. I am loyal to God) to the current idea of having an affirmative opinion about something which is commonly regarded as uncertain (i.e. I think God exists).[147] According to Smith, this shift also implied a gradual change in the subject associated with the verb 'believe', from the first person (i.e. I believe) to the third (i.e. s/he/they believe). Definitively counterposed to the concept of *knowledge* by the nineteenth century, *belief* became a keyword in twentieth century's pioneering works in medical anthropology such as W. H. R. Rivers' *Medicine, Magic, and Religion* (1924) and Edward E. Evans-Pritchard's *Witchcraft, Oracles and Magic among the Azande* (1937). Going through theirs and other works, Good noticed how *belief* has long been used to ultimately represent 'others' culture [and] authorise the position and knowledge of the anthropological observer. Though differing in content — he argued — anthropological characterizations of others' beliefs played a similar role in validating the position of the anthropologist as the description of native religious beliefs did for missionaries' (Good 1994: 20).

From a different perspective, anthropologists of religion and religious studies scholars also highlighted how in Western scholarship the term *belief* has problematically been used to identify others' 'religion'. Along the path opened up by Talal Asad's seminal work on the protestant and secularist bias that has informed the study of religion (Asad 1993, 2003), Birgit Meyer (2012b: 14, emphasis in the original) proposed to move from a Eurocentric 'more or less implicit *mentalistic* approach to religion' focused on the notion of *belief* towards 'a *material* approach to religion', with a focus on 'practices (what do people do?) and on the body, things, buildings (which senses are invoked? Which materials are used?)' (*Ivi*: 20; see also Meyer et al. 2011). Within the same 'material turn' framework, religious studies scholar Robert A. Orsi (2011) reflected on how the seventeenth-eighteenth century equation 'religion = belief' was rooted in the opposition between Catholicism and Protestantism: '"Belief" named a way of being religious that was the antithesis of Catholicism, of its hierarchy, its onerous proliferation of rules and sins,

[147] The difference between these two meanings can also be linked to the difference between 'believing in' and 'believing that'. The centrality of this distinction was highlighted by Malcolm Ruel (2002 [1982]) and Jean Pouillon (2016 [1979]) and more recently revived by Joel Robbins (2007), who suggested that 'Statements about what people "believe in" are generally a good clue to the values that organize their cultures, whereas their "believe that" statements are not so helpful in this regard' (*Ivi*: 16).

its saints, miracles, rituals, gestures, and above all the Catholic experience of the presence of the holy in matter, in things' (*Ivi*: 12-13). Thus, the religion-belief equation conveyed by colonial administrators, missionaries, and scholars projected in African and other non-Western contexts a particular historically informed idea of religion as opposed to 'superstition' (originally attributed to Catholics by Protestants).[148] Paradoxically, as shown by Good, pitted against knowledge and science, *belief* was gradually discredited, becoming a potential synonym of superstition itself. What is interesting is that it is with a similar connotation, to a large extent, that the concept of *belief* is generally evoked in contemporary discussions about mental health in Ghana. What is even more interesting is that this is true, '*but not always*', to adopt the powerful rhetoric expedient employed by Felicity Aulino in her recent article on the kaleidoscopic nature of 'belief', its multiple connotations, and context-dependent usages in Northern Thailand (2022): not differently from what she observed in her research, in my experience in southwestern Ghana belief was often evoked with different, sometimes incoherent, meanings. Indeed, as I will try to show, the ambivalence that has recurrently led scholars to suggest dismissing the term, could actually be a resource. Before digging deeper into this ambivalence, however, I would like to dedicate a few more words to the reasons why it could still be relevant in the first place to deal with the 'problem of belief' in the present.

The 'problem of belief'/2: Taking it seriously?

If *belief* is an imprecise term, the heuristic limits of which have been repeatedly discussed, if the concept itself is charged with a Eurocentric and colonial history of domination that denied the validity of other forms of knowledge and religious experiences, simultaneously making it difficult for researchers to really grasp them, why does it still make sense to write about it – even though not properly 'with it' (Lindquist and Coleman 2008: 15) – as I am doing right now?

In my opinion, there are at least two possible, and entangled, answers to this question. First, there is the relevance of the term for my interlocutors not only in everyday discussions like the one described at the beginning of this chapter, but also (and especially) in discussions related to

[148] On the issue of 'superstition' cf. also, among others, Imbo 2004, Oladipo 2004.

practices of collaboration between psychiatric nurses and traditional/spiritual healers. As argued by Alice Street in her reflection on patients' engagement with Christianity in a hospital setting in Papua New Guinea, in line with what was already suggested by Galina Lindquist and Simon Coleman in a *Social Analysis* special issue dedicated to belief they edited in 2008, 'it is difficult to abandon a term that those whom we study – or with whom we carry out our research, or with whom we hang out during fieldwork I would rather say – employ so readily to describe what they are doing' (Street 2010: 261).[149]

Secondly, there is the relevance of a particular question, specifically addressed to the ethnographer/researcher: *do you believe it?* In many conversations among anthropologists about events and experiences that could be alternatively labelled as magical, spiritual, or arguably 'extraordinary'[150] – both in formal and informal settings – it often happened to me to hear that 'perhaps we should stop asking whether people really *believe* such things', implying that it is not a productive question. The issue, however, is that, even if we agree – as I do – on acknowledging the mentalistic and rationalist bias of such a question, we should probably give it at least a second thought when it is our interlocutors who interrogate us in these terms. In this case, with a different overtone from the one attributed by Good to the expression, 'the problem of belief'

[149] Similarly, after having gone through some popular critiques of 'belief' (by Eduardo Viveiros de Castro, Martin Holbraad, Talal Asad, and Stanley Tambiah), in his book on Muslim patients treated in a Danish mosque and a psychiatric hospital, Christian Suhr asks: 'What then do we do if 'belief', 'faith', and even 'existential doubt' are what our interlocutors take seriously, or at least say they take seriously?' (Suhr 2019: 49).

[150] 'Extraordinary' is the term used by Goulet and Bruce Granville Miller to evoke 'events or [...] experiences that challenge our own epistemological, ontological, and ethical assumptions' during ethnography (i.e. ecstatic dreams, visions, etc.) (Goulet and Granville Miller 2007: 2; cf. also Goulet and Young 1994; Aria 2007). The use of the term 'extraordinary' to describe this kind of experiences should be problematised (e.g.: extraordinary for whom? Why describe them as extraordinary when they could rather be quite ordinary for some of the people the ethnographer carries out research with? What are the implications of such a description?), but this goes well beyond the scope of this chapter. Incidentally, however, it is interesting to notice how the idea of 'extraordinary experiences' resonates with the definition of forms of mental distress as 'extraordinary conditions' (Jenkins 2015, see chapter 2), especially if we think that Goulet and Granville Miller's edited book was deeply inspired by Johannes Fabian's work on experiences of ecstasy *and* madness in the early days of central African ethnography (2000).

has to do with the ethnographer's positionality in 'the field'[151] (Engelke 2002; Lauterbach 2013). Let me give a brief example of the ways in which 'the problem of belief', with this connotation, may materialise as a question in the course of fieldwork.

At the beginning of October 2021, I took part in a three-day intensive prayer programme at Maame Akuba's prayer camp. I participated in the all-night prayer sessions in the camp church – whose construction had been recently completed – and I was given a room in the same block where some of the patients and their caretakers usually reside during their stay, so that I could sleep and rest at dawn, after the sessions ended. I had already taken part in the activities of this and other churches many times, but this was the first time I had the opportunity to be immersed in the praying life of the camp for more than just a few hours. During those three days, the church was filled up with dozens of individuals, with a strong predominance of women among them: prayer camp residents, but also inhabitants of the town where the camp is located, congregants coming from other areas, and people who had been healed at the camp in the past, or were hoping to draw God's attention to their current predicaments by 'praying hard' with the rest of the worshippers. While I was in the church, rather than ask myself what people *believed* was happening, I tried to observe what people *did*: how their fingers moved through the beads of the rosary; how some mouths shouted and others whispered during collective moments of prayer; how some of the bodies danced with hands pointing to the sky, how some others spun around, or shook convulsively, or trembled quietly before falling down onto the floor, touched by the Spirit through the hands of preachers and catechists firmly placed on their heads; how the bodies on the ground that were still moving, at the risk of undressing themselves, were steadily covered with a wax cloth by church staff members and fellow worshippers; how, with the same diligence, bodies on the brink of falling asleep in calmer moments were nudged. 'Close your eyes', I was often told by people who were sitting next me in that and similar occasions, while looking at scenes that have been described countless times in the literature on Pentecostal and

[151] I put the term in inverted commas as I think that, used uncritically, it may sometimes contribute to create an artificial, neat separation with other life experiences, somehow denying the interconnectedness of the time of life and the time of the research and reifying a rhetoric imaginary of 'the field' as an inherently 'exotic', even 'mystical', experience.

Charismatic churches: I was invited to suspend my 'observation' in order to sensorily feel the presence of God, beyond what I could see.

In the morning after the end of the programme, when people from outside the prayer camp started leaving, Matthew, a young man who entered the prayer camp seeking spiritual assistance and then decided to stay and help with the daily activities of the healing site with the intention of becoming a prophet himself in the future, came to call me in my room: 'If you want, my grandmother – as he used to call Maame Akuba, despite not being biologically related to her – is ready to meet you'. We met, as we usually did, in the patio of her house that was located on a tiny hill from which it was possible to see the church building and a large part of the prayer camp. As the prophetess explained to me together with Matthew, she wanted to see me because usually after programmes like the one I had just attended the prayer camp staff had a meeting to discuss the outcomes. The programme was indeed a quite complex event to organise, with invited speakers and preachers, singers and musicians, and a schedule of activities aimed at engaging the attendants throughout the night: since I was to a large extent an outsider and it was the first time I took part in such an event, she wanted to know what was the experience like for me and whether I had any question. I told her that I did not think I was in the position to give her proper 'feedback', but that I was struck by the collective dimension of what I had witnessed, by the ways in which in some moments individual prayers and invocations uttered in so many different ways, also by some of the people I had previously met as 'patients', seemed to melt together in a single concerted voice. And then I asked her a few questions about some of the events that most caught my attention during those days.[152] After a while, however, she told me that she wanted *me* to answer a question: she heard from her sister, who lived in Italy and greatly helped her financially in expanding the prayer camp throughout the years, that people in

[152] During a testimony session, she talked about a miracle she performed by removing a shard of glass from one of her children's belly, showing proof (an opaque fragment of glass) to an amazed audience (cf. Chapter 2). I asked her a few questions about the episode and this brought her to speak at length about other miracles she performed and the many times in which some spirits (*awozonle*) – with whom her mother used to 'work' before her conversion – tried to attack her and her family. I also asked her to explain to me why some people shook, shouted and/or fell down when touched by the prophets: it was because the presence of the Spirit made the *awozonle* who dwelled within some of the congregants 'uncomfortable' and pushed them to leave.

Europe, especially those who completed higher education, did not believe in God because they felt superior. She wanted to know whether or not *I believed*. I told her that this was true to a large extent but it was not always the case, as I had some close friends I grew up with who were fervent Catholics. As for me, however, I was raised as a Catholic, but had stopped attending Church a long time before. I also said something about the constitutive relationship between belief and doubt – something that I will go back to below – and that ultimately it was not easy for me to answer such a question. Once again, even if I tried not to think in those terms for the whole duration of the programme, the issue of belief came up. I still wonder, however, if I actually answered Maame Akuba's question. Or not.

The same question was often asked to me in a multiplicity of forms and by a multiplicity of interlocutors (i.e. Christian pastors and catechists, young and more established traditionalists, nurses, and more generally friends who did and did not attend church or the mosque): 'What do you believe in?', 'Do you believe in *bozonle*?', 'So, do you believe in religion?', 'I know at your place you don't believe in witchcraft, right?'. As argued by Matthew Engelke in his brief but insightful review of the personal relationship with the religious and the 'supernatural' in Edward Evans-Pritchard's and Victor Turner's work (2002), 'the problem of belief' as a problem for the ethnographer is 'an old age question' (*Ivi*: 3). Understood in these terms, questioning belief means asking whether or not 'shar[ing], in some sense, a belief in the supernatural' might be useful, essential even, for the comprehension of religious phenomena. This issue has been implicitly and explicitly evoked in many different forms – including some that do not contemplate the vocabulary of belief at all, in line with some of the critiques presented in the previous section.[153] In all of them, however, there is a common thread: the call to take people and their religious experiences 'seriously', whatever this might mean.[154] It is not my intention here to address this problem directly, as I think it might often entail the double risk of exoticising and adopting an excessively narrow focus on the ethnographer's perspective. What I would

[153] An obvious reference here is to the strand of scholarship labelled as 'ontological turn' in anthropology and the social sciences, as key authors like Eduardo Viveiros de Castro (2013[2002]) and Martin Holbraad (2012: 54-74) have severely critiqued the concept of belief.

[154] For a reflection on the ubiquitous – and sometimes abused – call to 'take people seriously' see Suhr 2019:

rather like to ask, given the recurring feature of belief in my research, both in discussions about my subject of study and in solicited attempts to define my positionality in relationships with a variety of interlocutors, is: should we take 'belief' seriously then? What would it mean to do so? And above all, what do we really mean when we say 'belief'?

Between actor category and analytic category: a working (in)definition of 'belief'

Far from aiming to make any attempt to give a univocal definition of what 'belief' *is* in order to either reclaim it or reject it as a viable anthropological category (cf. Streeter 2020), I think it might be more interesting to start from the ways in which the term is evoked in non-scholarly contexts and explore the different meanings it might acquire in people's discourses and experiences, somehow accepting and embracing the impossibility of separating the concept from its inherent indefiniteness and polysemy. As recently shown by Aulino (2022), if we depart from the traditional anthropological uses of the category and the 'monotheistic' bias that informs its conceptualisation in terms of an either/or dichotomy (either you believe in something or not), we might 'find insight in incoherence' (*ivi*: 231) and be receptive in novel ways to the possibilities 'left open' by the 'problem of belief' (Engelke 2002: 3). In her article, rather than more classically creating a taxonomy or extracting a definition, Aulino creatively proposes to compile a 'list' of possible descriptions of 'belief' through her interlocutors' words: in northern Thailand, she illustrates, people might talk in terms of belief to describe a first hand experience, a bodily experience, something rooted in the experience of trusted others (i.e. family members), an experience marked by a 50/50 percentage (as one of her interviewees put it: 'I personally still don't completely believe in black magic, it's 50/50'), something connected to the idea of 'not challenging' (spirits or God), an activity connected to imagination and the exercise of mental power capable of orienting one's destiny, a goal setting activity, a proposition expressing an interpretation of a certain reality, a secular expression of non-belief (e.g.: 'I believe I have never seen a ghost') (Aulino 2022: 226-231). As highlighted by the author, these descriptions are not alternative to one another and can easily coexist not only in the same (geographical) context, but also in the perspective of a single person. It is interesting to note how some of the connotations listed in Aulino's paper would work well to describe the different interpretations that emerged in

the vibrant debate on Covid-19 between my friends Kodwo and Stephen, with which I opened this chapter: think, for instance, of the ways in which Kodwo stated that he only believes the *bozonle and* himself, conjuring in the same sentence many of these possible meanings.

It would be legitimate at this point to ask: are we talking about *belief* here as an actor category or an analytic category? An emic or etic term, to use a terminology more in use a few years ago? It is not easy to disentangle the two: they seem to be in a constant tension, but, going in a similar direction to the one suggested by Aulino's paper, I think it might be worth to start from the actor category dimension (i.e. the way the concept emerged in conversations with my interlocutors in southwestern Ghana) in order to reflect on the potentialities of the analytic category. Thus, taking the centrality of the category in the discourses of mental health professionals as a point of departure, in the next few pages I also aim to challenge the hegemonic employment of 'belief' in the history of anthropology and its classical conceptualisations, by moving the discussion out of the exclusive realm of religion.

Though many of the conversations I will refer to were held in English, a language nurses are obviously proficient in (unlike Nzema, which is fluently spoken only by a minority of professionals who originate from the area), it is important to highlight that in Nzema the verb used to convey the meaning of believing can be uttered, like the English word, in the 'I believe in' as well as the 'I believe that' form. Like its Twi equivalent (*me-gye x di*), in Nzema *medie x medi* literally means 'I receive x I eat', 'I receive and I eat', 'It's complicated, it's like I take it, I eat it and I keep it inside myself', as my friend Armoh told me when he explained to me what meaning the literal expression conveyed according to him.[155] In Nzema one can say *medie Nyamenle medi* (I believe in God), as well as *medie medi kɛ menli le kpalɛ* (I believe that people are good/I believe that people are enough). In the first case, the expression can be used as a synonym of trust (*rɛle*) : for instance, *medie Kofi medi* can be translated as both 'I believe (in)

[155] In colonial times, the depth of the akan expression (*me-gye x di*) called the attention of Christian missionaries like the Swiss-born reverend of the Basel mission Fritz Ramseyer, who stated in a report on the Gold Coast given to the Société de Géographie de Genève in 1886: 'D'autres expressions sont vraiment belles, en particulier celles qui répondent à l'acte de croire; pour dire je te (vous) crois, ils disent : me gye wo asem me di = je prends ta parole et je me l'approprie, dans le sens de : je la mange; au mot foi répond l'expression gye-di, prendre et s'assimiler, faire de quelque chose sa substance, on peut même la traduire par prendre et manger' (Ramseyer 1886: 121).

Kofi' and 'I trust Kofi'. A lot of the power of 'belief', I will argue, lies in the tension between the expression of declared trust and loyalty mainly conveyed by the 'I believe in' (*medie x medi*) form and the possibility of doubt and uncertainty mainly conveyed by the 'I believe that' (*medie medi kɛ*) form.

'We believe in medicine, we believe in science': between belief and doubt

Collaboration between competing 'beliefs'?

As already suggested previously, the attitude of psychiatric institutions and practitioners towards 'alternative' forms of healing with whom they are supposed to 'collaborate' is utterly ambivalent. 'We are starting to support them because we can't remove them', as an Accra Mental Hospital's psychiatric nurse once told me, echoing the title of one of the first papers published on the topic of 'collaboration' in Ghana: 'whether you like it or not people with mental problems are going to go to them [i.e. 'unorthodox' practitioners]' (Ae-Ngibise et al. 2010).[156] The way psychiatric practitioners talk about non-biomedical understandings of 'mental illness' often reveals an implicit opposition, in which belief is evoked, sometimes as an explicit synonym of superstition, to explain the choices of people who decide to resort to prayer camps and/or traditional healers. In this perspective, the use of the term suggests an incompatibility between the rational realm of science and the irrational territory of *belief*. Indeed, the latter becomes the main issue, 'the problem' that hinders people affected by mental suffering from getting proper care (see Chapter 2). This is in line with dominant approaches in Global Mental Health that, as observed by Stefan Ecks, tend to consider 'local definitions of mental health [as] irrelevant to the GMH project' (Ecks 2022: 197). Often, he notes, 'the only importance accorded to local meanings is that they produce "stigma" and erect "barriers to care"' (*ibidem*). The conflation of alternative understandings of mental health and mental distress with the 'problem of (others')

[156] Conversation with Mr. Sarpong, 14th October 2014.

belief' can effectively be summarised by the words pronounced by one of the nurses during our first group interview in 2013:

> 'You know in Africa, especially Ghana here, they believe in spirits, yeah *they believe in spirits*, mostly they believe that those bad spirits can cause those [mental] problems. So if you meet someone who has such an idea... that person may believe that someone who hates him or her is causing that condition... and it's mostly those people who don't come here... they try to seek help from [elsewhere]... here *we don't believe it*...'[157]

The predominant use of belief in the third person (*they believe*), identified by Wilfred Cantwell Smith as a historical result of the evolution of the concept in Western thought, emerged strongly also in many of the psychiatric nurses' discourses. In this case too, belief can often be explicitly pitted against knowledge. As Michael put it:

> Ideally, *per my knowledge*, I don't bear with *them*. When it comes to the community, *they* have a strong belief that maybe through a curse, or like... that one can get mental illness 'by curse' or 'by spirit', but me, I haven't experienced any psychiatric case [in which I] thought that it was [caused by] a spirit. [...] I don't actually believe that psychiatric conditions are caused by spirits, unless *those who* do not have ideas, they will assume that: 'no, it [must be] spirits', but per my *knowledge*, I don't side with them. [...] I do understand that *they don't have knowledge*, that it is why they are saying that it is spirits.[158]

When I asked her if it ever happened to her to think that a mental condition could somehow 'be spiritual', Pamela burst into laughter and answered:

> I don't believe in those spiritual [conditions]... I don't believe in it. But you know, us Africans as we are, Africans believe in those spiritual... spiritual things. If I hadn't been to psychiatric school, I would also say I believe in the spiritual [things, entities, causes, etc.]...in spirits when it comes to

[157] John, group interview with psychiatric nurses, 7th November 2013.

[158] Interview with Michael, 29th November 2021.

> mental illness. [...] I got educated and I had knowledge in mental illness, I got to know [that] it's not all about spiritual, maybe the spiritual aspect is there for those who have... they can foresee in a spiritual way, me I can't, I can't foresee that, so what *I believe* [is that] it is our lifestyle, and it's the stress that holds us up that makes all these things. It's not spiritual. [...]
> When it comes to the spiritual aspect, I don't believe in it. But I just tell them, if you believe in it, and you want to pray, or you have any other place you want to go, you can go, but you have to add the medication to it, 'cause I don't want to make you feel that what I'm saying is the best, I don't want to neglect what you are saying. I "believe" in yours, but I'm not going to use yours, I'm going to use mine, but I will just encourage you to add mine to what *you* believe in.[159]

Like Pamela, in describing their complex perspectives, sometimes the nurses played with one of the many troublous legacies of colonial times that keep haunting mainstream imaginaries of the continent: the stereotypical representation of 'Africans' (but also 'Ghanaians', or 'Nzema') as quintessentially 'believers', 'pagans' and/or excessively 'religious' to a secularised eye. This (sometimes ironic) distance from 'belief' is also narrated as a result of the nurses' education.

Michael decided to go to nursing school out of the gratitude and admiration he felt for the hospital staff who took care of him when he was stricken with appendicitis in his childhood and the training was in many ways transformative for him. Indeed, similarly to Pamela, he described his conceptualisation of 'mental illness' as marked by a 'before' and 'after':

> To my knowledge, in everything if you don't know... the time that I had not been trained as a mental health officer, if you asked me 'what do you think the cause of mental illness is?' I'd also think that it's spiritual...I'd say that I didn't know because I was not having any idea about that. But after I was trained...after passing through a lot of things I'd also say that it [i.e. the cause of mental distress] is not a spirit.[160]

[159] Interview with Pamela, 20th January 2022.

[160] Interview with Michael, 22nd October 2014.

'For us it's different, we believe in medicine, we believe in science', Mary told me in one of our first conversations, paradoxically using the idea of belief to declare her 'allegiance' – to rely on Smith's terminology – to what she and her colleagues studied in school, rather than what is commonly, often derogatorily, described as 'belief'.[161] Indeed, to some, giving credit to what is not 'science' in the hospital environment would be more than inappropriate; for Ernest, for instance, it would be scandalous:

> I don't give spiritual advice, I'm not a specialist, I can't know what is happening in a spiritual way, I don't go there. I once heard from one patient that a nurse told her that, it wasn't about mental illness, it was a general condition, the nurse told the mother: 'your child's sickness is not sickness for the hospital', that she should go and see for something else. I was furious! 'Cause how can a professional nurse tell somebody that your sickness is not a medical condition, and wants to attribute that to spiritual sickness, how can you do that? 'Cause when you do that psychologically you have put something in the woman's mind, and you are going to burden her psychologically 'cause she would be thinking about it: who would be doing this to my child? Who would be doing this? Who would be doing this... so the necessary medical attention the person needs will go away from that place, and the person will rather go for spiritual healing. Before you realise [that the person needs medical treatment], then it's too late (...) so I'm a nurse, and I do deal with my signs and symptoms, I give treatment, and that's it. I don't want to... fine, if you want to go to your spiritual [healer], go, but I'll advise you to still stay on your medication.[162]

Turning a piece of paper: from the third to the first person

What I have always found striking is that even though at the discursive level the recurrent statement was that of an essential difference, a neat separation between *us* (the nurses) and *them* (the prophets, traditional healers, patients, or more often those who could have been their patients *if only* they did not hold those *beliefs*), at the practical level this distinction was more difficult to identify.

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[161] Conversation with Mary, 3rd November 2013.

[162] Interview with Ernest, 21st January 2022.

First of all, it is important to restate that, as we have seen in Grace's case for instance (see Chapter 3), it can be quite common for people convinced of the spiritual origin of the 'illness'[163] — viewed as caused by a curse, the intervention of a spirit, or a demonic possession — to seek help from biomedical services along with traditional healers and/or prophets and pastors (cf. also Read 2016).[164] Moreover, patients' and relatives' convictions about the 'illness' may obviously change with time, as much as different hypotheses about a single condition can co-exists in the same time frame, even for the same person.

Secondly, as anticipated in Chapter 2 through the two 'case studies' described by John, in a few occasions psychiatric nurses admittedly shared with their patients the spiritual interpretation of some 'illness' cases. Sometimes sedative psychotropic drugs do not seem to work in 'calming down' and 'managing' the patient and doubts about the nature of the illness can come in. Sometimes, even in conversations, 'they' can become 'us'. Once, talking about the different perceptions of 'mental illness' in the area, Francis said: '[when] *they think* that the cause of the illness is a curse, *they pray* for the person [and] we cannot stop *them* from praying, yes. *We believe* that God can do everything. So *we have that belief* that sometimes it's a curse'.[165]

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[163] Being convinced of the spiritual origin of the illness usually means talking about the condition as 'something spiritual': *sumsum nu debie*.

[164] More broadly, the idea that biomedical facilities always serve as 'the last port of call' among all the possible options, as many institutions, NGO representatives, researchers, and health workers have often claimed is misleading (Read 2012a, 2016). As I could observe myself throughout my research, any attempt to identify a fixed model to describe people's therapeutic paths cannot but be inaccurate: they are multiple, heterogeneous, and informed by varying factors. Moreover, as highlighted by anthropologist Ursula Read in her ethnography of mental illness in Kintampo, it is definitely not uncommon for people to seek help from psychiatric institutions even in the first place (Read 2016: 48). The stereotype of psychiatry as the 'last port of call' has also been challenged by a quantitative study carried out at Pantang Psychiatric Hospital a few years ago (Ibrahim et al. 2016): according to the investigation, more than half of the sample of patients considered sought help from a formal psychiatric facility as their first point of contact for treatment of mental disorder.

[165] Interview with Francis, 7th August 2014.

Expressing a similar view, in which belief shifted from the third to the first person, Juliet stated:

> Some people are saying that mental illness is spiritual. Because some people can go and steal, and they will curse them, and sometimes they will go mad. I have seen some: there was this man, he went to steal, the person cursed him, and he became mad. So it can be spiritual as they are saying, but we shouldn't always relate it to spiritual: *it can be, we believe that there are spirits around, yes, we believe that*, so they can cause mental illness, but not always it is them causing it. Because some people... they had it in their family and they are getting it, some people too it's because they take drugs that they are taking it, so I believe it can be due to spirits, I believe that.[166]

Even Sarah – who did not hesitate in other occasions to express scepticism and detachment towards the practices of traditional healers, with the motivation of not only being a nurse, but also having been raised as a Jehovah Witness – used analogous words:

> That's what some people think. But you see, me, I don't have that eye to see that that issue is spiritual or not. So when you come here, we just deal with the orthodox, we do it medically, so when you finish, you go for your spiritual healing [...] but me, I learned medicine in school, I learned science in school, so I wouldn't know... even though, yeah, some... you know we are in Nzema... some of the causes they might be spiritually related, because someone will say 'I'm going to curse you, you will be mad' and the following day you see that the person is mad, then when they come you can control it, but they [spiritual healers] also have some other things they do, so that can also make them heal faster, but when they come here we just put you on the drugs to help you. But some are spiritually related, that one, I won't say it's not true. Some are spiritually related.[167]

The sharing of a common horizon of meaning emerged in the narratives of many of the nurses I met: the shifting of belief from the third to the first person indicates a simultaneous

[166] Interview with Juliet, 18th January 2022.

[167] Interview with Sarah, 17th January 2022.

proximity and distance (often expressed in terms of time: i.e. *before the training, I used to believe*) with/from the spiritual and religious implications of what psychiatric practitioners call 'mental illness'. Indeed, the proximity often goes well beyond the 'watershed' of professionalisation: not only do most of them attend church and the mosque, but the invisible and dangerous powers that inform the experience of 'mental distress' of many of their 'clients' have often played a role also in the nurses' lives. Michael, for instance, told me more than once that he was quite happy of working far from home (he was born in another region) because he was worried of the envy his successful career as a nurse might provoke, especially in his friends and relatives: 'What I was afraid of is that they can curse me to die. What I do believe of cursing is that you can curse me to die (...) me, I have belief in that curse (...) but before cursing, unless I perform something because if I use my mouth to say you would die I don't think it will work. Unless I do some process'.[168] Francis, on the other hand, is the son of a traditional birth attendant who used to work with a very popular priestess-healer (*kɔmenle*) and when he was a teenager, he was brought to the garden by his mother and started assisting the healer, beating the 'traditional dance' (*ahɔne*) for her. He was then involved in the foundation of a Pentecostal church in Takoradi and thus cut his ties with the *kɔmenle*, but that experience stayed with him, as he recalled many events in which the power of spirits – and that of those who have the 'extra eye' – was manifest: 'you cannot rule them out totally, if you don't want to follow them, fine, but don't say they don't exist, you'd be making a mistake'.[169] For many of the nurses, understanding the implications of what the people in front of them are saying when they suggest the need to intervene 'spiritually' to deal with a mental condition is as easy as turning a piece of paper, like the one on which Henry sketched a number during our interview:

> Imagine you don't see from where I'm sitting: which number is this? [Nine, I answered] And imagine I don't see it from your side too, I see it to be six. So you are right, that doesn't mean that I'm wrong. I only see that you are right when I can see from your side [...] If maybe a patient comes, we are dealing with the physical aspect, treating with medication or whatever knowledge that we have. And maybe the relative too will be like 'oh no, this is a spiritual [something]...', in

[168] Interview with Michael, 22nd October 2014.

[169] Interview with Francis, 11th January 2022.

> our field of work we don't have to let them... give them that go-ahead: 'yes, go to the spiritualist to help you out'. No! We *know* that those things exist, we really know, but we don't associate [them] with [our practice]. So me whenever I'm treating somebody and maybe they are thinking otherwise all I tell them is — I know it's not the right way though, but you can't force them — so if they think it's the spiritual way, me I know that those things exist, a whole lot, they exist...though even if it's spiritual you can do something about it with drugs and it will make the person ok, but maybe they have to treat the underlying cause, maybe what is always bringing the thing back, always bringing the thing back. So to me personally, I think it's true [...] it's very true...but in our field of work, nooo, we say 'noooo'. We always try to discourage it: 'no no no, don't worry about that aspect, it's all about this', and we try to use our knowledge to explain to them: 'no it's this, that, that's what causing it', we try to treat it with medication and we don't see any results...'cause sometimes...I believe. I believe it's true. I believe![170]

The horizon of meaning that nurses share with those who are not trained in biomedicine, however, is a horizon of possibilities (as Sarah put it: *I believe it can be... but not always*) rather than certainties. At the same time, to a large extent, the experience of uncertainty marks the practice of mental health professionals, even when we narrow our scope exclusively to psychiatric understandings of 'mental illness' and its associated remedies. Perhaps, together with belief, it is uncertainty and doubt we should turn our attention to.

'How can you believe if you don't see?': doubt in people's therapeutic paths and psychiatric nurses' medical practice

As I tried to highlight with the help of the initial vignette on believing or not in Coronavirus, to a certain extent the notion of *belief* always implies its opposite: doubt (*how can you believe if you don't see?*). Doubt is obviously only one of the many possible opposites of belief, which include for instance concepts like knowledge and science, as it clearly emerges from the nurses' discourses explored in the previous section. Indeed, the complex relationship between belief and doubt is perhaps more hidden and less intuitive, but nevertheless constitutive. This intriguing

[170] Interview with Henry, 17th January 2022.

opposition/interconnection between believing and doubting has been recently explored by scholars working on religion and psychiatry, both as separate and relational entities, such as Tanya Luhrmann and Christian Suhr.[171]

In line with reflections that already emerged in her first ethnographic research on witchcraft in late twentieth century England (1989), in her work on the ways in which American Evangelical Christians train themselves to hear God's voice and presence, Luhrmann observes how 'the idea of believers struggling with doubt can be disconcerting to skeptics, who tend to imagine belief as an either-or choice, and who imagine a good Christian has a straightforward commitment to God's reality. But when you are willing to take seriously the importance of doubt, you can see it everywhere in Christianity. The Gospels themselves expect doubt' (Luhrmann 2012: XIII; see also Boyer 2013).

Similarly, in Suhr's study on the interactions between Islamic healing practices and psychiatry in Denmark (2019), the presence of doubt is a fundamental feature. According to him, during therapeutic encounters, both in religious and psychiatric settings, doubt is produced in order for the patient to submit to the healing process: to really become a 'patient' – understood in the latin etymology of the word as an inherently passive subject – the person has to abandon all of her previous certainties. Doubt, however, seems to be more than a therapeutic device: it is a common thread that binds together both patients and healers. Indeed, reflecting on psychiatric nurses' practices, Suhr notices:

> It continues to puzzle me how the nurses seem to combine such belief and non-belief in biomedicine. In front of the patients there is not a shred of doubt in their statements about the positive effects of the medicine. But after their meetings with patients are over, they often tell me about the problems of not being able to control the side effects of the drugs, that the drugs seem to be working in unpredictable ways on different ethnic groups, the difficulties in poly-pharmacy, and the specific problems related to the generic drugs, which are the only ones most of their patients can afford (*Ivi*: 42).

[171] On the constitutive relationship between belief and doubt see also: Severi 2000, 2002; Pelkmans 2013.

Suhr's reflection resonates a lot with my own experience at the psychiatric unit. Let's go back to Mary's sentence, 'we believe in medicine, we believe in science': what if it represented a valuable entry-point to look at the intersections between psychiatry and spiritual/religious healing in the face of any incompatibility argument? In other words, what if *belief*, instead of being a hindrance, could actually be a common ground? As I have argued above, in Mary's statement *believing in medicine and science* seems to acquire a meaning which is closer to the original idea of *pledging allegiance to* a certain ideology of 'mental illness'. An ideology in which spirits and demons are not part of the picture. Indeed, *belief* is often uttered with certainty. However, if we look at it through the prism of doubt, it may be easier to understand what actually makes the combination of different healing practices possible in people's lives. For instance, if we looked at people's therapeutic paths and, in line with the discourse of 'the problem of (others') belief', we regarded the spiritual aetiology of illness as a monolithic, strong conviction that orientates people's choices, we would be puzzled by the ways in which patients actually navigate different healing resources. In fact, as we have already seen in multiple cases, the same people may simultaneously or consequently seek help from a *kɔmenle* (a possessed healer), a *ninsinli* (a herbalist), an *esofo* (a prophet), and a psychiatric nurse. Actually, the endurance of the topic of medical pluralism in medical anthropological scholarship since its introduction in the 1970s (Leslie 1975, 1976, 1980; Janzen 1978; on African contexts see also, among others, Hunt 2013; Olsen and Sargent 2017), and the relevance that the plurality of people's therapeutic pathways continues to have in many ethnographic accounts, make my observation almost obvious.[172] Generally, however, this phenomenon is explained in terms of 'pragmatic choices'. Though the generic application of this justification as self-evident may be criticised (see for instance Ram 2010), pragmatism is definitely a crucial dimension to understand the ways in which people – often collectively (Janzen 1978) – make their therapeutic choices with the aim of a successful healing. Here, however, I would like to focus on one of the factors that may contribute to making those kinds of pragmatic choices possible. Like Grace's parents (Chapter 3), many of the patients and relatives I met during my research would genuinely say that they 'didn't know', they were 'not sure' about the causes of the 'illness' or what was 'best to do'. Or,

[172] See for instance the rich annotated bibliography assembled by Alex and colleagues in 2012 (Alex et al. 2012).

perhaps more often, they would give multiple explanations and interpretations of the same 'mental problem' in different conversations, like Kaku's uncle (Chapter 2), or sometimes even during the same one. Similarly, the presence of doubt seems to mark the practice and discourses of psychiatric nurses: it is not uncommon for them to change their mind and discuss about people's diagnosis, call into question their previous decisions, and even wonder about the efficacy of 'science' in cases in which they get 'stuck'[173] — to quote the expression used by one of the nurses — between what they have studied and what they perceive, together with their patients, as being 'spiritual' instead of psychiatric. Since most of the psychiatric nurses' therapeutic practice revolves around medications, not differently from what happens to the Danish professionals described by Suhr, many of their doubts have to do with drugs. As it emerges from Pamela's words, uncertainties about medication and diagnosis are often closely related:

> Sometimes my colleagues attend to clients and then I review and I feel that this drug is not best for this person, so we discuss and we come to a conclusion then we change the diagnosis. Sometimes we change the medication as well. When I just review and think through and I feel... what the person gave isn't the right medication, is not going to help the patient. We all sit down, we talk about it then we review the diagnosis and change the medication. That one, we do it often.[174]

Psychopharmaceuticals can sometimes 'do more harm than good' in terms of side effects,[175] as it is often remarked by the nurses (e.g. rashes all over, stiff neck, tongue swelling, etc.). Thus, it is quite common for doubts to arise when a person does not react well to a medication and this can often be the object of disagreements (cf. Chapter 6) among psychiatric professionals as Pamela's words suggest (*my colleagues attend...and I feel*). More generally, however, doubts and hesitation are also part of the prescription process: they are largely concealed in front of patients and their caretakers, but can still emerge while a nurse is quickly taking his/her decisions. They can

[173] Group interview with psychiatric nurses, 10th July 2017; see Chapter 2.

[174] Interview with Pamela, 20th January 2022.

[175] Interview with Francis, 11th January 2022.

sometimes take a moment to count the drugs, before giving the prescription to the client: 'Am I doing polypharmacy?', they ask themselves, their colleagues (and sometimes even me). Some other times, they can wonder whether the dosage is too high, and change it last minute, worried about the risks of 'saturating the system' or provoking a 'desensitisation of the cells'.[176] In other words, doubt is part of the 'belief in science', as much as it is part of what is more commonly labelled as belief in the discourse of mental health institutions and practitioners.

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In this chapter I have tried to start a reflection on the potential of the concept of *belief* by putting in dialogue perspectives coming from medical anthropology and the anthropology of religion.

In discussions about mental healthcare in Ghana, the term 'belief' is often used in the third person and evoked by psychiatric institutions and practitioners as the main obstacle for 'mentally ill' people to get proper care: '*they* (wrongly) *believe* the illness is 'spiritual', thus they don't seek for help in the right places'. In the same context, however, the idea of 'believing in something' can often be used also with its original meaning of 'pledging allegiance to', 'giving your heart to' and be equally used to talk about spirits, God, and – interestingly – science. Paradoxically, in both uses – that is, having an opinion about something held to be true or putting trust in something – the term always conveys also an opposite: doubt, i.e. the possibility of 'it' not being true or of having put trust in the wrong thing.

It is precisely the doubleness of the concept of *belief* and, even most importantly, its constitutive relationship with doubt that could prove surprisingly illuminating in order to understand how people (patients, relatives, practitioners) navigate different therapeutic

[176] Obviously, doubts may also be related to ethical choices to be made (what to do in front of a patient who cannot afford drugs, see Chapter 3; or what to do in the case of a patient who refuses treatment, see Chapter 5).

resources and meanings during healing processes in the Ghanaian context. At the same time, as highlighted in different ways by scholars like Good, Asad, and Meyer, the term *belief* cannot be used without being aware of its Eurocentric and ultimately colonial biases.

As noticed by Robert Orsi, however, the 'deconstruction of belief' could also end up by 'construct[ing] religious actors as mindless practitioners whose interiorities and imaginations do not matter, or matter only as a function of the social' (Orsi 2011: 14). 'The multivalent reality of religious experiences [would] [be] thus diminished again. If this is where the critique of religion = belief has gotten us, we have merely made a long detour back to where it all started' (*Ibidem*). Playing with the concept's limits, but also determined to avoid these risks, here I have proposed to look at the concept of *belief* through the lens of doubt and to apply this category to both religious *and* non-religious ways of dealing with mental suffering, crucially inspired by the many ways in which people can mobilise *belief* in Nzemaland.

By doing so, I have tried to suggest the idea that far from being a concept that only puts people at a distance – *they believe* – *belief* could also lead us to understand more closely, and in a way that resonates more with 'our own' experiences (Western? Non-religious? Scholarly?), people's choices and conundrums.

5. CHAINS | TIES

Addressing the dilemma of care and control beyond colonial sensationalism

In Chapter 3, when I told the story of my first meeting with Ama – the Ivorian patient staying at Esofo Christ's prayer camp, whose ironic attitude drew my attention for the first time to the informal economies of mental health care and the ethical dilemmas associated with them – I omitted one detail. I wrote that she was chained to a tree, together with two other patients of the camp. What I did not write is that when I started talking to her, after having heard her comment on Michael's selling activity, I did not realise that she was in chains. For a few minutes, I thought she was just sitting there, on a bench in the shade of a big tree, without seeing the tiny green padlock that kept her shackled to that tree. Even though it was literally before my eyes.

It would be difficult to maintain that I was unprepared for such an event. Before starting my research, I had read a lot on the use of chains in prayer camps in local and international media outlets as well as in scholarly articles. I had also seen quite a number of pictures of men and women deprived of their freedom, their ankles bound to trees, poles, pillars, wheel rims, or metal rings in concrete floors. Frequently their faces were not shown, perhaps out of respect for them or to avoid complications associated with the attainment of informed consent for disseminating those images. The meeting with Ama was (also) my first direct meeting with someone in chains, but to be honest it was not the only time in which it took me a while to realise that the person in front of me was not free to move. On subsequent occasions, it kept happening to me. There could be a multiplicity of explanations for this, ranging from the psychological to the theoretical implications of an encounter like the one I have described. Here, however, I do not aim to carry out an auto-ethnographic reflection on my reactions to this kind of encounters: I think it would be a mistake, perhaps also a political one, to focus on the 'observer' (myself) when addressing an issue such as mechanical restraint, that is so crucial and often painful for the people who actually

experience it or have to deal directly with it. Indeed, I wanted to start from my 'incapacity' to see the padlock and the chain around Ama's ankle because I would like to suggest the idea that far from concerning (only) myself, it also has a lot to do with the humanitarian discourse that developed around the practice of chaining in prayer camps and traditional shrines, and the images, forms of representation, and narratives conveyed by such a discourse. As I will try to show, the international humanitarian discourse on the use of chains in religious sites in Ghana (as well as other contexts in Africa) often tends to deny the subjectivities of the people involved, transforming them into people *without faces*, reduced to their chained ankles, crystallised in an eternal present of victimhood and 'abandonment'. And whatever might be the case, people in real life can never be *just* that.

Together with 'superstition' and 'belief', the mechanical restraint of patients with chains in non-psychiatric facilities is one of the most commonly evoked elements of supposed incompatibility between biomedical and non-biomedical therapeutic resources. In this chapter, I aim to question this assumption and the dominant humanitarian discourse that supports it. Before exploring how the issue of chaining is addressed by nurses trying to 'collaborate' with traditional and spiritual healers who adopt this practice in their healing sites, I propose to briefly analyse dominant depictions of mental health care in Ghana, in the discourse of both international media and NGOs that have been quite active in the field (i.e. Human Rights Watch). As I will show, focusing on the practice of chaining and on non-biomedical contexts, many of these accounts project a powerful representation of 'backward Africa', often mediated by images of enchained naked bodies – figures of 'bare life' (Agamben 1995) that are reminiscent of the colonial imaginary of slavery (Read 2021). In this perspective, the debate 'on chains' not only acquires highly problematic, sensationalist, exceptionalist, and sometimes overtly racist connotations, but also misses the opportunity to interrogate the dilemmas of care associated with practices of restraint in a time in which calls to put an end to coercion in 'orthodox' psychiatric care are multiplying throughout the world.[177] In the second part of the

[177] In Europe, see for instance the 'E tu slegalo subito' campaign in Italy (<http://www.slegalosubito.com/>, last accessed 30 December 2022) and the '#0contenciones' campaign in Spain (<https://www.0contenciones.org/>, last accessed 30 December 2022).

chapter I will focus on the ways in which the practice of chaining was experienced and/or narrated by some of the healers, patients, and family members in the space of the prayer camp and beyond. I will propose to move the discussion of containment from the space of religious healing sites to which it is usually confined in the public sphere and to look at it in the broader framework of mental health care, in the attempt to unpack the entanglements of care and control that are so central in the life of 'mentally ill'/mad people and their caregivers.

Between colonial gaze and human rights

People without faces

Since the beginning of my research project almost a decade ago, the dissemination of images of chained people in Ghana and other West African countries in international media has not stopped. This has gone hand in hand with the development of a vital debate on mental health in the country and with the emergence in the public sphere of Ghanaian activists and mental health advocates who have amplified discussions on the wellbeing of people affected by mental suffering, addressing crucial issues such as stigma, neglect, underfunding, and abuse. At the same time, since the approval of the innovative *Mental Health Act 846* in 2012, Ghana has seen major improvements in psychiatric care provision that could be appreciated also in the Nzema area, especially in terms of human resources (cf. Introduction). However, as argued by Ursula Read in a recent article in *Africa is a Country* (2021), these changes have not been reflected in international media coverage. Focusing on an article published by British newspaper *The Guardian* in February 2020 and revealingly titled '"All we can offer is the chain": the scandal of Ghana's shackled sick' (McVeigh 2020), Read – drawing on Sadiya Hartman's work on the slave trade and the imaginaries associated with it (Hartman 2006) – highlights the similarities between Western representations of mental illness 'in chains' and the representations of slavery employed by abolitionists. As suggested by Hartman, the latter were aesthetic practices that

ended up by strengthening master-slave dynamics instead of destroying them.[178] Reflecting specifically on the collection of pictures that accompanied the article (McVeigh and Hammond 2020), Read observes how

> such images, then as now, are designed to provoke shock and outrage. Yet psychiatrist and anthropologist Arthur Kleinman has cautioned against this 'dismay of images' (Kleinman and Kleinman 1996). While aiming to elicit compassion, they result in a particular kind of othering. The desperation of the 'shackled sick' and the heroism of the lone mental health nurse construct a 'tragedy' that hides as much as it reveals (Read 2021, § 4).

The *Guardian* article reproduced the pathetic yet trite rhetoric of the humanitarian discourse applied to the issue of physical restraint in prayer camps that has often been employed by international organisations and NGOs working on mental health in Global South contexts like Ghana. This rhetoric, frequently embraced by international media, seems to have remained generally unchanged throughout the years.

In July 2017, for instance, *Al-Jazeera*'s online channel *AJ+* posted on Twitter a short video[179] about prayer camps and the violation of human rights taking place in these healing sites. The video opened with the supposed news of the 'freeing' of 18 chained people from a prayer camp – the audience was neither informed about the location nor about the timing of the reported 'operation' – and then it gave a short description of what prayer camps are, by showing some 2012 Human Rights Watch images and video excerpts of men and women in chains, shaken by convulsions, unconscious on the floor, and so on. The footage was accompanied by dramatic

[178] It would be interesting to put in relation the comparison established by Read between images of slavery and images of madness with the one proposed by American Studies scholar La Marr Jurelle Bruce between the same two experiences, but in a completely inverted perspective (Bruce 2021: 1-5). Instead of focusing on chains, Bruce focuses on the image of the ship: the slave ship and the ship of fools famously described by Michel Foucault (2006 [1961]). By 'staging an encounter' between the two, rather than proposing a mere analogy, he aims to suggests that 'the slave ship (icon of abject blackness) commandeers the ship of fools, helps orient Western notions of madness and Reason, and helps propel this turbulent movement we call modernity' (Bruce 2021: 5).

[179] See: <https://twitter.com/ajplus/status/886254299763810304>, last accessed 30 December 2022.

music and superimposed words: 'They were *forced into "prayer camps"* to *correct* their *"aggressive behavior"*, often by their own families or police. *Shackling* is considered a *spiritual form of healing* in parts of *Asia* and *West Africa*. People *as young as seven* have to *sleep*, *urinate*, and *defecate* where they are *chained*' (emphasis in the original). The video, then, reported the first-person testimony of a woman, Doris Appiah-Danquah,[180] who recounted her experience in prayer camps: she had to sleep outdoors chained, sometimes under the rain, while her mother was there, unable to say anything 'because they thought what they were doing was good for me'. 'Many of the people we talked to in the prayer camps reported that mental disability is as a result of evil spirits' – added the disability rights researcher Medi Ssengooba. The whole video suggested the idea of an unclear geographical site (Ghana? West Africa? Africa and Asia? The 'Rest'?[181]) clearly located outside 'our modern world' (where people know that 'evil spirits' do not exist!). At the time of its publication, a comment – later removed – appeared under the video: 'jesus christ these places are backwards'. It was not pleasant to read, it was obviously offensive, but I would say that it represented quite well the reaction a video like that may elicit in an uninformed Western audience, as well as the conceptual standpoint from which it originated.

The latest reports on the status of 'people with mental health conditions' in Ghana disseminated by Human Rights Watch (Human Rights Watch 2022; Kamundia 2022) are still

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[180] Her experience is reported as a 'success story' in De-Graft Aikins 2015. The excerpt of the interview shown by *AJ+* is drawn from a video produced by Human Rights Watch, see: <https://www.hrw.org/video-photos/video/2012/10/02/ghana-abuse-people-disabilities-0>, last accessed 30 December 2022. Interestingly, in the mentioned video Appiah-Danquah also denounces the treatment she received at the psychiatric hospital where she was admitted, frequently going in and out, after having left the prayer camp: 'You don't have control over anything that is done to you. When I had to have electro-convulsive therapy, I was just told: "you are going for a test". And we were just taken into the room, put on the bed. But I didn't know... I didn't have any idea of what was going to happen to me. You go and it's done for you, you come back to the ward confused'. Her words, however, were not included in the *AJ+* video, which deliberately focused on the most 'exotic' traits in her account. For an interesting interview with Appiah-Danquah and a short film that recounts her experience, see also the following video produced in 2015 by the Ghanaian platform *Creative Storm*: <https://vimeo.com/109473357>, last accessed 30 December 2022.

[181] The reference is to the postcolonial critique of the constitutive discursive opposition between Western and non-Western societies in terms of 'the West vs. the Rest', see Hall 2019 [1992].

focused on human right violations in prayer camps, with a specific emphasis on the practice of chaining. They denounce that despite in 2017 the Mental Health Authority had announced its commitment to enforce the ban on shackling – a ban that was indeed already in place since the approval of the *Mental Health Act* in 2012 –[182] the practice is still widespread in the country, as it emerged from visits that were recently carried out to five different healing sites. In the mentioned documents, the NGO describes the extremely serious conditions of abuse observed at the visited prayer camps, ranging from being shackled and caged in narrow rooms to not having basic access to food and hygienic services, to being raped and not having received any form of 'post-rape care'. At the same time, in line with philosophical and anthropological critical readings of the 'human rights' discourse that have effectively unpacked its inherent contradictions, shortcomings, and hegemonic applications (see, among others, Malkki 1996; Rancière 2004; Fassin 2011; Perugini and Gordon 2015), we can observe how the NGO's narrative has the paradoxical effect of dehumanising the subjects it talks about. In an article on chaining in Ghana based on the organisation's latest statements published in the Italian magazine *Africa Rivista*, after having almost literally reported the words used in the NGO's documents, the author writes:

> During the visits [carried out by Human Rights Watch representatives], many 'patients' asked for help, begging to be released. 'We want to go home and stay with our family. Help us. Please help us', one of them said.
>
> This condition is widespread in many African countries where physical or mental disability is seen as a stigma. Something that pertains to spiritual misfortune. A condition that can hit anyone, even the most vulnerable ones, like children who are often not considered as 'true' offspring, but are regarded as the manifestation of the spirits' hostility towards the family. That is why, besides the society, the family they belong to hides them, does not take care of them or look after them as it does with the rest of the children. Above all, the family hides them in order to avoid making the stigma – the ancestral adversity that has hit that family unit – public.

[182] See: <https://www.modernghana.com/news/810710/mental-health-ghana-seeks-to-end-chaining-of-mad-people.html>, last accessed 30 December 2022.

> Disability in Africa is still considered a shame. It is not accepted, rather it is seen as a curse that darkly precipitates on the family. It is also for these reasons that families, especially the very poor ones, recur to the so-called 'prayer camps' of revival churches. They 'entrust' their children to them, not only the children who are believed to be disabled, but also those who are seen as wizards or witches, who bring curses to the family and for this reason are deemed as socially dangerous, that is people affected by psychosocial disability. Often this phenomenon is linked with the economic conditions of the family, which is not able to provide properly for all their children and thus 'dumps' some of them, by ascribing to them a mental handicap, understood as the capacity to bring the 'Devil' within the family. And for this reason they rely on prayer camps and their pastors, for their healing. These people, however, are often neither ill nor carrying evil eye. This notwithstanding, they are subject to forms of bodily punishment in order to push the devil away from their bodies, when, instead, they would simply need care (Africa Rivista 2022, my translation).

A lot could be said on these words, which would perhaps deserve a textual analysis *per se* – something that would be well beyond the scope of this chapter. In any case, it is clear that building on the humanitarian and sensationalist discourse that describes people in chains as 'begging to be helped' (Human Rights Watch 2022), the article portrays the backward image of a whole continent 'still' affected by 'stigma' – the latter actually being an elusive concept that has become a buzzword also in discussions about mental health in the Global North... but this does seem to be of interest to the writer, who is exclusively preoccupied with 'ancestral' connotations of 'stigma'. I will not focus on the many inaccuracies, stereotypes, and generalisations the article presents to the reader, but just on two crucial elements that are particularly relevant to the analysis I would like to develop in the following pages. The first is the double dehumanisation the article operates in the name of human rights: not only it reduces 'mentally ill' people or people deemed as such to victims begging for external help, but it also – perhaps more strikingly – dehumanises their close ones, relatives and family members cynically represented as individuals incapable of care. This leads us to the second aspect I would like to address: the representation of religious healing sites as places where care is not performed. As I have already anticipated (see Chapter 2) and I will further discuss below, prayer camps – at least the ones I visited in Nzemaland – may be conceived of as zones of abandonment, but also as zones of care, where – it

is important to stress it again – 'patients' are usually accompanied throughout their stay by the presence of at least a family member who looks after them. But if they are sites of care, how can a practice like chaining take place there, and, what is more, before the eyes of loving and caring family members?

To start digging into the complexities and dilemmas this question poses, let us begin from the ways in which slightly more 'peripheric' caregivers – as compared to the family (i.e. nurses) – engage (or not) with the practice of chaining in prayer camps.

'Our methods are far, far different': policy and practice dilemmas

In the ambivalent discourse of collaboration described in the previous chapters (especially Chapter 2 and 4), together with 'belief', the violation of human rights represented by the act of chaining is often mentioned by mental health institutional actors as an irreconcilable element of difference and thus a potential obstacle to the cooperation of psychiatric and 'unorthodox' practitioners.

Talking about her professional experience of outreach visits to traditional and religious healing sites, Pamela said:

> When you go to traditional healers', the shrines, and the prayer camps... sometimes the way... the methods that they use... it's barbaric, you know? They use chains, shackles, and the rest... [if] we try telling them that these days we don't use the chains anymore, it's like you are trying to tell them what to do... so we try to encourage them to desist on such activities, even though they are still not listening to us, but we try our best. We just encourage them to call on us if they need help in restraining the patients, not to use the shackles and the chains [...] they can call on us anytime, then we bring in our medications, our injections, just to help in restraining and calming the patients down. So they sometimes rely on us. [...] Our methods are far, far different.[183]

[183] Interview with Pamela, 20 January 2022.

Obviously, the issue of the use of chains in prayer camps came up very often in my conversations with nurses. In line with national guidelines, they talked about their relationship with 'un-orthodox' practitioners also in terms of 'education' (cf. Chapter 6): collaboration with them had to be based on a sharing of knowledge aimed at putting an end to 'barbaric' practices like chaining, as it clearly emerges from Pamela's words. As the nurse suggested, however, this is not an easy task: '[if] we try telling them that these days we don't use the chains anymore, it's like you are trying to tell them what to do…'. And – she implicitly entailed – 'we can't do that'.

As retraced by Lauren Taylor (2019), a Global Health and bioethics scholar who in 2011 was a member of a policy consultation and support team from Yale University aimed at 'advancing the discussion' (*ivi*: 265) on mental health legislation within the Ministry of Health in dialogue with mental health advocates, the widespread practice of physical restraint in prayer camps was a key problematic element in the policy discussions that led to the approval of the Mental Health Act in 2012. The new legislation was highly informed by human rights concerns and by the principles stated in the UN Convention on the Rights of People with Disabilities, which Ghana signed in 2007 and ratified in 2012.[184] Prayer camp chaining practices did not comply with these principles, but some policy-makers and mental health advocates saw in the hypothetical collaboration with them the potential for a two-fold prevention strategy: preventing the worsening of unattended severe mental conditions – especially thinking of areas where psychiatric services were not capillarily present as opposed to religious facilities – and preventing human rights abuses from happening in those sites, through the involvement of trained mental health workers. Others, however, were sceptical about the proposed collaboration and saw in it a form of legitimation of human rights violations. In the end, policymakers chose a pragmatic approach that represented somehow a middle ground between the extremes of the two positions. The Mental Health Act did not introduce any form of 'regulation' or 'accreditation' of prayer camps – as some policy makers were suggesting to do – but it promoted a general collaboration with un-orthodox leaders and envisioned the creation of a Mental Health Tribunal

[184] The Convention stated that 'State Parties shall take all appropriate measures to promote the physical, cognitive and psychological recovery, rehabilitation and reintegration of persons with disabilities who become victims of any form of exploitation, violence or abuse' (cit. in Taylor 2019: 275).

and visiting committees 'to ensure that the rights of persons with mental disorder within the community are protected' (Mental Health Act 2012: 16). As it was repeatedly denounced in the last few years by NGOs as well as institutional actors like the Mental Health Authority, these measures were not supported by appropriate funding to the point that the Mental Health Tribunal and the visiting committees were formally established only in 2022, ten years after the passing of the new law.[185]

Meanwhile, however, informal and non-codified 'experiments at collaboration' were already in place and nurses on the ground had to deal with the same ethical dilemmas that had dominated discussions among policymakers and international organisations before the passing of the Mental Health Act. How have they been dealing with such conundrums *in the meantime* (cf. McKay 2018)?

As for the nurses I met in Nzema, somewhat similarly to what happened at the policymaking level, they tend to opt for a pragmatic approach, like the one employed by Michael when we visited Esofo Christ's prayer camp. As I described in Chapter 3, he consciously 'skated over' the fact that some of the camp residents were chained and focused on assessment. Indeed, both hospital practitioners and healers are very conscious that the practice of chaining could be an object of conflict and they tend to avoid addressing it directly, especially if their aim is trying to build some kind of cooperation. For instance, in a similar outreach occasion in 2014, this time with Francis, we visited a prayer camp with which the psychiatric unit did not have any already established relationship. The pastor was not there, but we were welcomed by his assistant, elegantly dressed in white: they were having a prayer programme, with many guests coming from outside. He did not have much time, but he was happy to sit and talk to us briefly. Francis wanted to visit that particular prayer camp because he had heard that a client of the unit was staying there at the time. So, after a short introduction, he asked about him. The man answered that he was staying there, indeed he was the only resident patient at the time. Asked about his conditions, he answered that he had greatly improved since his arrival. Francis then asked to see him, the pastor's assistant agreed and went to call him. After a few minutes, however, he came

[185] See: <https://www.gbcghanaonline.com/news/health/mental-health-2/2022/ >, last accessed 30 December 2022.

back alone: the patient was not well on that day, he was in chains, and it would have been dangerous for him to move in the current conditions. The man had avoided mentioning the fact that the patient was chained until that moment, but Francis did not seem particularly surprised. On our way out, after giving his telephone number to him, the nurse told me that he had the impression that the pastor's assistant was one of the 'sceptical ones': 'he doesn't believe that the hospital medicine can work in any way on the patient, he is convinced that the condition is due to a curse and that's all'. 'It would have been pointless – he added – that I insisted on telling him that he was wrong... Why do you think I didn't say anything about the chains? You have to know the person beforehand. It takes a lot of time. I cannot just go there and tell him that what he is doing is not good, otherwise he will not allow me to come anymore'.[186] As it has also been recently observed by Ursula Read and her research team on the occasion of a pedagogical visit carried out by a group of trainee community mental health workers to a prayer camp in Kintampo (Bono East region), 'rather than enforcing legal prohibitions, mental health workers seek to avoid confrontation and manouver within existing hierarchies, thereby preserving sentiments of obligation and reciprocity within a shared moral landscape and established forms of sociality' (Read 2019: 613). In her article, Read also points out that the object of the potential conflict mental health workers seek to avoid in their negotiations with healers (and of the ethical dilemmas associated with such negotiations) is the specific practice of chaining, not the practice of containment *tout court* (*ivi*: 626). Indeed, as it also emerges from Pamela's words, restraint, that is 'the need to restrain patients', may actually be conceived of as a common ground upon which collaborative relationships can be built, with drugs as 'mediators' as I have suggested in Chapter 2. This is a crucial aspect that needs to be addressed, if we want to move forward the discussion on mental health and human rights and avoid the risks – to say the least – entailed by the mainstream humanitarian discourse that have been explored at the beginning of this section.

[186] Conversation with Francis, 6th August 2014.

Healing in chains?

The prayer camps I had the chance to visit in Nzema, like Maame Akuba's and Esofo Christ's ones, are relatively small-scale, especially when compared to the ones that are often mentioned in media and NGO reports, such as the famous Edumfa Heavenly Ministry Spiritual Revival and Healing Centre (see Goldstone 2017). To a certain extent their modest size makes the healing sites I visited slightly different from the popular ones described in the news, especially in terms of the magnitude of prayer sessions, the costs of living within the camp, or the kind of relationship residents can have with pastors, prophetesses, etc. This, however, does not seem to have an impact on the practice of chaining, which was widely used also by the healers I met.

As I said (see Chapter 2), the *asofo* I met tended to describe chaining as a 'management' measure rather than a therapeutic one. As Esofo Christ put it:

> It's true that they [doctors and nurses] say that [that it's not good to put people in chains], but once the person has come and he's fighting, once the person has come and he's using a cutlass to hit people, *ei!* If you don't put him or her into chains it will cause a lot of trouble. I remember once, there was a failed chain [..] so [a patient] was able to remove the chain from the tree holding it, it was very long. Immediately and suddenly he hit one girl. The expenses I made [...] were more than – he laughed – nine million cedis[187]... he hit the girl very well, he went deep inside, yeah... [..] I spent a lot before she was healed. If somebody comes in such a strange condition you have to chain him. Sometimes when he is freed from the chains, then he goes into the bush and you have to search for him all the time, you will not be able to do all these things, you have to chain him, simple. When he's sitting there quietly you will also have to pray over him or if medications are also available you can give him some.[188]

[187] As many people still do in Ghana, he was talking in terms of the old currency (before the 2007 redenomination): the amount is equivalent to 900 Ghanaian cedis.

[188] Interview with Esofo Christ, 10 November 2014.

Reading the evangelical episode of the exorcism of the Gerasene demoniac,[189] which he often quoted in conversations with me as a crucial point of reference for his activity as a healer, he commented: 'You see? In the Bible also people were chained. As we are saying now. If you don't put such a person into chains he will destroy so many things [...] You see now, he would break the chain and, by the power and inspiration of the demons, go to the bush or into the desert'.

This idea of chaining people not only to prevent them from hitting people or 'destroying things', but also to prevent them from fleeing, to *keep them in*, clashes with a straight-forward idea of prayer camps as zones of abandonment. Isn't the idea of 'keeping in' the opposite of abandoning/letting go? As disturbing as it may be, for many people, care and physical restraint coexist in the space of the prayer camp. In Chapter 2, drawing on João Biehl's and Janis Jenkins's work, I have proposed to reframe 'social abandonment' (Biehl 2005) as an interpersonal condition that can encompass the 'mentally ill' and those who 'struggle' (Jenkins 2015) with them and to think of prayer camps as *zones of interpersonal social abandonment*, which paradoxically provide a form of care for patients and their caregivers. In the next pages, I propose to look more closely at stories of healing and restraint in the prayer camp from the perspective of these people: patients and their caregivers.

Cyprus

The first time I met Cyprus was at the psychiatric unit. At the time, he was staying at a shrine nearby, where a *kɔmenle*, Auntie Afiba, was taking care of him. He came accompanied by the

[189] 'Then they came to the other side of the sea, to the country of the Gadarenes. 2 And when He had come out of the boat, immediately there met Him out of the tombs a man with an unclean spirit, 3 who had his dwelling among the tombs; and no one could bind him, not even with chains, 4 because he had often been bound with shackles and chains. And the chains had been pulled apart by him, and the shackles broken in pieces; neither could anyone tame him. 5 And always, night and day, he was in the mountains and in the tombs, crying out and cutting himself with stones'. (Mark 5: 1-20, New King James Version; see also Luke 8: 26-39).

kɔmenle's son because he was still not completely fine and she wanted to make sure that everything went smoothly at the hospital and on the way back to the shrine.[190]

He was in his mid-twenties. He had his first 'illness' episode when he was in school. After completing Junior High School (JHS) he decided he wanted to quit studying and told his father that he wanted to become an artist. His father sent him to a bigger town where he could be trained properly.[191] While living there, he started learning and realising billboards, signboards, and so on, but then his father died, and he changed his mind: he wanted to go back to school. The first two years at Senior High School (SHS) were good, the teachers liked him, he enjoyed studying, but then in the third year the illness came: 'when the illness came, everytime I had to go somewhere, I had to ask around, I was lost... I started saying strange things, people didn't understand me'.[192] He didn't know why, perhaps it was because he had started drinking and smoking cannabis ('weed'). Now they told him he had to stop, he had stopped. In 2020, the year before we met, his mother brought him to a prayer camp: 'I was there for eight months, they chained me. It was painful. It rained and I was there. The pastor prayed for me, told me to bath, then we worshipped in the church, and then they chained me again'. After eight months, the pastor told him to leave and go to Ankaful Psychiatric Hospital in Cape Coast.

He talked about his stay at the prayer camp as a terrible, agonising experience that did not solve anything for him. He had done it with and for his mother, but it didn't seem to have worked for him. His path within psychiatric services was not straight-forward either and was marked by common issues of economic inaccessibility. He had been to Ankaful Psychiatric Hospital twice before he was referred to the district hospital where I met him. After having been to Cape Coast, he had started taking medications, but then discontinued them: his mother didn't have money, neither to send him back to the hospital, nor to buy drugs for him. So he

[190] It was after this first encounter with him and the *kɔmenle*'s son accompanying him that the unit decided to organise an outreach visit to Maame Afiba's shrine (see Chapter 2).

[191] On the training of local artists, see Cristofano 2014.

[192] Conversation with Cyprus, 8 October 2021.

went to work in *galamsey*[193] mines, but there he started drinking and smoking again, because the work was too tough: 'You work for three weeks and you get 9 or 10 millions,[194] but the work is very hard. When you go down, and the water hits you... if you don't drink or smoke the cold is too much!'. After a relapse episode he had been brought to Maame Afiba's shrine, but he had also decided to use the money he had earned to resume taking medications, because he felt they made him feel better. He had to adjust to them, because if he took them in the morning he felt too weak to work, but since he had started taking them in the evening things had improved.

In his story – at least in the phase of his life in which we crossed paths – the 'passing of the baton' that many mental health workers work and hope for, that is being 'referred' from the prayer camp to the hospital, moving from chains to drugs, seemed to have worked.

Robert (and Priscilla)

Robert's story – or rather the piece of his story I will report here – is quite different from the previous one. Even though his one too has to do with 'substances'/'substance abuse'.

The first time I saw Robert was at Maame Akuba's prayer camp. I went there with Ernest, who had proposed to me to accompany him in one of his routine visits to the healing site. Robert was sitting under a big tree situated on a rise in the ground from where he could clearly see another tree, located on the opposite side of the narrow footpath that led from the entrance of the camp to the rooms where some of the church residents and staff stayed. To that tree was tied Priscilla, a young girl who was crying in despair. Her mother was sitting close to her, with watery eyes and dark circles under them. Ernest assessed her first, introducing himself, trying to calm her down, and asking her a few questions. She had been just recently 'admitted' at the camp, she said her name and answered a few more questions, but then refused to look Ernest in the eyes and started crying again and shaking. She didn't 'cry for help', but her gestures suggested that she demanded to get rid of the shackles. Ernest talked to her mother to get more information for his assessment, he would have proposed to give her an antipsychotic injection,

[193] Artisanal small-scale gold mining.

[194] 900 or 1000 Ghanaian cedis.

but the girl refused any kind of medicine, and since the mother did not insist, he did not insist either. However, he prescribed her some oral drugs, telling her that she could have tried putting them in the girl's food.

Then he moved to the other 'new client', Robert, who was sitting quietly under his tree. He had been observing the scene from afar: 'you see a girl suffering like that and you don't do anything? Sleeping on the ground? What happens if a snake comes?'. Ernest, burdened but calm, answered to him that he was there to try to help her, that it wasn't easy, but he would have done his best in order to do it. He then started assessing Robert, who got defensive in his answers at the beginning, but gradually started enjoying the conversation. It was his first time in a prayer camp. As he told me more in detail some time later,[195] he lived in Takoradi, he had a degree in Social Science and was a Catholic seminarian, but had recently left the seminary after a bad argument with some members of his church. He said he had long lost the essence of his vocation and felt that 'God wanted to use him in a different way', but also referred to a number of fights he had at the church and elsewhere. At the church, he didn't like the way they treated him and how they reacted to his decision, trying to keep him and accusing him of betraying them after having been sponsored. He also defined himself as 'a serious weed smoker', a habit he started when he was in SHS. He was brought to Maame Akuba's prayer camp after he had almost trashed his church. He remembered being so high that day that when they were bringing him to the prayer camp he was convinced they were flying. Some time earlier, after 'causing commotion' in a restaurant, he had been admitted to Ankaful Psychiatric Hospital, so when Ernest told him that he was thinking of prescribing him an antipsychotic medication (*olanzapine*), he said he had been taking it before.

When I met him again at the prayer camp, almost a week later, he was about to leave with his mother, who had been taking care of him during his whole stay. Talking about his experience there, he told me that he felt very grateful towards the head catechist of his church, who decided to send him to a healing place instead of reporting him to the police, and went back, unsolicited, to the issue of chains:

[195] Interview with Robert, 18 December 2021.

Coming here, it has helped me. The only... – he laughed – the only strange thing is the chain that they will put on your leg, you understand. It's a bit risky. This place is a bush, look at how bushy this place is. If you are there and a snake is coming, you want to run away and they have chained you, you see... it's very... but she [Maame Akuba] is working on it.[196] Last time, yesterday, I met her because I'm about to leave, so she even told me that she is thinking about it a lot, because it's very dangerous. [...] there is a reason for putting chains on you: when I came I was high. If they had not chained me, me, I could have gone to town and caused trouble there. And who would be the person in trouble for me causing trouble? She [the *esofo*] would be in trouble because they would say it [happened] because I came to her. That is a very good reason to put someone in chains. It's like controlling the person, because the person is not behaving normally. When I came, to be truthful, I wasn't behaving normally. But me, I didn't have *any* problem with the chain on me. Me, what I was thinking about was my food, so every second I would call my mother: my mother was eating here [and I told her] that she should bring me food. The way I was eating, *eh!* Somebody was sitting here, there was a guy, he is still around, he has also been chained before, but he said he didn't have any appetite to eat, but when he was sitting here and he saw me ordering for food like that, he said: 'Ah, this guy! You, you are in chains, you will not think about your freedom, you are always ordering for food!'. And I said: 'You! You are not a serious guy: the chains, they will always open [them for] you, by this time, they will open. They can't keep you in chains forever. So if you are hungry you have to ask for food. But... when it's raining, the rain will be beating you and stuff, that's the real one... if there was shelter... but for the meantime, it's ok. But it's all part of the healing process, do you understand? You know it's spiritual, it's all part of the healing process: if you stay in the rain for two days, you think once, you think twice [about] what made you come and stay there [...] Me, I would even like to come and be chained here again. Yes. Even though I have gotten my medicine. Yesterday when I spoke with her [Maame Akuba], I have come to realise that, like I was saying, it has taken me back to somewhere I have been before, very close to God. You know I was very close to God as a seminarian, and here... [from] here to the town is a bit far, you see how quiet this place is, and when you came you saw where I was sleeping, inside the chapel, if I was in town, maybe, probably, I would have been at the ghetto[197] now, smoking, you understand. For the time getting to two months that we [my mother and I] have been here, I have

[196] He was referring to the fact that Maame Akuba and the prayer camp staff had started building a new sheltered structure for mentally ill people, see below.

[197] Informal meeting place where people can buy and smoke cannabis.

> been out of weed, I have been out of alcohol, and it has been good for my health, even though I'm better fit spiritually, I'm better fit socially too. I'm really happy about coming here. Before, I was rushing to go. But I think being here has prevented me from a lot of misfortunes. You can't tell. The way I was high that day, you can't tell what would have happened to me if they had not brought me here. So maybe God saved me from something. Very bad, yeah. So, that's what I would say about being here.

Robert, who was chained for three weeks at Maame Akuba's prayer camp, went on to compare his stay there with his admission at Ankaful Psychiatric Hospital: 'I would choose this place a hundred times!'. He said that the medicines he had been prescribed there helped him to 'sleep and eat well', but in 'that place you are confined, in the ward you are very limited, when they lock the gates and you are inside there is no fresh air there. [...] That place you can't go out, it's not open like here'. He also talked about the difficulties for a 'weed smoker' like him, who described his 'medical condition' as 'pretending to be mentally ill', of living with people who were 'really sick', who had serious accidents, and shocks, 'who would wake up and urinate on you'. There were scheduled activities 'for those like him' at the hospital, but he appreciated more the structure of the day at the camp, with prayer sessions that focused on specific topics: it was something that made him feel like he was not wasting his time. The experience at the camp and the meeting he had with Maame Akuba the day before made him remember 'something he already knew': 'If you pray, and there is a Devil inside you, you pray and you remove that Devil out of you, you don't go back again to bring that Devil back'. That is, he would have not started smoking again. During his stay, a new idea came to him: he wanted to use his degree to start teaching, he wanted to talk about it with his catechist so that he would know that 'something positive' had come from that whole experience.

As I hope it will be clear, I did not present here Robert's narrative with the aim of illustrating the benefits of chains or physical restraint. And though, in contrast to his own healer, he talked about chaining 'as part of the healing process', I think his words point toward different directions. His perspective is interesting because it subverts mainstream narratives of victimhood in prayer camps, making sense of that experience in his own terms (and even playing with stereotypes and common assumptions, if we think of his emphasis on food in a place known for

endorsing the practice of fasting!). With his ambivalent attitude towards the experience of chaining, his continuous references to his mother's presence, his comparison with his previous experience at the psychiatric hospital, and his emphasis on the daily schedule revolving around praying activities, Robert's account also allows us to think of prayer camps as potential and contradictory sites of care. At the same time, I thought it was important to juxtapose his intense experience, expressed in a somewhat provocative and irreverent form, with the image of a completely different one: Priscilla's. I turn briefly back to her. Indeed, I do not know many details about her story, as she was not in condition to talk to me the few times we met at Maame Akuba's prayer camp, and I did not feel comfortable in disturbing her mother too much with questions in a moment that seemed incredibly heavy for the two of them. When I went back to the prayer camp to meet Robert, Priscilla was not in chains anymore and her mother had secretly started putting medication in her food. They had started sleeping side by side inside the church, together with some other camp residents like Robert and his mother. Priscilla's mother told me that nobody had opened her daughter's padlock: she had got rid of the chains by herself. Perhaps her mother had helped her. Perhaps it was a strategy commonly used by the prayer camp staff that I had not heard about before, as Robert too had told me something similar about his chain 'miraculously coming out itself'. Perhaps it was true that, instead of being freed by somebody else, she had unchained herself and, rather than fleeing, she had decided to stay with her caring mother, hoping to be healed.

Egya Kofi

'Break the chains! If you are not free it's your fault!'. This sentence was shouted by one of the church leaders during an all night programme I participated in at Maame Akuba's prayer camp. On that night, when one of the camp residents stood up during a testimony session as if he was about to make a statement on the stage, the same church leader looked at him harshly and crossed his wrists in a kind of 'handcuff gesture'. The grown man who stood up slowly went back to his chair in the audience. His name was Egya Kofi, he was from Côte d'Ivoire, but had been staying at the camp, coming and going, for a long time. He had his own private room there – a tiny room that was full of objects, books, clothes, shoes, posters, religious paraphernalia,

candles, and so on. He seemed comfortable there, but he went out very often: it was very common to meet him in town, sitting at a drinking spot, chatting with – and sometimes disturbing – someone.

Egya Kofi was one of the very few people I met in a prayer camp staying alone, without any family member or even paid 'accompagnant' – to use the francophone terminology of Fann (cf. Kilroy-Marac 2014; see Chapter 3). His family, however, sent him money for his living expenses in Ghana. He was the youngest of ten children and he often mentioned his older siblings who took care of him, especially one brother. When I went to visit him in his room, while chatting, from time to time he suddenly stopped and said: 'Do you see all these books? All these shoes? They are from him!'.[198] The older brother had died a few months earlier. According to Maame Akuba, the brother he talked about had also been a resident of the camp before his death. Indeed, it was precisely this event that had brought Egya Kofi's sickness (*ewule*) back. It was not the first time he was 'admitted' to the camp, he had been there before, but he had recovered and gone back to Côte d'Ivoire. Now the sickness was back, and he was back at Maame Akuba's prayer camp.[199]

According to him, his first episode of mental distress occurred when he was twelve: he remembered not being able to stay still, behaving strangely, and roaming about. His family even brought him to the psychiatric hospital in Bingerville, but the hospital staff said it was not necessary to admit him. According to Maame Akuba and other members of the prayer camp staff, he often did not behave appropriately, he wore ostentatious clothes like leather jackets and hats or bright red shoes, he had (short) 'rasta' hair, he drank alcohol, and smoked 'weed'. Egya Kofi did not deny any of it and seemed to be proudly 'over the top'. Ernest prescribed psychotropic drugs to him and from time to time, when called by Maame Akuba, he gave him an injection. Maame Akuba directly administered his oral drugs to him, they made him sleep well, and he did not have any particular complaint, but sometimes – he said – he forgot to take them. Indeed, at least from what people said about him, sometimes he liked to stay awake at night.

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[198] Conversation with Egya Kofi, 14th October 2021.

[199] Interview with Maame Akuba, 15th January 2022.

One day I went to the prayer camp bringing with me a mobile phone charger that he had asked me to buy for him at the market, but I could not find him anywhere. When I asked another camp resident about him, she told me that 'he had moved into the new building'. I followed her directions and called him to identify the room where he was staying. He answered, but was not coming out. As usual, it took me a while to realise that he was not coming out because he was chained in a corner of the room. Indeed, 'the new building' was the one Maame Akuba and her staff were implementing in order to provide a shelter from the rain and the sun for the camp residents when they were chained.

He told me that it was not the first time for him: he had caused trouble at the prayer camp more than once. This time *la vielle* – the epithet he and other Ivorian camp residents used for Maame Akuba – was angry at him because he had been sleeping with 'some girl' and she did not want to. When I asked the *esofo* what happened she told me:

> Egya Kofi took some woman, but this 'wife' he took does not attend church, she is a *ninsinli*... a *kɔmenle* (*ɔdi ahɔne*). Later the woman realised that he was mad (*yezɛ*) and she left him. And now Egya Kofi wants to be back here. When he came [to me] I said: 'I don't have any relationship with *ahɔmenle*, so go away. He may bring a [bad] medicine to disturb me, [so] I sacked him.
>
> [...]
>
> He used to move with that woman up and down, she always came and slept here. He didn't recover, he always went to that place where he always goes [probably the spot where he used to hang out]. He smokes weed, he roams about (*ɔkpɔsa*), he doesn't stay home. Around midnight he will be going to [the woman's town]. Around 2 or 3 in the morning he walks on the road, maybe one day a car will hit him and I will have a lot of problems.[200]

Though Maame Akuba used the argument of restraint as a preventive measure – to prevent him to be in the risky situation of being hit by a car – and as an instrument of care – to facilitate a recovery that is not happening and to stop potentially damaging behaviours, such as drinking and smoking – in this case chaining seems to be first and foremost used as a repressive and

[200] Interview with Maame Akuba, 15th January 2022.

punitive measure aimed at 'policing' social life within the camp and disciplining religious and moral transgressions.

It is interesting to point out that this use of chaining took place in one of the new rooms that were built in the prayer camp in an attempt to be more compliant with human rights recommendations: giving a shelter to chained patients. It is also interesting, and sad, to notice that the strongest denial of care occurred a few days later, when Egya Kofi unceasingly demanded to be freed, and Maame Akuba decided to sack him from the prayer camp where he had been building his life for months.

Beyond chains: 'aggressiveness', management, coercion, and 'the right thing to do'

In November 2021, Francis gave a presentation about schizophrenia in front of the hospital staff on the occasion of a weekly clinical meeting. He briefly illustrated the condition, focusing on the possible causes, the prognosis, the forms of assessment and treatment, and the importance of adopting a biopsychosocial approach in mental health care (cf. Chapter 6). During the Q&A session that came afterwards, a nurse in the audience asked: 'If I tell healers not to put the person in chains, h*ow can I manage*?'. Francis said that that was an important question, because chaining was not an acceptable measure, but in some cases physical restraint was 'the right thing to do'. The issue of 'illness management' led at a certain point to an ignited discussion around the 'management' of 'mental patients' within the hospital. Psychiatric unit nurses had often been complaining about the fact that general nurses working at the ward *de facto* refused to take care of psychiatric patients when they were admitted (either for acute psychiatric conditions or for other unrelated pathologies). They relied heavily on the unit, often calling its members even outside of their working hours to administer drugs, carry out assessment, and engage with patients, especially during the night. This had to do with the perceived potential 'aggressiveness' of psychiatric patients. Francis and his colleagues insisted on the fact that psychiatric clients 'are people like us' and patients like the others, and they should be treated as such. The general nurses' approach was a reflection of what psychiatric nurses often referred to as 'stigma', a discriminatory attitude that was directed both towards their patients and themselves (cf. Chapter 1 and 2). The issue of 'aggressiveness', however, came up often also

in conversations taking place at the psychiatric unit, and was sometimes a central preoccupation.[201] I heard many stories of patients suddenly bringing out an unexpected strength when nurses were trying to inject them, asking for water and then spitting it on the nurse's face, trying to throw the unit's computer on the ground, threatening to assault mental health workers, and so on. Especially when injecting patients, it is – nurses say – very important to be cautious: 'you have to try and talk to them, try to calm them down, explain in detail what you are going to do to them... but it is never safe'.[202]

The issue of the potential 'aggressiveness' and 'dangerousness' of patients was obviously central in cases in which nurses decided to administer involuntary pharmacological treatment. To reflect on the ambivalent nature of this practice and on the ethical dilemmas it poses in community psychiatric practice, I would like to go back to the outreach visit carried out by Ernest, which I described in Chapter 3. As I illustrated, on that occasion the nurse had to face the ethical dilemma of whether or not to give antipsychotic medication to a patient, since his mother was not able to pay for it. He decided not to charge them and 'give' the young man the medication: first, because according to him the client was affected by acute psychosis and had to be treated as soon as possible; and second, because he had been physically threatening his mother multiple times, the woman felt in danger, and Ernest thought the medication would have been crucial in cooling off the conflict between them. That, however, was not the only ethical conundrum Ernest had to face during the outreach.

Before coming back to formally assess patients, Ernest had already visited the prayer camp to introduce himself. As soon as we arrived, in line with the pragmatic approach adopted by his hospital colleagues on different occasions, he commented to me: 'You will see that here people are in chains: this is wrong and it's against the law, but here there is no sheltered facility were mentally ill people can be kept to avoid them running into the bush'. He had encouraged the pastor to think of making this kind of changes, but it was a long process. Meanwhile, assessing patients could be something to do in the direction of improving their conditions, and making it

[201] On the continuity between psychiatric nurses' discourses about the aggressiveness of 'mentally ill people' and colonial imaginaries, see Read 2020, cf. also Chapter 1.

[202] Conversation with Francis, 27 October 2021.

easier for them to be unchained. The pastor seemed glad about Ernest's visit and told him that he would have certainly allowed him to talk to the mothers of the mentally ill residents, who were there with them. Ernest, however, immediately pointed out that on the previous visit he had noticed that one patient – the one he would have later 'given' medication for free – had persecutory delusions and was convinced that his mother was the real cause of his illness. Thus, he preferred to talk with patients beforehand, and only afterwards, in a spot out of sight, with their family members.

Ernest proceeded in that way. He moved closer to the young man, who was standing under a tree he was chained to. The man, however, refused to talk to him, told him that he did not trust him and did not want to have anything to do with his drugs. He was not particularly agitated, but firmly stated that he would have not taken anything from him. After assessing some other patients, Ernest quietly went to talk to his mother, who insisted on the need to do something for her son, and for her. The nurse took a few minutes to evaluate his options. As he told me later, he was very conflicted about 'the right thing to do' – to employ the expression used by Francis during the clinical meeting. He had just met the patient once, and did not have enough time to build a relationship of trust with him. Had he injected him against his will, it would have been more difficult to establish a good therapeutic relationship, especially given his persecutory delusions. At the same time, he was concerned that the tensions with his mother might escalate: he had already tried to hit her, and according to him he really needed to be put 'on drugs'. He decided to inject him, and asked the pastor and another camp resident to assist him in holding the patient while he administered the medication. The young man struggled violently yet silently, without saying anything. After the first *haloperidol*[203] injection he was still upright, so he was 'given' a second one.

From what Ernest told me in subsequent meetings, the man did not become a regular patient of his. That was, perhaps, a therapeutic failure, but the ethical dilemma the nurse had to face was not an easy one: how to build a relationship of trust with a patient that refuses to be treated? How to take care of patients *and* their caregivers when their interests seem to collide? How can the violence of forced treatment become an act of care?

[203] Typical (first generation) antipsychotic medication.

These questions are essential in the daily lives of 'mentally ill people', caregivers, and psychiatric professionals: they cross the boundaries that ideally separate spiritual and psychiatric care, and encourage a radical rethinking of what mental health care is and/or could be today across geographical and cultural contexts. In his analysis of the ways in which US community psychiatric nurses ethically navigate a therapeutic environment in which 'constraint becomes both a component of care and its ethical limit' (Brodwin and Velpry 2014: 525), Paul Brodwin suggests that the key questions ethnographers interested in the ethics of mental health care should ask are:

> 'why do people ferret out one particular issue, but not another one, as raising ethical stakes? Why do they puzzle over the rightness or wrongness of this particular clinical maneuver, but regard that maneuver as unproblematic (see Brodwin 2013)? These are empirical questions about the shape of collective ethical debate, and an exclusively private and interior model of conscience cannot fully answer them.' (Brodwin 2014: 546).

As I have tried to suggest in this chapter, these are crucial issues also in the Ghanaian context, where the exclusively humanitarian, often dehumanising, spotlight on constraint practices in prayer camps might divert the attention from deeper questions about care and control which psychiatric nurses – as well as caregivers and patients – have to grapple with on a daily basis.

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In this chapter, I have tried to call into question the humanitarian discourse that has developed around the practice of chaining in prayer camps and other spiritual healing sites in Ghana, highlighting its colonial connotations and inherent contradictions. In order to challenge simplistic and sensationalist narratives that ignore disturbing yet tangible entanglements of care and coercion in prayer camps, as well as in the field of mental health care more generally, I have proposed to look more closely to the multiple and contradictory ways in which some of the

healers, patients, and family members I met engaged with restraint – both physical and pharmaceutical.

It is crucial to point out that an analysis like the one proposed in this chapter is not aimed at 'justifying' in the name of an uncritical 'cultural relativism' the practice of chaining, nor to convey the idea that psychotropic drugs are always a mere substitute for chains, but rather to suggest that the effort of disentangling care and control, or rather of digging deeper into their entanglements, should be made both in the field of spiritual healing and of psychiatry in order to imagine new, possible meanings of mental health care beyond 'people management'.

6. COLLABORATION | DISAGREEMENT

Looking at frictions at the intersection of psychiatry and 'the-rest-of-what-is'

We're the buffer between
you and madness,
we're not the madness.

Akwaeke Emezi, *Freshwater*

Categories of madness and 'mental illness' tend to inherently challenge clear-cut interpretations, definitions, and solutions, blurring the boundaries between the materiality of life and its spiritual and often hidden dimensions – what Mattijs van de Port has powerfully called *the-rest-of-what-is* (van de Port 2011).[204] This, I would argue, may always be true regardless of the context, but is particularly accurate in a context like the one I describe in this thesis, where shrines, prayer camps, spirits, and 'spiritual' explanations are very often a relevant part of the picture. As we have seen in previous chapters, these sites and the people who 'work with' or against the spiritual entities associated with mental distress in non-biomedical constellations of meaning appear at the same time as competitors and desirable allies in the institutional discourse of 'collaboration'. Despite these ambivalences, as soon as I started attending the psychiatric unit, accompanying the nurses in their outreach activities, and visiting multiple healing sites with and without them, I started thinking – as I illustrated in Chapter 2 – that 'collaboration' was something 'already there': it appeared to me not as a policy to be implemented, but as a practice that already existed on the ground, at least since 2013. In other words, one of my research questions was: 'is collaboration possible?'. And my short answer was: 'Yes, it is already there'. To

[204] In his definition, *the rest-of-what-is* is 'the "surplus" of our reality definitions, the "beyond" of our horizons of meaning, that which needs to be excluded as "impossible", "unknown", "mere fantasy" or "absurd" for our worldview to make sense' (van de Port 2011: 18 and *passim*).

a certain extent this is true. But in the course of the research I realised that there was a more relevant question: what do we really mean by 'collaboration'? What is hidden behind the policy language I was so quick in embracing without questioning it?

Partially building on Rancière's conceptualisation of 'disagreement' (1999[1995]), in this chapter I take as point of departure a particular moment of friction that occurred at the psychiatric unit between a young patient, her caregiver, and the two psychiatric nurses who received them. By doing so, I aim to complicate current paradigms of collaboration by suggesting the importance of looking specifically at the multiple tensions, doubts, and moral conundrums that arise in the everyday experience of mental health practitioners and their patients. What happens when patients and their caregivers disagree with their therapists? When practitioners dissent even among themselves? And what can these disagreements tell us about collaboration?

If on the one hand it is crucial to deconstruct the supposed incompatibility of mental health care with a traditional/spiritual medicine that has long been represented as radically other and ultimately 'superstitious' (cf. Kong et al. 2021), in this last chapter I would like to suggest that focusing on disagreement at the crossroads of different conceptualisations of madness and mental illness could also be a valuable entry point to reflect on the limits of psychiatric care and the model of collaboration proposed by public healthcare institutions, and to envision new, collective paths.

Disagreement

'She is not mad!'

Mondays are usually busy at the psychiatric unit, especially when compared to the slowness – sometimes even boredom – that often characterises normal working days during the rest of the week. 'Clients' and caregivers come and go. People wait. Patient files are created or updated. Questions are asked. Drugs are prescribed. There is kind of a rhythm that usually defines Monday mornings at the unit, with the nurses rapidly moving from one patient to the next. If

the possibility of tensions, arguments, and complaints is always there and somehow punctuates the unit's Monday rhythm (i.e. people complaining for the waiting, for the lack of the required psychopharmaceuticals, for their excessive price, or for their unwanted effects), it is not common for this rhythm to be interrupted. Sometimes, however, particular occasions of unexpected friction may arise and force psychiatric nurses to stop for a while, somehow interfering with the way they are used to imagine and perform their daily activities. These occasions are rare, but powerful. So, it was a November Monday morning in 2021 – during the last phase of my fieldwork research – when the fifteen-year old Fadhila and her twenty-year old family friend Dave visited the unit for the second time, as they were asked to do by the nurses during their previous meeting a couple of weeks earlier. Fadhila was first brought to the hospital by Dave, who introduced himself, as it often happens, as her 'brother'. Her record said that she was diagnosed with psychosis, as she claimed to see and hear the voices of multiple spirits, some of whom looked like cats and pushed her to attack people. 'Everything is fine now' – maintained Dave, holding tight a tiny plastic sachet full of antipsychotic tablets. Francis and Henry, two of the unit nurses, asked Fadhila to come closer to their desk. They asked her how she was feeling and whether she could still see and hear the spirits. Speaking softly, almost murmuring, she said 'only sometimes', but she was now ok, she was feeling a lot better than when she first came. Her eyes were looking down, but her gaze was lively and bold. The nurses agreed, she looked healthier: the drugs were working – they commented. Dave, however, was shaking his head: she didn't need them, her family didn't want her to take them anymore. Francis and Henry looked at each other, then turned to Fadhila: 'What do you think? Do you want to take these tablets or not?'. She nodded timidly, but didn't look – at least to me – too convinced either. They repeated the question a couple of times, obtaining the same, feeble answer. 'She is not mad!'– insisted Dave – when the nurses started to *educate* him (to use the unit jargon) about mental illness, the drugs, and the need to keep taking them even when the sickness seems to be gone, because 'you never know when it is going to come back'. Dave kept shaking his head, raised his voice, and put the tablet sachet on the nurses' desk: what had happened to Fadhila was 'something else', she didn't need any pharmaceuticals, this was her family's decision. After a long moment of silence during which the two nurses kept looking at each other, and then at me, disheartened, Francis, the unit's 'in-charge', said there was nothing they could do, the girl was a minor and from a

juridical point of view it was up to her family to decide for her. As we have seen in previous chapters, psychotropic drugs are the main tool used by psychiatric nurses to perform their job: questioning and/or refusing them meant rejecting *in toto* the forms of care they represented and could provide.

After they took off, Henry picked up the drugs Dave had previously bought from the unit and turned the sachet over in his hand. He looked outraged: what the family was implying was that Fadhila's condition 'was spiritual' and they knew, from their previous consultation with them, that she had already visited the shrine of a traditional healer before going to the hospital. But how could they refuse treatment when it was evident that the girl's condition had improved? How could they not *understand* that? How could they not *agree* on that?

An episode of friction like this – which is not so common to observe at the psychiatric unit, as I will clarify below – could simply be used to support the hypothesis of the supposed incompatibility between psychiatric care and spiritual conceptualisations of mental suffering analysed in previous chapters. The immediate explanation would be: Dave and Fadhila's family members *believe* that the illness 'is spiritual', so they will not allow psychiatric nurses to take care of her, even though she would need it. In other words, the obstacle to care is *belief* (see Chapter 2 and 4). What I would like to suggest, however, is that there is a lot more to it and that such an episode could indeed reveal something quite different: : if we reject – as I have tried to do so far and I think it is important to do – the idea of an inevitable clash between psychiatric and spiritual visions and practices, what was really going on there?

Understanding-not understanding

As I said, what happened during Fadhila and Dave's visit to the unit was quite uncommon. In Nzemaland, similarly to many other contexts, and for a multiplicity of reasons (which may include economic difficulties, severe side-effects of the prescribed drugs and the perception of their inefficacy, and conflict with caregivers),[205] it is quite frequent for people to 'discontinue' their psychiatric treatment. But it is rare for somebody to embark on a two-hour journey, just to

[205] On the first two factors see Chapter 2 and 3; cf. also Read 2012b.

be assessed by the nurses and then inform them about their will to stop taking the medications. Dave and Fadhila embarked on such a journey because what the girl's family actually wanted from the unit was, in fact, something different. As I learned a few minutes after their arrival, they were 'referred' to the hospital by their home town police station, because in the previous weeks Fadhila had acted out: first she had accused a woman of being a witch and threatened to attack her with a knife while she was in her house, then she went to a local shop and aggressively accused the owner of hiding something inside. She was reported to the authorities and a case was opened. Actually, she was first referred to Ankaful Psychiatric Hospital: her hometown was quite far from the district hospital and the local police were probably not aware of its existence. However, through the mediation of a general nurse working at Fadhila's hometown health centre, she ended up at the district hospital. As it is common in so-called 'court cases' – even though this was not properly one because there was not a real trial going on – before producing a certificate attesting her condition, the nurses wanted to observe the patient (for two weeks in this case) before confirming their diagnosis.

So, on that Monday morning, Fadhila and Dave were at the unit to finally collect a certificate they could bring back to their home town police station. However, after learning about the family's intentions, the nurses told them that they could not agree to sign it since Fadhila refused to be their client and to comply with the prescribed pharmaceutical treatment. Indeed, the pharmaceutical treatment was something that the family could not accept, as it would have meant admitting that she was sick, that she was 'mad', while what was happening to her was something else: she was possessed by spirits and on the path to become a spiritual healer. Actually it was some spirits, whom she called 'her people', talking through her, that told her family not to give her the medications in the first place. Indeed, even though the nurses attributed the improvement observed in her condition to pharmaceutical treatment, during subsequent visits to their hometown, Fadhila, Dave, and some of her family members maintained that she had never started swallowing those tablets.

These few elements are of course part of a more complex and layered series of events that is still in the making and will unravel in unpredictable yet hopefully gentle ways for Fadhila. As many others, hers is an intricate story that points our attention in different directions: namely, towards the continuities between psychiatric services and policing; the blurring of boundaries

between categories of madness, mental illness, and spirit possession; the role of the patient (and her family)'s relationship with the rest of the community in the outbreak and management of the condition; gender dynamics and issues of self-determination in the case of female and minor patients; and perhaps – at least in my perception – the inevitability of moral considerations about what *is/would be* 'the right thing to do' (cf. Chapter 5). In any case, it appears evident that what from a psychiatric angle might be labelled as a patient's 'lack of insight' is something that seems to encompass the whole caregiving community around Fadhila – the whole 'therapy management group', to use John Janzen's influential terminology (Janzen 1978; see also Janzen 1987).[206] A 'lack of insight' that they share, so to speak, also with the spirits who possess Fadhila: 'She is not mad!'. And the spirits do not want to be silenced (by drugs).

Though it might have been partially triggered by the frustration of not being able to get what they were supposed to (the certificate), the described episode of friction could be conceptualised not as a moment of simple tension or mere incomprehension – dimensions that can also be relevant in psychiatric encounters, as I illustrate below – but as a proper 'disagreement' in Jacques Rancière's terms. In his book on the relationship between philosophy and politics, the French philosopher defines 'disagreement' as 'a determined kind of speech situation (...) in which one of the interlocutors *at once understands and does not understand* what the other is saying'. It is not a 'misconstruction', which 'supposes that one or other or both of the interlocutors do or does not know what they are saying or what the other is saying, either through the effects of simple ignorance, studied dissimulation, or inherent delusion (Rancière 1999 [1995]: x-xi; emphasis added). Nor is disagreement 'some kind of misunderstanding stemming from the imprecise nature of words' (*ibidem*). According to Rancière, disagreement 'is not to do with words alone', but is rather something that 'bears on *the very situation in which speaking parties find themselves*' (*ibidem*; emphasis added). In such a conceptualisation, the issue of patients and caregivers' *lack of understanding* often evoked in the ambivalent discourse of 'collaboration' (cf. Read 2017, 2019; Chapter 2) seems to be at the core of the disagreement

[206] Janzen briefly defined the notion of 'therapy management groups' he introduced in his classic *The Quest for Therapy in Lower Zaire* (1978) as 'the set of individuals who take charge of therapy management with or on behalf of the sufferer', where 'therapy management' is briefly defined as 'diagnosis, selection, and evaluation of treatment, as well as support to the sufferer' (Janzen 1987: 68).

between Fadhila, Dave, and the nurses. Indeed, it was when Francis and Henry started *educating* their interlocutors that the disagreement exploded. As observed by Rancière

> In ordinary social usage, an expression like 'Do you understand?' is a false interrogative whose positive content is as follows: 'There is nothing for you to understand, you don't need to understand' and even, possibly, 'It's not up to you to understand; all you have to do is obey.' 'Do you understand?' is an expression that tells us precisely that 'to understand' means two different, if not contrary, things: *to understand a problem and to understand an order* (Rancière 1999: 45, emphasis added).

What does 'understanding-not understanding' mean in the episode of friction between Fadhila, Dave, and the nurses, which I am here proposing to read as a 'disagreement'? Who is posing the 'false interrogative' (*Do you understand?*)? What does it mean to reflect on the 'very situation in which speaking parties find themselves'?

What I suggest, partially building on Rancière's theorisation, is that the diagnostic/therapeutic encounter between Fadhila, the 'mouthpiece' of her therapy management group and the two psychiatric nurses is based on the implicit assumption that the patient and the caregiving community around her *do not understand* and *do not know*. This is not a specific judgement on them as individuals, but rather the expression of a general presumption that separates (first and foremost in their own conceptualisation) nurses from their patients not only in terms of a professionals vs. non-professionals distinction, but also – as previously analysed (Chapter 4) – in terms of a (precarious) distinction between 'non-believers' and 'believers'. This of course has to do with the power imbalance between practitioners and patients in the therapeutic setting – *the very situation in which speaking parties find themselves* – but also with the more general hierarchisation of epistemologies that dominates the nurses' practice. It is for this reason that this episode can be particularly relevant to reflect on collaboration, even though it is not situated within the framework of an established cooperative relationship between the psychiatric unit and a particular shrine or prayer camp (indeed, quite the opposite).

On the other hand, inverting the perspective, we could also see in Dave's upset reaction not only a refusal to accept the nurses' interpretation (in Rancière's terms: the refusal to 'obey' and to 'understand the order'), but also an accusation of 'not understanding' addressed to them. And to a certain extent we could definitely say that the nurses did *understand-not understand* what was going on, as I will try to show below. Before going into that, however, let us explore a bit more the implications of Francis and Henry's attempt at *educating* Fadhila and Dave in the broader context of psychiatric care at the unit.

Language, ignorance, and 'education' at the unit

Reading the episode at the centre of the previous pages in terms of disagreement suggests in some way an idea of the psychiatric unit as a site of ignorance production, that is a space where the condition of ignorance is produced and projected onto patients and caregivers. Even though Rancière specifies that in his theorisation 'disagreement' must be distinguished from mere 'incomprehension' or 'misconstruction', I would argue that the conditions that make 'disagreement' possible within the context of the psychiatric unit also have to do with the simple dimension of misapprehension and misunderstanding.

As observed by Sumeet Jain and Sushrut Jadhav (2009), the use of language plays a crucial role in informing relationships between patients and practitioners within rural psychiatric settings. Similarly to the Northern Indian context where they carried out their research, in Nzemaland too health workers use a language that contributes to creating a distance with patients in a twofold way.

First, since the majority of the nurses were posted to the area from other parts of Ghana[207] they do not speak the local language and communicate with patients either in English or in Twi (the *de facto lingua franca* in southern Ghana): while a large part of the local population speaks

[207] When I started my research in 2013 there was only one psychiatric nurse hailing from Nzema (Francis); in the last couple of years two more Nzema nurses started working at the unit (Sarah and Juliet). Since the expansion of the unit staff (see Introduction), the nurses have increasingly started working on shifts, meaning that it still can happen to have no Nzema-speaking nurses available at the unit on certain days.

or at least understands either one or both of these languages, it is not uncommon to witness moments of doubt, on both parts, in comprehending and translating what the practitioner, the patient, or the caregiver is saying. Often the nurses consult among themselves to be sure to have understood correctly what the person in front of them is saying. Misunderstanding is always a risk. Sometimes, if there isn't any Nzema-speaking nurse around, a third party (another patient/caregiver or a nurse from another unit) has to intervene and act as translator. The highest level of incommunicability is reached with patients who come from Côte d'Ivoire that, given the closeness of the hospital to the border and the relative cheapness of health services as compared to medical costs at home, choose to seek care in Ghana, but often only speak French and/or Nzema.

Secondly, of course, nurses use their professional language, the idiom of psychiatry and 'mental illness', to assess patients, 'translating'[208] what patients say into signs and symptoms and diagnostic categories in line with their 'mental status examination' criteria.[209]

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[208] On nurses as 'translators' and cultural mediators, cf. Cozzi and Nigris 1996; Cozzi 2002; on the historical specificities of nurses' mediation role in Africa, see Hunt 1999.

[209] The assessment criteria generally used by the nurses are the following: *appearance* (e.g. hair, scars, wounds, dressing, smell, nails, tattoos; or simply 'neatly dressed up'); *speech* (e.g. 'coherent / incoherent', 'word salad', 'irrelevant'); *habit* (e.g. 'alcohol', 'smoking'); *general behaviour* (e.g. 'aggressive / orientated', 'restless / disruptive'); *affect* (e.g. 'euphoric'); *mood* (e.g. 'depressed'; as Michael explained to me the difference between *mood* and *affect* is that 'for affect you don't ask, you see it and it has to be appropriate to the situation, you have to look to the outwards expression [while] mood is the opposite: it has to do with the inner expression, it's not obvious, you have to ask', conversation with Michael, 14th September 2021); *thought process/form* (e.g. 'clang and loosen of association'); *thought content* (e.g. presence of 'illusions' or 'delusions'); *perception* (e.g. 'voice hearing'); *abstract thinking* (i.e. the practitioner asks the meaning of an English proverb, for example: '"A book is not judged by its cover": what does it mean?'); *orientation* (i.e. the practitioner asks a question like: 'where are you? What day is it today?'); *judgement* (i.e. the practitioner asks a question like: 'there is a fire, what do you do?' or 'There's a car coming, what do you do?'); *intelligence* (i.e. the practitioner asks a question like: 'where did you reach school? What courses did they offer?'); *general knowledge* (i.e. the practitioner asks a question like: 'who is the president of the nation?'); *insight* (i.e. awareness of the 'condition', which can be limited to 'being unwell'). These criteria were recently complexified by the digitisation of hospital services and the introduction of an administration and management software, with a new detailed checklist for patient assessment. Since the introduction of the new system, all nurses had to start digitally recording cases, diagnosis etc., but some continued to use the old criteria for assessment.

Similarly to what medical anthropologists observed in a multiplicity of contexts, in their article Jain and Jadhav highlight how in addition to the use of English, the 'use of an experience-distant language' (i.e. the biomedical idiom) tends to 'alienate the mental health professionals from the experiences of the patients' (Jain and Jadhav 2009: 71). This is definitely true also for the nurses working in Nzemaland and contributes in defining the distinction between them and their patients, especially from their point of view. At the same time, it can be interesting to point out that in performing assessment (see note 209), nurses usually do not share their 'experience-distant language' with patients at all and tend to operate the translation only within themselves, asking simple questions to patients and converting the answers they receive in appropriate categories to be marked onto their forms and checklists. Since they are aware that they speak *a different language*, nurses do not see the point in communicating with patients and caretakers in biomedical terms and, unless they see them as 'educated' (e.g. patients who completed high school or attended university), they do not share the diagnosis with them. Health workers restrict themselves to prescribing the drugs to their clients and advising them on how to deal with their (undefined) condition, the drugs themselves, and the possible life troubles they might be facing (especially in the case of marital or family issues). Differently from traditional and spiritual healers, which during the therapeutic process reveal at list some details about their patients' conditions – albeit usually not 'everything' – psychiatric nurses tend to keep patients and their caregivers in the dark. Though, as I have already highlighted, the condition of uncertainty tends to characterise the experience of mental distress across therapeutic practices and interpretations, not knowing anything at all about the biomedical illness identified by psychiatric nurses was problematic for some of my interlocutors. For Auntie Sylvia, for instance. She was the mother of two young unit patients and could not stop thinking about them all day, especially her only daughter Daralice, whose condition appeared to be more severe than her brother's: three years earlier she started behaving strangely during a Jehovah Witness study session and they had to bring her to the hospital. Since Auntie Sylvia and her husband were both Jehovah Witnesses, they never considered bringing her to a traditional or spiritual healer's place: 'hospital only'. And they had visited many in the area, until somebody referred their daughter to the Ankaful Psychiatric Hospital in Cape Coast. There, she was given an injection and prescribed a pharmaceutical therapy. Her father kept accompanying her to

Cape Coast almost every month until they were finally referred to the district hospital and met Francis, who accompanied me to visit their house in September 2021. Since Daralice started the pharmaceutical therapy, she did not run furiously anymore as she used to do in the beginning, but she had not really 'recovered': sometimes she talked nonsense (lit. 'she talks differently', *ɔtendɛ ngakyile*) and she couldn't do almost nothing but staying in the house. Auntie Sylvia complained that no doctor told her what that thing (*deɛ ne*) was, nor what the cause was. The pain for her daughter's condition was worsened by *not knowing* what happened to her. This started making it difficult for her to sleep. She even started taking sleeping pills, but could not sleep anyway: 'Unless the doctor [nurse] says: "this is the thing that brought [the sickness]". They haven't said that. I don't know what brought the thing. [...] If [they said] "it is because of birth", it wouldn't disturb me. Old people die, young people die, but a disease that does not go away... this is what disturbs me'.[210] *Not understanding*, *not knowing* anything about her daughter's condition ended up translating into her own condition of distress: 'We go to the hospital [...] but still if they give me medicine I don't sleep. [...] If you give that medicine to anyone, she will sleep. Me, I take it, I don't sleep. *I don't understand* (*Mende ɔbo*).[211] *Not understanding*, *not knowing* about Daralice's condition was clearly not Auntie Sylvia's main preoccupation or problem, but her words seem to suggest that this was in some way also part of it, especially since she could not recur to any other particular explanation of what had happened to her family, not even a 'spiritual' one.

Thus, while on the one hand the use of 'experience-distant' categories can amplify the gap separating nurses from patients and those who *struggle* with them,[212] on the other hand for the latter not receiving any indication about what the illness *is* or *might be* could make it more difficult to make sense of what is happening (cf. Lupo 1999). Usually, however, in the nurses' conceptualisation of their patients' *lack of knowledge* or *lack of understanding*, this dimension of 'not knowing' (which to a certain extent could even bring them closer to their patients'

[210] Interview with Auntie Sylvia, 27th September 2021.

[211] *Ivi*.

[212] In the terms defined by Jenkins (2015), see Chapter 2.

experience, cf. Cooper 2016b)[213] is mostly absent. They refer instead to a gap of knowledge that generally defines the position of rural laypeople / patients / non-professionals / 'believers', beyond any specific medical diagnosis. The notion of *education* often evoked in the practice of psychiatric nurses (cf. Chapter 3) is to a large extent linked to this notion of 'gap of knowledge'. The idea of having to *educate* people is obviously an expression of the constitutive power relationship between practitioner and patient, but also of broader, and at the same time more specific, power dynamics between Western psychiatry and local epistemologies.[214]

As outlined in previous chapters, these power dynamics are a key feature of the Global Mental Health discourse that informed the promotion of the practice of 'collaboration' in Ghana (as well as in many other countries in the Global South). Indeed, together with the 'treatment gap', the idea of a 'gap of knowledge', often described in terms of 'lack of mental health literacy', is one of the key axes of GMH. In the recently issued *World Mental Health Report,* for instance, it is stated that: 'Low demand for mental health care can also be driven by *low levels of health literacy* about mental health, including a *lack of knowledge and understanding of mental health* as well as prevailing *beliefs* and attitudes that undermine the value placed on mental health and effective mental health care' (World Health Organization 2022: 65-66, emphasis added).

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[213] In her analysis of different Africa-based psychiatrists' narratives on the mental health 'treatment gap' in the continent, Sara Cooper focuses on the dissonant voices of some of the medical practitioners she met (Cooper 2015). Without ignoring the risks of creating a reified opposition with a supposedly univocal 'patient perspective' that could be easily objectified as a mere 'variable' in public health scholarship and policies (*ivi*: 333), listened carefully to these practitioners' narratives. By doing so, she was able to identify a common perspective in which, rather than biomedical knowledge, it is actually *uncertainty* that 'might be a precondition for assisting practitioners to negotiate more responsive and appropriate kinds of care' (*ivi*: 334) with their patients (cf. Chapter 4).

[214] The imperative of 'education' in the specific context of psychiatric care should also be put in relation with critical reflections and debates on the infantilisation of psychiatric people deemed 'mentally ill' or 'mad'. Indeed, as observed by China Mills and Brenda A. LeFrançois, adopting a transdisciplinary and intersectional perspective, it can be observed how infantilisation, that is projecting the metaphor of childhood onto certain categories of adults and/or more simply treating someone as childlike, 'has been used for centuries to denigrate and subordinate certain groups including racialized/colonized others, and/or psychiatrized and disabled people' (Mills and LeFrançois 2018: 504) and is ultimately rooted in colonial reason (cf. also Studer 2021).

Thus, analysing the episode that involved Fadhila, Dave, Francis, and Henry at the unit through the theoretical lens of disagreement can help us enlighten the power imbalance that structures patient-practitioners encounters at the unit, but can also invite further reflections on the role that the *production of ignorance* plays in psychiatric healthcare within the broader framework of Global Mental Health. The power asymmetries that emerge from this analysis are crucial, but somehow also quite obvious to imagine, even without Rancière's help. What could be perhaps more interesting, however, is combining this reflection with the fact that the described episode of disagreement – conceived of as a *mutual understanding/not understanding* – developed around two elements: madness and drugs. What is (not) madness? What is the purpose of drugs? Asking these questions means also asking, again: what is mental health (care)?

(Non)madness and the refusal of drugs

What if it is not 'a curse'?

'Even if it's a curse you need the hospital, you need the psychotropic drug to deal with it'. [215] To explain the ways in which collaboration with spiritual and traditional healers is imagined and performed by the nurses with whom I carried out my research, I often quote this sentence Francis uttered a few years ago, one of the first times we talked about his and his colleagues' cooperative relationships with local non-biomedical healers. Francis's sentence was a good example of the *drugs+prayers* nexus proposed by institutions and practitioners in the discourse of collaboration (see Chapter 2) and with time it has become almost a mantra for me – probably even more than for my nurse friends. This explanation can work apparently well when 'mental illness is spiritual' or rather when 'mental illness' is perceived by patients and/or caregivers to be 'spiritual', in the sense that it is the result of a curse, an act of witchcraft, an evil spirit possession. But what happens when it is spiritual in another way? When madness might *not be madness* but

[215] Interview with Francis, 7 August 2014.

just a transient state to be negotiated with spirits on a path that leads to healing (self, and perhaps others)?

The denial of Fadhila's 'madness' put forward by Dave at the unit brings us back to the fuzziness of 'madness' as a concept, something we started dealing with since the very beginning of this thesis (see Chapter 1). Saying that she was *not mad* implied not only that the family refused the girl's psychiatrisation (i.e. her not being 'mentally ill' according to them), but also that they refused the idea of her being associated with the stigmatising image of *ɛzɛlɛ* (i.e. the haunting, unrestrained madness of 'vagrants' and outcasts). Saying that she was *not mad* implied that she might seem or act *as if ɛzɛlɛ*, but indeed, not differently from the apparently mad protagonists of *Les maîtres fous* (who *only* looked 'abnormal', as we realise at the end of the film), she was not. Hers was *a madness that was not madness*, a madness that actually entailed the possibility of its own *mastery* – through the relationship with spirits.

Reflecting on Fadhila's condition in these terms is extremely tricky and, with the risk of being redundant, I believe it is important to point out that by doing so I do not aim to convey a conceptualisation of spirit possession and mediumship as a local alternative to mental suffering and/or madness, whatever we might mean by it. The romantic idea of Africa and other non-Western (imaginary) spaces as sites where 'mad people', far from suffering or being viewed as 'ill', were and are instead recognised as mediums, healers, or 'shamans' – as the jargon of a particularly thriving imaginary most commonly has it – is unfortunately an exoticist simplification.[216] In other words, as I hope it emerges clearly from the previous pages, the 'possibility of spirits' (cf. Van de Port 2016) – that is the possibility of their existence and that of having multiple kinds of relationships with them – does not rule out the possibility of suffering.

On the other hand, however, the particular kind of *(non)madness* that emerged in Fadhila and her family's encounter with psychiatric services pushes us to delve deeper into the multiple dimensions and temporalities of a 'spiritual condition' like hers. Indeed, the situated experience of 'madness' that often characterises the training path of spiritual practitioners is a classic theme and was recurrent in my ethnographic experience too.

[216] It is interesting to point out that there is a similarity between this imaginary and colonial psychiatrists' racist assumptions about the virtual absence of 'mental illness' in Africa (see Chapter 1).

When Maame Amuah, an elderly *kɔmenle* living close to my house, told me the story of how she became a healer, the word *ɛzɛlɛ* was not pronounced but its echoes could clearly be heard:

> [After] they overthrew Kwame Nkrumah,[217] one day I was sitting there, then I went to church: I didn't believe in certain things [at the time]. Then my head started shaking [*ɛnee meti ɛlɛkpusu*]: that was all. The *bozonle* came to attack me [lit. *dele dɔle me nwo zo*, tore and fell on myself] and threw sickness [*ewule*] on me. They made it like my tongue could not occupy my mouth, my sandals could not fit my legs, my breast... you would say that a child was drinking from it. In that way the *bozonle* was still within me: it is within me, it shakes me but I don't see it... but [people could] see that something was within me [lit. *debie do me*, something has cooked me]. The thing shook me for a long time and I [finally] went for training [as a healer]. [...] [The person who trained me, in whose custody I was] mixed [herbal] medicines for us to bath in them: if you bath with the medicine and the gods haven't come within you, you sit [quietly] like I'm sitting here right now. [...] [But] if the *bozonle* comes within you, *you will roam about* [*ɛbakpɔsa*]. You will roam about in the community, you will roam about a lot, then at a certain moment your eyes will open.[218]

As we have already discussed (Chapter 1), 'roaming about' is a key feature in the multiple narratives and practices that develop around the condition of madness, to the point that in some cases the expression 'ɔkpɔsa' (he/she roams about) could be described as a synonym of 'ɔlɛ ɛzɛlɛ' (he/she is mad).

In a similar fashion, Auntie Manza – a woman I first met in 2014 in the family compound of a famous Twelve Apostles Church *esofo*, who was well-known in the area for his competency in healing from madness, but whom I never had the chance to meet since he died not long before my visit to his place – told me about the overwhelming chain of events that led her to be there,

[217] President Kwame Nkrumah was overthrown in a violent *coup d'état* in February 1966, while he was in Vietnam on a state visit. As it is often the case in Nzemaland as in many other contexts, Maame Amuah's story starts with the reference to an important event in the history of the country that serves as a chronological marker, in place of an explicit reference to the year in which she was first 'visited' (or, as she says, 'attacked') by the *bozonle*.

[218] Interview with Maame Amuah, 4 October 2021, emphasis added.

projecting the shadow of madness:

> When a *bɔvolɛ* (angel, spirit)[219] comes for the first time you can fall sick. If you are a business woman, you simply lose your belongings, and you don't understand why, you lose everything. And this means that that thing is coming to you. If that thing is coming and you don't want to, and you insist on going to church *you can become mad*! If your family understands what is going on, they can bring you to an experienced *esofo* and he can tell you that it is the *bɔvolɛ* who has come to you and can train you to become an *esofo* yourself. [...] I used to be a saleswoman, everyday when I went selling something I would lose everything. So I came here and Esofo Awah explained to me: 'this, this, and that.' That is how my training started.[220]

'If you are meant to become *esofo*, when you are looking for something you lose it, sometimes *you can become mad*...' – commented Auntie Bomo, the deceased *esofo*'s wife who was sitting with us.

In some stories of both healers and mentally-distressed people I had the chance to listen to in Nzemaland, the early days of initiation to mediumship were associated with the behaviour of someone *acting as if mad*, but were also described as incredibly delicate moments in which

[219] The Nzema word *bɔvolɛ* (or *anwumabɔvolɛ*, pl. *bɔvolɛma* or *anwumabɔvolɛma*) is usually translated into English as 'spirit' or more specifically 'angel'. As I briefly mentioned in the Introduction, Twelve Apostles churches depart significantly from the aesthetics, practices, and narratives of pentecostal and charismatic churches and should be understood as located, more explicitly than in the case of other Christian assemblages, in continuity with traditional cosmologies and healing practices. Accordingly, similarly to what happens to *ahɔmenle* who are often possessed by more than one *bozonle*, Twelve Apostles Church *asofo* are not possessed by a single spirit (the Holy Spirit), but by a number of spirits/angels, with different names (usually coming from the Bible) and features.

[220] Interview with Auntie Manza and Auntie Bomo (Esofo Awah's wife), 28th October 2014.

defying the spirit(s)'s will might result in a permanent condition of *ɛzɛlɛ*, madness.[221] Think for instance of Grace, the girl we met in Chapter 3: according to one of her condition's aetiologies, she fell sick after opposing resistance to the *awozonle* trying to possess her, refusing *de facto* to become a *kɔmenle* and becoming *mad* instead.

If we put Fadhila's unconcluded story in relation with the conclusive narratives of healers who experienced 'transient madness' (*acting like* someone who is mad) at the beginning of their career, it becomes clear that the formula 'in any case (*even if it's a curse*) you need the psychotropic drug to deal with it' can prove problematic in circumstances in which surrendering to the spirits' will might actually be the solution.

'Maybe she is already a healer then!': (non)engagements with the-rest-of-what-is

The first time I went to visit Fadhila at her house, we were sitting with her, Dave, and some other members of the family when one of the spirits came to her: she started shaking and trembling and we all moved to a closed room in the compound. The spirit requested some objects (a lot of perfumed talcum powder, some cigarettes) that were diligently given to the girl by her uncle, they gave pieces of advice to some of us, and asked us to read some flipped words Fadhila would write on the floor, including her nickname 'Credit'. When the spirit was gone and she resumed consciousness, she saw herself covered in talcum powder, and she started laughing, appearing embarrassed and proud at the same time, as she understood what had just

[221] Madness is not the only risk would-be healers run in those delicate moments: all kinds of sicknesses and misfortunes are around the corner for both Twelve Apostles Church *asofo* and *ahɔmenle* who try to go against their spiritually determined destiny. For instance, Esofo Anyimah, another Twelve Apostles Church priest who is quite well known in the area, told me: 'When the spirit picked me I said I won't do it. I said: I go to Pentecost [the church he attended at the time], so I won't do it. But this turned into sicknesses: I vomited blood, I had a lot of illnesses, it wasn't easy. After more than one year I was almost dying!' (Interview with Esofo Anyimah, 30th September 2021). Similarly, Maame Afiba, the *kɔmenle* taking care of Cyprus (see Chapter 4) and at whose garden I met Comfort during the outreach visit with Pamela (see Chapter 2), recalled: 'I went to the farm and the thing affected me. When the thing affected me, I said I won't do it. I will not become *kɔmenle* (lit. *menrɛyɛ ahɔne*, I will not do the traditional dance), so I kept going to church. I said I won't do it. Then, I was there and I couldn't succeed at all. I gave birth to two daughters and they died. [That's when I understood] I had to leave [church, my previous life] and become a *kɔmenle*. Then I left.' (Interview with Maame Afiba, 19th January 2022).

happened but she did not seem to remember. She knew, also from pictures and videos of her that Dave had taken in previous occasions when she was possessed, that she had acted strangely (like she was mad?), smoking and so on. Dave told me that the last time he showed her those images she deleted all the media depicting her in that bizarre condition; that day instead she insisted that we took a picture together with her still covered in white powder, smiling.

Though it was definitely not my place to determine, it was difficult for me not to wonder to what extent what I had just witnessed was a moment of self-determination in which Fadhila was opening herself to 'the-rest-of-what-is' (van de Port 2011) and to what extent, instead, she was responding to other people's expectations, and more specifically in that particular occasion to her family's willingness to let me really *understand*: that she was not 'mad', that people at the hospital *did not understand*. By all means, Fadhila's spirit possession was forcing me to take seriously the role of *the-rest-of-what-is* in the girl's story: in subsequent meetings, she told me that she was scared at the beginning, but now – after having been to another shrine where she and her family were given a set of strict rules to follow – it was getting easier for her to get to know 'her people' and to somehow manage them. With Dave they had started joking about 'her' spirits, by giving to some of them nicknames that reflected the different ways in which they made her behave when she was possessed by them. Like Dave, whom everyone called 'Koko',[222] and Fadhila aka 'Credit', some of the spirits were referred to by them with playful names: they were becoming less frightening to her, the 'bad ones' had gone, and things – she told me – were 'small small', gradually, getting better.

When I told Francis what had happened at Fadhila's house and I shared with him my doubts, he did not seem particularly surprised to me and commented: 'maybe this girl is already a healer then!'. Reflecting on Fadhila's experiences outside of the hospital and on Francis' comment, and going back to the previous moment of disagreement at the unit, we can now try to unpack the implications of the nurses' *understanding - not understanding*.

Indeed, if we invert the perspective and look at nurses from the point of view of Fadhila's 'therapy management group', to a certain extent Francis and Henry really seemed not to understand what Dave was trying to tell them. But was that really the case? Was there a 'gap of

[222] From the name of a popular breakfast drink in Ghana (also referred to as Hausa koko).

knowledge' between them to the detriment of biomedical practitioners? On the other hand, if nurses – as many of them recognise – share a dual 'spiritual-biomedical lens' (Arias et al. 2016: 13; cf. also Chapter 2 and Chapter 4) and are not alien to the horizons of meaning evoked by patients and family members who refer to the 'spiritual' side or nature of the 'illness', how is that even possible? And if that is not the case, how should we conceive of the nurses' approach towards 'the other side' of Fadhila's condition? What are the implications of their approach in the provision of mental health care for a patient like Fadhila?

After a preliminary reflection, we could advance the hypothesis that Francis and Henry, rather than not 'knowing' what was *really* going on, preferred to withdraw from any further engagement with *the-rest-of-what-is* – a dimension that Dave was asking them, instead, to acknowledge. In this perspective, we could look at them as not creating *the conditions for* understanding and/or acting *as if* they did not understand.

In the introductory chapter of their edited book collecting critical insights on the *Movement for Global Mental Health* from the perspective of South and Southeast Asia (Sax and Lang 2021b), William S. Sax and Claudia Lang propose to replace the expression 'treatment gap' with the expression 'treatment difference'. While the first is grounded, as already pointed out, in the centrality of psychotropic drugs in contemporary psychiatry and their actual and/or perceived lack in the Global South, with the expression 'treatment difference', they aim to highlight the fact that non-pharmaceutical resources 'for maintaining or improving [...] mental health' (*ivi*: 18) may be varied and abundant (as they suggest in the case of South Asian contexts), but are largely ignored, if not vilified in the framework of Global Mental Health. 'The problem – they argue – is that such resources are rarely "seen" by advocates of global mental health' (*ivi*: 15). In some way, we could say that in the situation of the disagreement with Dave and Fadhila, as representatives of Global Mental Health 'on the ground', Francis and Henry rejected the possibility of 'treatment difference', by not 'seeing' or seeming not to 'see' what was happening to the patient according to her and her family, nor the other therapeutic options she may have recurred to. What they could mainly 'see' was how drugs could have helped Fadhila. Put another way, as apparently suggested by the lack of surprise Francis showed when I told him what I learned about the girl's condition during my first visit to her house, the nurses did not completely ignore the possibility of Fadhila's condition being 'something else' (i.e. not 'just

mental illness', not 'a curse'), but the unit was ultimately a space where *the-rest-of-what-is* could not be 'seen'.

This approach could be understood as the result of a kind of 'secular' ideological separation between the realm of science and that of spirits that nurses, after having been trained, refuse to transgress, as it seems to emerge also from some of their words on their patients' 'beliefs' (and their own). Think for instance of the outrage expressed by Ernest when he told me about a colleague of his who suggested to a patient's mother to go and find a therapeutic solution elsewhere because her child's condition 'was not sickness for the hospital' or of Pamela's amused detachment when she stated: 'I "believe" in yours, but I'm not going to use yours, I'm going to use mine, but I will just encourage you to add mine to what *you* believe in' (see Chapter 4). Here, again, the issue is that sometimes it is not so easy to schematically 'add mine to what *you* believe in', without really exploring what the 'belief' is about and engaging with it.

In a provocative article on the relationship between ritual healing[223] and psychiatry in India (Sax 2014), William Sax argues for the incommensurability of the two. According to him, 'the Indian state should retain its structural *blindness* to ritual healing' (*ivi*: 843, emphasis added) for three main reasons: first, because of the individualist conceptualisation of the person that governs Western psychiatry and is radically at odds with local, more communitarian and collective notions of the self; second, because 'social asymmetries between ritual healers and health professionals are so great that it is difficult to imagine how a truly respectful relationship between them could develop' (*ivi*: 841); third, because of the inability of local institutions to take ritual healing 'seriously'. 'Neither the science of psychiatry – he argues – nor the regulatory apparatus of the state can or will acknowledge the validity of ritual healing; moreover, even if they could (and did), state regulation would destroy what is most valuable about it' (*ivi*: 831). On the one hand, his normative approach and his idea of incommensurability are not quite

[223] Sax's definition of 'rituals' and 'ritual healing' is particularly interesting as he aptly observes that the very definition of something as 'ritual' is rooted in the Eurocentric idea of its lack of efficacy: 'According to our meteorological theories, dancing cannot really make it rain, and so when someone performs a rain dance, we call it a "ritual." [...] But for those performing the rain dance, or the initiation, or the healing, "rituals" do indeed fit into a cosmology in terms of which they are rational and effective means for attaining certain ends. That is why participants typically refer to them not as "rituals" but rather as dancing, or healing, or simply as "work". (Sax 2014: 830).

convincing to me, at least if applied to the Ghanaian case: indeed, this whole thesis is aimed at demonstrating the opposite. On the other hand, however, as it should appear clear by now, it is difficult to deny that the arguments advanced by Sax do play a role in the ways in which psychiatry articulates with other forms of healing in Ghana: the individualism (and biological reductionism) of pharmaceutical care, the asymmetrical way in which collaboration is envisioned and proposed at the policy level, and the refusal to take other forms of healing seriously within the psychiatric therapeutic setting are key elements in these articulations and become almost explosive in the episode of disagreement presented here. On the other hand, however, inspired by his provocative suggestion we may also ask whether an approach like the one adopted by the nurses towards Fadhila (and Dave) could be instead a form of acknowledgement of *the-rest-of-what-is* and non-biomedical epistemologies *through withdrawal and non-engagement*. In this perspective, keeping *the-rest-of-what-is* 'outside of the unit' would not necessarily mean denying the legitimacy of dealing with a mental condition like the one experienced by Fadhila in a ritual, non-biomedical way, but actually accepting, quite voluntarily, to keep 'the unit' (and its pharmaceutical approach) outside of Fadhila's condition: *maybe she was already a healer then*... therefore there was no need for the unit to intervene?

After returning from Cape Coast with his recently earned degree in 'Mental Health Nursing', both in conversations with me and with his colleagues Francis would often mention the 'biopsychosocial model' proposed by American psychiatrist George L. Engel in the late 1970s (Engel 1977), stressing how important it was to treat 'mental illness' at the unit taking into account the entanglement of its biological, psychological, and social/environmental dimensions – almost sounding like a medical anthropologist, as I told him a couple of times. 'Here – he commented to me once, having known for a long time what my research interests were – we should add the *spiritual* to it... that would be a *bio-psycho-socio-spiritual* model'.[224] As previously described, Francis was very critical towards the univocal understanding of psychiatric care as the administration of drugs. For him, in line with what some of his colleagues also often declared – but collectively struggled to put in place – 'medication can only do 50% of the

[224] Conversation with Francis, 12th October 2021.

work'.[225] His decided embracing of Engel's model and his adaptation of it to the Ghanaian context seemed to have a lot to do with his scepticism – and sometimes frustration – towards the predominant use of pharmacological treatment at the unit. But, taking seriously his coinage of a *bio-psycho-socio-spiritual model*, we may ask: what is really the place of the 'spiritual' within the unit? Perhaps what is most important is not so much whether the non-engagement with *the-rest-of-what-is* involved in Fadhila's condition is the result of an (indirect) acknowledgement of its crucial role or the rejection of it, but rather what this non-engagement tells us about the ways in which psychiatric care and 'collaboration' are currently imagined and put into practice. In this perspective, the operative simplification of 'spiritual' dimensions of life (e.g. as curses and/or prayers, cf. Chapter 2) and the essential separation between the realm of psychiatry and *the-rest-of-what-is* in the therapeutic setting (to the point that certain 'things' seem impossible to be *understood* or *seen* at the unit) emerge as key elements, somewhat hidden behind the policy language of 'collaboration'.

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In this chapter I have tried to take a particular moment of friction that happened at the psychiatric unit as a point of departure to interrogate the ways in which collaboration between psychiatric institutions and religious/traditional healers is currently conceptualised, promoted, and practised, in line with global mental health directives, in the Ghanaian context. The described episode is not situated within the framework of an established collaborative relationship between the psychiatric unit and a shrine or a prayer camp, but it could instead be useful to reflect in a novel perspective on the limits of such relationships when they are created and on why sometimes they may fail to be established in the first place. Using Rancière's notion of *disagreement* as a theoretical lens and reflecting on the psychiatric unit as a site of 'ignorance production', I have highlighted the asymmetric nature of the model of collaboration currently

[225] Francis, Presentation during weekly hospital meeting, 29th November 2021. Cf. also Chapter 3.

enacted by psychiatric nurses in the Nzema area and the problematic role of the notion of *educating/letting people understand* that is one of the grounds upon which ongoing collaboration attempts are being developed. The disagreement between Fadhila and Dave and the nurses revolved around the notion of (non)madness and the refusal of drugs, whose implications they *understood and did not understand at the same* time during their encounter. In this perspective, the role of psychopharmaceuticals as the only mediator of relationships with healers *and* patients emerges, once again, as a key problematic aspect in the way collaboration is envisioned and promoted ('even if it's a curse you need the psychotropic drug to deal with it'). Though, as also revealed by Francis's comment on Fadhila's trajectory, *the-rest-of-what-is* is part of the worldview of both nurses and patients, exploring the girl's ongoing story more deeply, it is evident how psychiatric care withdraws from any kind of engagement with 'the 'surplus' of our reality definitions' (van de Port 2011: 18) in the therapeutic setting. Such an approach may also result in reducing the patient's subjectivity to merely 'somebody *to be managed* through drugs' (cf. Chapter 5), when in a situation like Fadhila's, looking at her condition from a spiritual angle could also mean recognising her some capacity of *managing* and making sense of her own condition through her relationship with spirits.

More broadly, in this chapter I have tried to suggest the idea that taking disagreements and tensions as points of departure to analyse competing yet perhaps compatible engagements with madness/mental illness could prove useful to overcome the dead-end of incompatibility vs. (pharmaceutical) juxtaposition and envision more truly cooperative projects of care and healing.

IN | CONCLUSION

'Freedom does not exist other than in the tie that helps us struggle against what keeps us apart' (Ongaro Basaglia 1978: XIX, my translation). Paraphrasing these powerful words written by the scholar and activist Franca Ongaro Basaglia – who together with her husband Franco Basaglia had a crucial role in the cultural and political movement that famously led to the closing of asylums in Italy[226] – we could say that the same is true for care: *care does not exist other than in the tie(s) that help us struggle against what keeps us apart*. In the field of mental health, care and freedom are equally crucial and often demand us to be questioned, turned upside down, and reinvented in a definition process that is continuously ongoing in people's practices – as Ongaro Basaglia's words hint at with their emphasis on the collective struggle against 'what keeps us apart'. The eagerness to question what mental health care *is* and to imagine what it *could* be was one of the reasons that initially animated my interest in anthropological studies of madness and 'mental illness'. Trying to be faithful to the initial urgence that inspired my research, in this thesis I moved across the thin lines that separate and connect the experiences and constellations of meaning that patients, practitioners, and caregivers navigate, struggling – often collectively – to find their way to care, healing, and freedom.

Focusing on the Global Mental Health-promoted practice of 'collaboration' between psychiatry and so-called 'unorthodox' therapeutic resources in Ghana, I looked at the ways in which 'collaboration' is actually experienced and practised in people's everyday lives. As I tried to highlight throughout the chapters, any binary understanding of religious/spiritual experiences and mental health as neatly distinct dimensions would prove misleading: in the lives of the people I met in Nzemalad psychiatry and spiritual healing can easily be entangled (e.g. the conviction about a supposed 'spiritual' origin of the illness does not necessarily constitute an

[226] On Ongaro Basaglia's scholarly and political work see Valeriano 2022. For a detailed history of the closing of asylums and the development of the anti-psychiatry movement in Italy see Foot 2015.

obstacle for seeking psychiatric care; people can be treated by a traditional healer and a psychiatric nurse at the same time; psychotropic drugs can be administered in prayer camps). This, however, does not imply that there are no contradictions, tensions, dilemmas entailed in practices of 'collaboration'. Indeed, quite the opposite.

Pointing out the necessity to dig deeper into these ambivalences with the aim of questioning the meaning(s) of 'collaboration' beyond its exclusively discursive dimension, I first proposed to investigate its historical antecedents, highlighting the presence of haunting continuities between colonial and postcolonial mental health care policies and reflecting on their impact on narratives and perceptions of what 'madness', 'mental illness', 'stigma', and 'belief' are today. Moving onto the present, I proposed to explore 'collaboration' as both a *discourse* characterised by inherent ambiguities and an *'experimental' practice* already in place, mainly framed in terms of a juxtaposition of drugs and 'prayers'. I paid particular attention to the contradictory ways in which representatives of Ghanaian psychiatric institutions tend to describe 'un-orthodox' practitioners: as potential allies and dangerous competitors, often blamed (together with the conceptualisations of 'mental illness' they convey) of constituting an obstacle to proper care. I suggested that before engaging with the 'incompatibility' argument advanced by the portrayal of spiritual cosmologies as obstacles to care, it is crucial to address the material implications people living with mental suffering have to face in a context like the one where I carried out my research. It was crucial to start from here because the materialities of mental health care are often blatantly ignored and/or taken for granted in the institutional discourse of collaboration, but are often decisive in people's therapeutic paths. Describing in detail the 'extraordinary conditions' (Jenkins 2015) of poverty, pharmaceutical scarcity, and constant 'emergency' that characterise mental health care in Nzemaland and the informal economies that arise in such circumstances, I argued that particular attention should be paid to the impact that processes of commodification and pharmaceuticalisation of mental health care have on both patients and practitioners. An analysis of these processes reveals that in the articulations of psychiatry and spiritual healing, psychopharmaceuticals acquire a paradoxical role of mediation: not differently from the money with which they are bought and sold, they are simultaneously capable of creating relationships and exclusion. Obviously, this has critical implications for psychiatric nurses working in such conditions, who often end up not only prescribing but also trying to sell medications to people

who cannot afford them. As I described, nurses work in an unstable balance between market and care, dealing with ethical dilemmas (and often frustrations) on a daily basis. On the other hand, the centrality of drugs in the articulations of biomedical and 'un-orthodox' mental health care (as well as in psychiatric care more generally) invites a complexification of debates around the pharmaceuticalisation of the self from a 'remote' Global South context like Nzemaland, where psychotropic drugs seem to be scarce and hegemonic at the same time.

After having delved into the crucial material conundrums that inform people's experience of mental health care in Nzema, I turned back to the 'incompatibility' argument, addressing it from different perspectives. First, I engaged with the issue of 'belief', a concept often evoked by psychiatric professionals and international organisations to discredit non-biomedical understandings of mental distress. Taking the ubiquity of 'belief' in my fieldwork as a point of departure, I tried to explore the possibilities that might be opened by a reconsideration of this 'old fashioned' anthropological term. Specifically, focusing on the ways in which nurses talk about 'belief' (i.e. to refer to spirits, God *and* science), I suggested that, besides revealing the evidently ambivalent role of nurses within the discourse of 'collaboration', a focus on the term and on its constitutive other (i.e. doubt) could help us enlighten the crucial role of uncertainty in the ways in which people – patients, relatives, *and* nurses – navigate healing options and worldviews in dealing with 'mental illness'. Inverting the perspective, belief could constitute a common ground between patients and psychiatric practitioners rather than being a marker of separation. Moving to another supposed 'incompatibility' factor, I addressed the extremely delicate and problematic issue of physically restraining mentally ill patients. Having retraced how the humanitarian debate on chaining in prayer camps is deeply informed by colonial, essentialist, and even racist assumptions on 'Africa', I analysed the pragmatic, yet often highly conflicted and contradictory, ways in which different actors – practitioners, patients, caregivers – deal with practices of coercion in a continuum that goes from violence to care, from suffering to healing. Far from aiming to justify violent practices, I contended that in order to advance the reflection on practices of restraint in a context like the Ghanaian one it would be crucial to address coercion in its multiple forms (both pharmacological and physical) and constitutive ethical ambivalences, emphasising its entanglement with care beyond simplistic narratives of 'abandonment', in synergy with discussions going on in other parts of the world where chains

and shackles might not be used anymore, but coercion and restraint are nevertheless very tangible issues. In the final chapter, through the examination of a particularly complex and stratified event that occurred at the hospital, I focused on the potential of disagreements (Rancière 1999), tensions and conflicts to interrogate the meaning of 'collaboration' and its limits. After having deconstructed in previous chapters the idea of an 'incompatibility' between psychiatric care and spiritual understandings of mental distress that engage with 'the-rest-of-what-is' (Van de Port 2011), I maintained the importance of making a move also in the opposite direction, exploring what happens when things do not work and a dialogue does not seem possible. Looking at these aspects, the role of epistemological hierarchies and power imbalances in the psychiatric setting emerged as a key problematic issue that might push towards a radical questioning of 'collaboration' as it is currently imagined, and towards the envisioning of new forms of cooperative mental health care.

One of the key aspects that I tried to stress throughout the thesis is that the explored conundrums in mental health care – *things that keep people apart*, if we may use Ongaro Basaglia's powerful definition – are relevant in Ghana *and beyond*. Looking at them in these terms allows us to overcome the paradox of a Global Mental Health that defines itself as 'global', but seems to a large extent to be still rooted in a neat separation between the Global North and the Global South. By analysing how a particular Global Mental Health policy is put in place, experienced, and challenged in everyday life from the peripheral (yet obviously global) perspective of a supposedly 'remote' site, I also wanted to draw the attention on the need to bridge the gap between discussions happening in the Global North and in the Global South in the field of mental health care.

Bringing into focus the aspects that *keep people apart* and equally exploring coexistences and frictions in (an aspiringly decolonial) global-local perspective could be instrumental to take more seriously the *possibilities of care* that might open at the intersection of different conceptualisations of suffering and healing options.

My project initially revolved around the question: is collaboration possible? During the research, however, observing people's practices, their struggles, their resourcefulness, their ambivalences, and their dilemmas, I gradually realised that it would have been more important

to question the meaning of 'collaboration' itself. By doing so, I started addressing the issue of what was (im)possibile in another perspective (cf. Kilroy-Marac 2019): what forms of care did that particular discourse of 'collaboration' – the foundations upon which it was developed and the way it was put in practice – make (im)possible? With this work I tried to give some preliminary answers to this question, hoping to contribute to an ongoing, collective reflection on what 'collaboration' and mental health care *could be* in Ghana, and beyond.

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