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Madness, medication and miracles: family, state and community approaches to the control and cure of people with severe mental illness in rural Ghana

This paper is based on research conducted with people with mental illness and their families living in and around Kintampo, a market town in the geographical centre of Ghana in the Brong Ahafo region. Kintampo's settlements and villages are typical of notions of the rural periphery, far from the centres of power in the coastal capital and Kumasi. The Rural Health Training School in Kintampo was initially established to train primary health care workers to work in rural communities, the only training institute of its kind in the country. Kintampo Health Research Centre pioneers research into health interventions in rural areas, and villages in Brong Ahafo often feature as examples of 'rural communities' in research projects based elsewhere. A psychiatric ward and clinic are available in the regional hospital in Sunyani, and two psychiatric nurses operate a clinic in nearby Techiman, but these local services, introduced under a policy of 'decentralisation' and 'community mental health care', are still relatively unknown and underused. More notorious are the 'asylums', the three large psychiatric hospitals down on the coast. Sources of non-state funded treatment for madness are diverse, prominent among which are 'Pentecostal' churches which offer prayer, fasting and 'deliverance' from spirits, *akɔmfoɔ* ('fetish priests') who treat mental illness predominantly through the use of potent herbal mixtures (*abibiduro* – African medicine) and rituals of confession and vengeance, and Muslim mallams who offer prayers and readings from the Qur'an to combat possession by *jinn*.

The history of psychiatry in Ghana and the formation of the mentally ill as a category of persons in need of containment and treatment within state institutions arose in the context of a colonial response to a perceived crisis framed as an increase in mental illness arising from modernisation and 'acculturation'. With growing urbanisation the mad had become increasingly visible in the cities and towns of West African colonies, leading to the introduction of legislation to allow for their removal and confinement, firstly in

prisons, and then later in lunatic asylums. Fears regarding an 'epidemic of madness' were reflected by psychiatrists, medics and anthropologists of the colonial period leading to the British government commissioning an investigation into the 'care and treatment of lunatics' in the West African colonies which was conducted by a Dr. Robert Cunyngham-Brown. In his report, published in 1937, he predicted that 'Looking to the future of a country like the Gold Coast, originally primitive and now rapidly adopting European standards, a steady increase in the number of lunatics *coming to official notice* is to be expected. The experience of other countries shews that as economic conditions become more stable and communications increase, as material progress advances and social conditions become more complex, more and more cases of mental disorder come to notice.' (Cunyngham-Brown 1937, my emphasis). Just over a decade later, towards the close of the colonial epoch, Raymond Firth, then Secretary of the Colonial Social Science Research Council, identified 'the forms of psychosis and neurosis among Africans' as one of the 'social and economic problems in West Africa which needed investigation urgently', an investigation which was carried out by Geoffrey Tooth, a British doctor, and published in 1950 (Tooth 1950). Shortly after independence, Margaret Field, anthropologist then psychiatrist, made the ominous forecast: 'There are three programmes now being mooted in the new and eagerly go-ahead Ghana: universal literacy, industrialisation, and compulsory non-military training-camps for unemployed literates. Any one of these schemes put resolutely into operation could probably provoke a startling outburst of acute schizophrenia' (Field 1958:1048).

Such catastrophising discourses, which reflect teleological notions of the civilising mission, a reification of the primitive and traditional, and a mounting disquiet with the effects of the colonial project, continue to influence mental health policy and practice in postcolonial Ghana. Care of the mentally ill is no longer a concern solely for the family and local community, but a duty of the state, though one at which it is manifestly failing. The figure of the mad vagrant, naked and potentially violent, looms large in the public imaginary, reflected in popular media, the creation of a 'vagrants' ward' in the capital's asylum, the clearing of undesirables from the streets prior to the visits of international

dignitaries, and in the behaviour of the mentally ill themselves, some of whom indeed wander the streets semi-clothed. Media headlines contain dramatic and dire predictions, such as the chief psychiatrist's recent claim that '40% of Ghanaians have a mental problem', a claim which was loudly ridiculed in on-line comments.

This perception of a mental health crisis is reinforced by the international psychiatric community which draws on this discourse to argue for more resources to improve mental health care. 'Burden of disease' projections employing the DALY (disability adjusted life years) methodology are frequently cited to argue that mental illness is among the 'leading causes of disability worldwide' (Lopez et al. 2006 ;WHO 2008). It is striking how anxieties regarding 'modernisation' and a perceived 'breakdown' in 'traditional' family care continue to inform contemporary appeals for the scaling up of state provision of mental health care in low-income countries, as revealed in this quote from Vikram Patel, an Indian psychiatrist at the forefront of the recently launched Global Movement for Mental Health: 'The lack of evidence-based care exacerbated by *rapid changes in social and economic conditions in less-developed countries* that compromise the ability of informal systems to care for people with schizophrenia represents *a looming mental health crisis* in these countries' (Patel, Farooq, and Thara 2007:963, my emphasis).

In Ghana the crisis rhetoric of mental health feeds on perceptions of the moral degeneration of youth and their use of cannabis which is strongly linked with madness in popular discourse as well as among psychiatric professionals, and, like madness, is perceived to be increasing to dangerous levels. African religion, Christianity and Islam place mental illness within a moral frame through causative association with smoking cannabis, as well as with malign 'spiritual' powers unleashed by the breaking of taboos, the use of *sikaduro* (the exchange of a relative's sanity in return for money), witchcraft, and demonic possession. This informs practices of control and chastisement through the use of chains, beatings, fasting, and confession within shrines and healing churches. The perceived 'mental health crisis' is therefore also a moral crisis, rendering the

management of the mentally ill a moral as much as a health imperative, and reinforcing the continued use of psychiatric institutions as forms of social control and containment more than rehabilitation. Thus the crisis rhetoric employed by psychiatric professionals and international agencies may paradoxically work to reinforce the very stereotypes and stigma they seek to counteract through the more systematic and widespread provision of psychiatric treatment. The asylum carries a significant stigma, underscored by its isolation from the communities it serves, and the 'contamination' of madness to those who live and work with the mad. '*Abodamfo* nurse' – mad nurse – was a common taunt directed at those who worked in the psychiatric hospitals. For some the asylum offers a useful option for the disposal of troublesome mad relatives and a sizeable proportion of patients remain in the hospitals indefinitely.

By contrast to such 'zones of social abandonment' (Biehl 2001), churches and shrines offer solidarity within communities of suffering, and hope for a cure through confession, deliverance from evil spirits, fasting, and herbal medicines which address the spiritual agents which may cause and prolong mental illness. Family members spend long periods in shrines and church compounds tending to their sick relative, and sharing day-to-day life such as cooking, farming and other money-generating activities, as well as the ongoing trials (and, very often, humour) of their caring role. In a burgeoning landscape of healing choices offered through the entrepreneurial enterprises of aspirational healers, the state appears to be struggling to contain an imaginary of miraculous healing which promises a complete and lasting cure for illnesses like madness, which often recur despite hospital treatment. The tantalising promise of the miraculous, drawing on a recognition of spiritual powers which have cross-fertilised within 'traditional religion', Christianity and Islam, animates the imagination of those seeking a solution to life's misfortunes, stubbornly resisting attempts to impose a scientific rationale on the treatment of mental illness and other chronic conditions. Mental health NGOs working alongside international agencies and the state, propagate a message which counterpoises the 'ignorance' of the relatives of those with mental illness who patronise shrines and churches and hold to a spiritual view of mental illness, with the 'correct' 'scientific' view of

mental illness as a 'medical condition requiring medical attention' (Commonwealth Human Rights Initiative Africa 2008). Implicit in this discourse is the use of 'injections' and 'restraint' as modern and hygienic, compared to the 'primitive' and 'inhumane' use of chains. However psychiatric hospitals in Ghana are far from the clean, efficient and infallible havens implied. Overcrowded, unsanitary, and understaffed, they offer little other than brief assessment and treatment with psychotropic medication, often by workers with limited specialist clinical training and expertise.

In this narrative of the 'ignorant' versus the 'expert' it is common for health professionals and policy makers in Ghana to claim that the psychiatric hospital is the 'last port of call' after all other avenues of treatment at the shrines and churches have been tried and failed. However my own research suggested otherwise. Over a hundred years since the establishment of the first psychiatric hospital in Ghana in 1906, people are certainly not ignorant of the asylum as a place of treatment for the mad. Virtually every informant had used the hospital at some point, sometimes more than once, and often at more than one psychiatric facility. Many of those we met had used hospital treatment *before* visiting the shrines or churches, or had tried hospital treatment after visiting a church or shrine and then, when the illness returned, or the side effects of anti-psychotics became intolerable, returned to traditional or church treatment. The father of Stephen who lived in a remote village and whose son was now untreated told us:

> I wanted to know which way to get healing. In its first stage, as I remember, I took him to somebody. Afterwards as it didn't work, I took him to Ankaful [psychiatric hospital]. There he escaped so I made them take him back. So when we took him back, the doctor there said the way the boy escaped from the compound I am worrying them. So if they admit him and he escapes, he will put them into trouble. So there, he was not accepted. So when I brought him back, I took him to mental hospital, Sunyani [regional hospital]. There also they gave him some medicine. Even there,

> when I came, he said he was not going to drink it. He cried and cried. He even destroyed the medicine. So up to now I took various paths but it didn't help me.
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> Interview with Stephen's father, 17th October 2008

We encountered many informants who had similarly stopped taking 'hospital medicine'. Mentally ill informants found the medicine 'too strong' and complained of feeling 'fat', 'lazy' and tired when they took it. Most importantly, many said that hospital medicine left them feeling too weak to work. Whilst the sedating effect of hospital medicine was valued, the prolonged lack of energy and drowsiness ran counter to a view of medicine as providing strength and energy, and health as synonymous with physical strength and endurance, vital for participating in farming, manual labour and many everyday household chores such as headloading, carrying babies, and pounding fufu. Furthermore the pills seemed ineffective in the long-term since when they were stopped the illness came back. Akosua, who had been ill for over ten years, had been taken to hospital by her sister, who worked as a ward assistant in the district hospital and was thus educated in a view of biomedicine as the first line of treatment:

> I took her also to the hospital. At that time, I brought her here and they gave her medicine that will let her sleep, yet when the medicine gets finished, it also returns. Sometimes when they give her medicine it goes for about two months then it returns.
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> Interview with Akosua's sister, 10th November 2008

The experience of severe and relapsing mental illness within the families I met in Kintampo, where treatment, whether within shrines, churches or hospitals, rarely achieved the hoped-for cure, necessitated a creative negotiation with and against the orthodoxy of healing practitioners. As noted by colonial researchers, in the rural communities of Kintampo the majority of mental health care takes place within the family compound, often far from the reach of the state. Disruptive, aggressive, dangerous and anti-social behaviour may necessitate resorting to the use of chains, shackles and logs as forms of restraint and

containment, and precipitate a search for treatment from state hospitals and informal healers. However the form of treatment employed seemed to be driven less by causal attributions, than by an opportunistic 'try it and see' approach. Whilst the illness prompted speculation as to the cause, including spiritual factors, definitive causal attributions were the exception rather than the rule and scepticism applied equally to all healers: doctors as much as pastors and fetish priests, whose motivations for material gain were often suspected. However the recurrence of mental illness even after the use of 'hospital medicine' fuelled suspicions of its spiritual status, for spiritual diseases are notorious for their failure to respond to hospital treatment, and for their chronic and recurring nature. In such a case, God/Allah/ *Nyame* (the Akan high God) was the ultimate arbiter of one's fate, above the uncertain powers of those who claimed to heal, as articulated by this Muslim informant:

> First they say there is some town they call 'Asylum' that whoever has a serious one, if he is taken there he becomes so well that if you see him you won't think it is him. So I know that doctors can treat that illness very well. […] Unless God has ordained that he will be well, he will be well. If he says he won't be well, even if you take him to a doctor [he won't be well].
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> Focus group discussion with Muslim women, 9th June 2008

Whilst psychiatry is held by the Ghanaian government to be the only legitimate state-sponsored provision for the treatment of mental illness, a policy of community-based mental health care, as promoted by WHO, NGOs and international agencies, advocates commandeering 'traditional' resources in the care of the mentally ill, drawing on an imaginary of 'the extended family', the 'local community', and the traditional healer as 'native psychotherapist' (Brautigam and Osei 1979), a counterbalance to the moral degeneracy of modernity and its pathological consequences. These plans echo the advice to strengthen family support offered in the conclusions to the colonial reports of Cunyngham-Brown and Tooth. However to date attempts to introduce community mental health care through training community psychiatric nurses

and primary health care workers have been limited in scope, retaining an emphasis on the dispensing of medication, and inevitably concentrating specialist services in urban areas. Whilst the imagination of sufferers and their families may retain, however tentatively, hope for a miraculous cure, the approach of the state seems at times to demonstrate a failure of imagination, caught in a cycle of repeated attempts to create a pale imitation of the psychiatric systems of industrialised societies in response to the initiatives and funding of external donors, and offering little in the way of locally-grounded alternatives in terms of treatment methods, outcome, or family support. Yet, as this research shows, such an approach fails to acknowledge the limitations of biomedicine in the treatment of mental illness which have long been recognised, not only by professional psychiatric dissidents, but by those most affected: those who take psychotropic drugs and those who care for them.

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