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COLLEGE OF HUMANITIES
SCHOOL OF SOCIAL SCIENCES**

THE ROLE OF THE ASANTE TRADITIONAL HEALERS IN THE
MANAGEMENT OF MENTAL DISORDERS IN GHANA

BY

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Declaration

I

declare that except for references to other scholarly works which have been duly acknowledged, this research work I carried out in the Department of Psychology, University of Ghana, Legon, under the supervision of Dr. Samuel Atindanbila, and Dr. Joseph Osafo, is the result of my own research work and that it has neither in part nor in whole been presented in this University or elsewhere for another degree.

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Dedication

I dedicate this work to the SACRED HEART OF JESUS whose mercy and love, through several persons who believed in me, have brought me this far.

To HIM be the highest glory.

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Abbreviations and terms

IRIN	Integrated Regional Information Network
MoH	Ministry of Health, Ghana
TMPC	Traditional Medicine Practitioners Council
ATH	Asante Traditional Healers
WHO	World Health Organization
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders (fourth edition)
DSM-5	Diagnostic and Statistical Manual of Mental Disorders (fifth edition)
ICD-10	International Classification of Diseases (tenth edition)
APA	American Psychology Association

ABSTRACT

The role of traditional healers in Africa, in general, and Ghana, in particular, cannot be underestimated. The many reasons leading to this could include, but not limited to, inadequate access to quality health care in terms of facilities, health personnel and affordable health care. Inasmuch as efforts have been put in to standardize the practices of traditional healers to offer health services in Ghana, there seem to be challenges especially in the area of mental/psychological health service. This research report gathered and documented the role of traditional healers in the handling of mental/psychological disorders in Ghana and limits itself to Asante Traditional Healers (ATHs). The report sought to find out the common mental disorders handled by the Asante Traditional Healers, the diagnostic criteria and/or tools with which they conduct their mental health service, their ways of treatment as well as their evaluative plans. It is a generally qualitative designed work yet having amount of quantitative data as a form of validation. Participants included forty-five (45) participants within the Asante Kingdom: these included fourteen practitioners, one in-charge chief and thirty (30) of their clients. Interviews and questionnaires were used to gather data. This was between May and June 2017. After appropriate analysis it came out that the ATHs sometimes really attend to real cases of mental and psychological disorders through divination and other means and they attempt to manage the cases to some level of successes amidst some few challenges. The write-up include some few suggestions for further research.

CHAPTER ONE

INTRODUCTION

1.0 Introduction/Background

The place of traditional healers in Africa, in general, and Ghana, in particular, is becoming increasingly important in the recent times. This may be due to a couple of factors. Very obvious of these factors is access to quality health care which is essential to every human survival as well as proper functioning in life has remained a challenge in most part of Africa. Access here, is seen either with regards to health facilities, health personnel or affordable health care. For instance demographics in Ghana, show according to Integrated Regional Information Network (IRIN) report that, for a population of almost 23.5 million, there were only 1,439 health care facilities in 2007 (IRIN, 5 August 2008). This reflects how even those who get access may have to struggle at these centers, perhaps because of higher numbers against limited personnel.

The irony of it is that these health facilities are not evenly distributed across the country. It is evident that most of the rural areas lack adequate health care facilities as well as personnel; like doctors and nurses. This assertion is supported by a study by Van den Boom, Nsowah-Nuamah & Overbosch (2004) which revealed that “Ghanaians on average live about 16 km from a healthcare facility where they can consult a doctor, but half of the population lives within a 5 km radius: the other half cannot consult a doctor within 5 km, which corresponds to a 1 hour walking distance, and one quarter even lives more than 15 km from a facility where a doctor can be consulted (Van

den Boom et al., 2004, p. 4, 20). Many people in the country still rely on either self-medication (Van den Boom et al., 2004) or traditional means to access health care which are cheaper and easily accessible (WHO, 2003). No wonder this concept of restructuring of traditional approach to mental care goes beyond Ghana and has been preferred to orthodox medicine in many developing countries (Abdallah and Prinz, 2009).

With all these challenges facing the country, the alternative as indicative above, that is traditional medicine which is easily accessible and cheap seem not to have had attention until recent times (it may be noted that efforts had been made in Ghana since the 60s). It was not until the year 2000, that the government enacted the Traditional Medicine Practitioners Council (TMPC) Act, Act 575 for the establishment of Traditional Medicine Council which is tasked with the responsibility of the registration of all Traditional Medical Practitioners. This came in handy and till now there are several registered traditional healers and medications to which people get access. However these may seem polarized towards herbal medicines for many and diverse health problems as against another rather important health issue namely: mental health; meanwhile traditional healing systems still play a significant role in help-seeking behaviour for the mentally ill on the continent, despite advances in western-style psychiatric services (Quinn, 2007).

Demographics show that in/out patients in terms of mental illnesses seem to increase by the years in Accra 34,801 (2011) 39,536 (2012) 35,898 (2013) Pantang 20,822 (2011) 23,331 (2012) 23,360 (2013). The worse of it is human resource which according to the Ghana Ministry of Health report (MoH, 2007), remains a major problem in mental health care. The report quoted 500 psychiatric nurses for 22 million people in Ghana, giving a ratio of 1 nurse to 44,000 people. The ratio for consultant psychiatrists is 1:2 million people. Thus posing "...a great challenge to accessibility and quality of care. Mental health services are skewed to the southern sector as there

is no psychiatric hospital north of Accra” (MoH, 2007). Meanwhile there are currently over 45,000 traditional healers in Ghana alone and thus leaving majority of the populace, mostly in rural areas, consulting traditional healers on issues of mental health (Ewusi-Mensah, 2001), many as the first point of call for an individual or their family (Roberts, 2001) perhaps due to beliefs in a spiritual origin of mental illness. We may note that whether issues are based on common cultural/traditional or spiritual beliefs or unknown scientific facts; these people more often get some level of treatment or intervention that relieves them of their conditions.

Current studies by scholars like Ae-Ngibise, Cooper, Adiibokah, Akpalu, Lund, Doku, & Mhapp Research Programme Consortium (2010), Atindanbila & Thompson (2011), Chowdhury (2012), Ofori-Atta, Read, and Lund (2010) as well as Smith (2003) ended up recommending some high level of collaboration between traditional, faith healers, orthodox psychiatrists and psychologists in the treatment of mental illness. The last two, namely; the orthodox psychiatrists and psychologists, may have had some high form of documentations and standardization in terms of assessments, diagnosis, treatment and treatment plan, etc; however the same could not be said about the traditional and faith healers. This has led to severe stigmatization against the traditional and faith healers perhaps due to unstandardized nature, leading to speculations and superstitions.

This could be the reason why those who patronize the service of the ATHs most often are unsure about the results from their form of treatment. The researcher believes that if enough material is gathered about all levels of traditional mental health care and with it standardize them, Ghana and Africa as a whole will stand at a greater advantage at easy access to quality and affordable mental health care.

1.1 Statement of the problem

There has been no consensus reached in psychiatry and psychology with reference to mental health. The issues range from whether it is to be considered as a medical discipline or a psychological issue, whether it is globally or socio-culturally defined or whether it should be classified as pathological or as normal stressors or problems of living. All these depend on how mental conditions are viewed and thus diagnosed. For instance globally now, the DSM-5 and ICD-10 offer an opportunity to confront these conceptual issues and improve the validity of psychiatric diagnosis. However these same documents recommend that cultural factors should not be underestimated. The consideration of the cultural factors may include the main, well-recognized and defined cultural variables, high level data on family, explanatory models within the cultural as well as global context, and individual differences based on surrounding conditions.

To a very high extent orthodox psychiatry and psychology advanced in terms of standardization and documentation in the management of mental disorders: evident for example in most Western oriented documents as DSM-5 and ICD-10 as mentioned above. However, when it comes to our African and for that matter, Ghanaian traditional healers there is lack of this standardization. Research into the activities of traditional healers has been done by many scholars in Ghana and they include; the mode of healing, their beliefs, conditions of service, implications of their activities, as well as stigma attached to their services and their patients. Yet till now there is no well documented materials leading to a holistic “clinical in-patient” process in the management of mental disorders by the traditional healers in Ghana: from their diagnostic process and criteria, through treatment plan and modalities to evaluation of a successful treatment, which will be a collective representation to Ghanaian traditional healers for which knowledge could be

tapped: Thus the basis of this research is to find a collective view of the Asante traditional priests' role in the management of mental disorders. It will therefore seek to find out the common mental disorders handled by the Asante Traditional healers, their diagnostic criteria with which they conduct their mental health service, their ways of treatment as well as their success ratings.

1.2 Delimitation/Scope

The main aim of the study is to explore the common mental disorders handled by ATHs, their diagnostic tools, treatment modalities, the success rates of the treatment processes and the challenges of the treatment processes. Therefore, participants: will include the traditional priests/priestesses of the Asante traditional jurisdiction, and will consider the actual sub-chiefs in charge of the spiritual healing in that jurisdiction. The research will also include sampled clients of the above mentioned who may be “diagnosed” with mental disorders by the ATHs. The research will be limited to Schizophrenia, Depression, Anxiety Disorders and Alcohol Dependency Syndrome.

1.3 Research objectives

The purpose of this research is to:

1. find out the common mental disorders handled by ATH
2. examine the diagnostic tools used by the ATHs
3. describe the treatment modalities of the ATHs
4. find out the success rates of the treatment processes of the ATHs

5. identify the challenges of the treatment processes of the ATHs

1.4 Research questions

From the above objectives the research report will hope to answer the following questions; all in the context of schizophrenia, depression, anxiety disorders and Alcohol Dependency Syndrome, as follows:

1. What are the common mental disorders that the ATHs handle?
2. How do ATHs diagnose a person with mental disorders?
 - a. Criteria
 - b. Tools
 - c. Elements
3. What goes into the treatment plan for mental disorders?
4. How accurate are their uses of diagnostic tools?
 - a. successes
 - b. challenges

1.5 Research Design

This research design will be a convergent mixed method. This study addresses holistically, the therapeutic journey of the ATHs in attempt to treating clients with various kinds of mental disorders. This design will be used, and it is a type of design in which qualitative and quantitative

data are collected in parallel, analyzed separately, and then merged. In this study, quantitative data on various mental statuses of clients of ATHs, to be gathered with a modified questionnaire will be used to access the efficacy claims or success claims of ATHs that predicts their claims of accuracy of diagnosis leading to accuracy of treatment plans and treatment. The qualitative data which would be gathered from in-depth interviews from the ATHs will explore their views of common mental disorders, the diagnostic criteria they use to conduct their mental health service, their ways of treatment as well as their success ratings. The reason for collecting both quantitative and qualitative data is to strengthen the knowledge claims (qualitatively) with statistical data to back them.

A qualitative research is “an inquiry process of understanding” where the researcher develops a “complex, holistic picture, analyzes words, reports detailed views of informants, and conducts the study in a natural setting” (Creswell, 1998: 15). In this approach, the researcher makes knowledge claims based on the constructivist or advocacy/participatory (Mertens, 2003) perspectives. In qualitative research, data is collected from those immersed in everyday life of the setting in which the study is framed. Data analysis is based on the values that these participants perceive for their world: Ultimately, it “produces an understanding of the problem based on multiple contextual factors” (Miller, 2000: 34).

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This section takes a critical look at other experts' view on the subject matter of this thesis' topic. After all there would not be any honesty to invent or create anything from scratch, without enquiry and building on views from and of others, as if experts have not dealt on any aspects with regards to music and its industry before, would be inefficient and irresponsible. The researcher thus agrees with Bowman when he opines, that "shared understanding of foundational beliefs and values is vital to any claim to any professional status" (Bowman, 1998: 132). This means that the review of the literature below would provide a methodological rationalization for this work/research (Hart, 1998). Literature herein this theses (not limited to this section only though it carries the chunk of it) would review topics like: common psychological and mental disorders in Ghana, world view of general ailments and mental ailment in Africa, elements of a diagnosis and treatment, diagnostic criteria and descriptors, psychopathology and psychotherapy in Africa, and Ghana, culture diagnosis and treatment from an African view; among others all in the aim of informing the materials of this research, answering the research questions as well as guiding in data gathering and analysis.

2.2 Common psychological and mental disorders in Ghana

Records on prevalence of mental health in Ghana can be difficult to access (Read, Adiibokah and Nyame (2009). This might be due to poor record keeping coupled with majority of patients preferring traditional or indigenous treatment which are, most often than not, done without proper documentation. However a few researches done by individuals and international agencies as well as the scanty documentations from the mental health facilities show that just a hand full of the various mental and psychological disorders come up in the country. These according to Read (2012) as suggested by other researchers included mental disorders such as psychosis, depression, substance misuse and self-harm (Appiah-Poku, Laugharne, Mensah, Osei & Burns , 2004; Asare, 2003; Osei, 2001a, 2001b; Lamptey, 2001; Laugharne & Burn, 1999; Redvers, Appiah-Poku, Laugharne, 2006). Thus she suggests future research on the cultural context of these disorders in Ghana. In confirmation of Read's report the World Health Organization (WHO, 2007) in its country summary series on Ghana found out that the top three mental disorders that were reported at the various psychiatric units in the country in 2002 only were schizophrenia recording 1,599 cases representing 25.32%, substance abuse, 1101 representing 17.43% and depression, 736 representing 11.65% (Asare, 2003). The full table of this report shows below.

Rank	Diagnosis/cause of admission	Number of cases	%
1	Schizophrenia	1,599	25.32
2	Substance abuse	1,101	17.43
3	Depression	736	11.65
4	Hypomania	629	9.96
5	Acute organic Brain syndrome	495	7.84
6	Manic depressive psychosis	343	5.43
7	Schizo-affective psychosis	284	4.50
8	Alcohol dependency syndrome	215	3.40
9	Epilepsy	191	3.02
10	Dementia	131	2.07
Other cases of admission		592	9.37
Total		6,316	100.00

Table 1: Source: World Health Organization (WHO, 2007)

For the sake of details and better in-depth work, the researcher would want to pick out just three and organize the report around it. Ideally it would have been better to consider the top three. However, after an initial contacts with Nana Duruwaa (the president of ATP Association) it came out that without recourse to well collected and documented records; yet based on her experiences and interaction with her members, ‘Abodam’ (schizophrenia), substance abuse, alcohol dependency syndrome and what she could not really label but described to be manic depressive psychosis, ranks high among cases that come to them. It is in this context that this research would be limited to these three common ones in Ghana; namely Schizophrenia, substance abuse, and

epilepsy. This is not to say the others do not exist. But for the sake of in-depth findings; this research will be limited to Schizophrenia, depression, manic depressive psychosis, substance abuse and alcohol dependency syndrome.

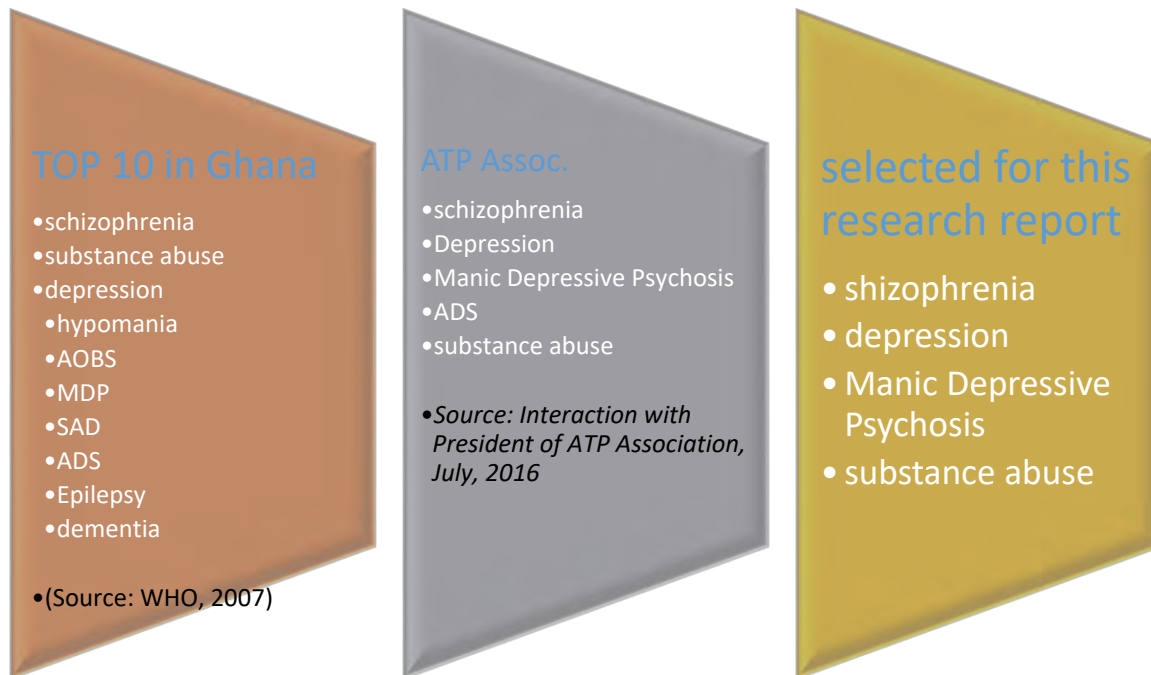


Table 2: Focused selected psychopathologies or Mental Disorders in this report

2.3 Elements of a Diagnosis, Diagnostic Criteria and Descriptors

There may be a couple of manuals that have formally and/or informally guided the practice of psychiatrists, psychologists and even counsellors in their practice with regard to mental and psychological issues. Two main ones that have dominated are the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* and the *International Classification of Diseases (ICD)*. These have gone through stages now the DSM is on its fifth (5) edition and the 10 for ICD. Thorough

exegeses show that apart from the suggested clinical features that they recommend for practitioners to be on the lookout, *frequency and intensity as well as cultural factor are serious key indicators for diagnoses* (APA, 2013; ICD-10). This is to help in the practical, functional and flexible auxiliary to the practitioner and is intended for use by trained counselors in different contexts and facilitates a common language to communicate the necessary characteristics of mental disorders present in their clients (APA, 2013). It is therefore recommended that after assessment of diagnostic criteria (clinical manifestations), clinicians may have to consider application of disorder subtypes and/or specifiers as appropriate as well as the severity and course specifiers should be applied to denote individual's current presentation.

For instance in DMS-5 the suggestion is that after an assessment of the clinical features, a qualification of specific criteria for defining severity in terminologies such as mild, moderate, severe, extreme; is encouraged: thus apart from clear note like, specifiers indicating course e.g., in partial remission, in full remission etc, severity specifiers must be provided to guide clinicians in rating intensity, frequency, duration symptom count, or other severity indicator of disorder indicated by instruction "Specify current severity" (APA, 2013). This will be aside the descriptive features specifiers that would be provided, such as obsessive-compulsive disorder, with poor insight. Not all disorders include course, severity, and/or descriptive features specifiers. It has become clear that psychopathology can be viewed not only as absent or present, but dimensionally, via measures such as frequency and severity that can assist in determining a therapeutic path (Kessler, 2002; Krueger et al. 2005; Saha et al., 2006).

2.3.1 Schizophrenia

This is a form of mental disorder whose definition and description has evolved with time. It is generally seen as a group of related mental disorders that share some symptoms, for which reason it is considered a spectrum (DSM 5, 2013). These common symptoms affect the persons' sense of what's real and also affects how he or she thinks, feels, and acts. These symptoms must be devoid of any significant impairment in intellectual functioning of the person. This is the most distinguishing characteristics of condition and is important to the icing of its diagnosis according to most diagnostic systems (e.g., APA, 2013). There are some main presenting symptoms, these include among others; catatonic, disorganized, paranoid, residual, and undifferentiated. It is argued that there is considerable evidence of a genetic predisposition to develop schizophrenia. Again empirical evidence prove that elevated levels of dopamine are related to symptoms of schizophrenia.

Other times evidence have also shown that differences in brain structure (abnormalities in the frontal and pre-frontal cortex, enlarged ventricles) have been identified in people with this condition. Despite the above, research have suggested that this condition normally presents itself in three main dimensions (Curran, & McHugo, 1997; Van Der Does, Dingemans, Linszen, Nugter & Scholte, 1993), namely; positive symptoms, negative symptoms, and cognitive impairments.

2.3.1.1 Positive symptoms

These are the somatic and cognitive experiences as well as behavioral expressions that are in contrast to reality (Copolov, Mackinnon, & Trauer, 2004). Examples include hallucinations; either auditory or visual like hearing or seeing non-existing stimuli, delusions like having a strong

feeling or belief that the some person(s) hate(s) them or they are greater than reasonably possible or some person(s) intend harming them; and finally bizarre and/or disorganized behavior. This could include among many others, sitting or standing or assuming a particular posture regularly for no justifiable reason, dressing in an extremely inappropriate manner, or not even dressing at all (Bentall, Corcoran, Howard, Blackwood, & Kinderman, 2001).

2.3.1.2 Negative symptoms

On the other side of the positive symptoms are the ‘absence’ signs. These refer to the diminution of thoughts, feelings, or behaviors which are on a normal regular situation should have been present in any person at a given time and condition (Breier, 2005). Common among these are the blunted or flattened affect (e.g., unreflective/under-reflective facial expressiveness), reduced propensity of speech, anhedonia, apathy, psychomotor retardation and/or inability to start a physical activity when there is not physical illness or impairment (Tandon & Greden, 1990).

On a normal day there could also be some other symptoms that could be associated with this condition. Among these are negative emotions/cognitive processing like depression, anxiety, and anger, suicidal ideations and tendencies (Freeman & Garety, 2003). These negative emotions, according to scholars normally happen during the early stages of its manifestations and attenuate as the active psychotic symptoms come up (Birchwood, Iqbal, Chadwick, & Trower, 2000).

Finally most often, and associated with the positive symptoms, is the assumption and manifestations of violence. Persons with this condition are normally seen as violent or otherwise dangerous. However research shows that this behavioral expressions are rather on a lower rate (conf. Swanson, Holzer, Ganju, & Jono, (1990); Monahan, Bonnie, Appelbaum, Steadman, & 2001; Dean et al., 2006), and could be as low as 8%.

2.3.1.3 Diagnostic criteria

Clinically, in diagnosing schizophrenia there must be a combination of three main domains; contextual socio-cultural factors like degree of work, social, or self-care impairment, symptoms (positive and negative) which must have been consistent for about 6 months or more and finally possible differentials. DSM-5 (APA, 2013), for instance consider that there must the presence of two or more of five symptoms (delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, or negative symptoms). It goes further to suggest that one of these be must be *delusions, hallucinations, or disorganized speech*. It also considers all the above three domains as well as the duration of onset.

2.3.2 Substance abuse, substance induced psychosis and substance dependency syndrome.

Linked to the positive symptoms and negative emotions normally found with schizophrenia (its manifestations, diagnosis and management) is substance use disorders. Epidemiological surveys have seen to conclude that most persons with psychiatric disorders usually abuse substances or are having some level of substance dependency linked to its cause (aside other risk factors or causes) and often too have an increased risk for alcohol and drug abuse (Mueser, Yarnold & Bellack , 1992). For two reasons; namely the misuse of illicit drug quite high in Ghana and that the ATHs seem to see it as one of the main disorders they regularly handle, a brief look at literature around it. It may be noted that drug misuse has become a major concern in mental health in Ghana today. Some research has revealed that this is phenomenon is high in senior high schools and tertiary educational institutions in Ghana (Adu-Mireku, 2003; Akyeampong, 2005).

The DSM-5; (2013) gives quite an elaborate protocol for assessing and leading to an eventual diagnosis of a substance use disorder. This protocol revolved around 10 main drug classes which included, among others; alcohol, cannabis, phencyclidine, other hallucinogens, inhalants, opioids, sedatives, stimulants, tobacco, and other/unknown (DSM-5, 2013). It insisted on evidence of continued use of the found substance even if it was causing a level of significant injury or discomfort to the person. A main issue here is a change in the user's neurological circuitry; its effects persist long enough after the substance has been used. Again this neurological disturbance should be causing a significant level of behavioral stress manifesting itself in the user's behavior and can therefore be linked to relapse. These behavioral stress may be grouped under four broad labels; namely, *impaired control, social impairment, risky use, and pharmacological criteria*.

2.3.2.1 Impaired control

This is normally the case where the user is either unable to accomplish a simple task of cut back on use, or it looks like clinical intervention must be applied in order to cut back on use, and/or even if the first two would work, it would have to take much more time and effort. Generally symptoms include, among others, strong craving for the substance because of prior use. For instance this strong craving is triggered by the mere presence the company with which he/she uses the drug or the sight of the location of usual use, or similar occasions of use among others: in brief when the strong desire to use the drug then becomes so obsessive.

2.3.2.2 Social impairment

This is the cases where the person is unable to function fully in his rather usually functional environment where he/she could have on a daily bases function well. It could even be the inability to carry out ‘normal’ tasks and obligation or would prefer the use to engaging in social activities.

2.3.2.2.1 Risky use

Emphasis on risky use is on continues use of the substance even though there is imminent danger and/or obvious inception of danger by the use of the substance. It involves the use of the substance when there is a clear danger or perceived vulnerability to a physical/psychological/social issue(s) that would likely be made worse by further use.

2.3.2.2.2 Pharmacological criteria

This focuses on tolerance as well as issues on withdrawal. Tolerance described as a state where there is a progressive increase in the dosage of a drug or substance/drug by a person just to have the same/similar desired effect. On the other hand withdrawal or dependency could also be the case of talking about pharmacological issues. World Health Organization considers this condition as ‘a cluster of behavioural, cognitive and physiological phenomena in which the use of substance or a class of substances takes on a much higher priority for a given individual than other behaviours that once had a greater value’, (WHO, 2015). In summary it is a somatic reaction to specific stimuli from the continual/consistent use of a substance. Usually there are feelings of trembling, cold or hot feelings, hot-flashes, headaches, diarrhea, and drowsiness among others.

The DSM-5 puts all the above in summary and suggests that: Substance Use Disorder (SUD) could be considered if at least two or three of the following checklists are present within a period of at least 12months:

1. The substance is often taken in significant amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control its use.
3. So much time and effort is put in at obtaining the substance, use the substance, or recover from its effects.
4. There is a strong desire or urge for its use.
5. The frequency of its use results in a failure to fulfill major role obligations at work, school, or home.
6. Its continual use even in obvious harm caused or exacerbated by the effects of the substance.
7. When the substance use is preferred to better social, occupational, or recreational activities.
8. Recurrent use of substance even in situations in which it is physically harmful.
9. Continual use even in full appreciation of its use harming and having recurrent physical or psychological problem and this could have been the case because of its use.
10. When there is tolerance (outside official medical recommendations). And
11. When there is withdrawal (APA, 2013)

2.3.3 Depressive disorders

Among all the mental disorders depression seem be the most common (Waraich, Goldner, Somers & Hsu, 2004). Clinically they come with common symptoms like feelings of sadness, anhedonia, as well as abnormal increase or decrease in sleep and eating patterns. Others include feelings of worthlessness, and at the extreme suicidal ideations or even attempts. Hybels, Landerman and Blazer (2012) had suggested that these conditions could be very disturbing and usually have more negatively impact the quality of life of those afflicted.

The DSM-5 (2013) considers this condition as a cluster of illnesses which include, among others; disruptive mood dysregulation disorder (which normally applies only to children below 18years of age), Major Depressive Disorder (MDD), persistent depressive disorder, premenstrual dysphoric disorder, substance/medication-induced depressive disorder, and depressive disorder due to a medical condition. Generally in any of these there could be the presence of the few of the following for a specified period of time; anhedonia change in appetite, change in sleep, agitation or slowing loss of energy, decreased concentration/ trouble making decisions, thoughts of death/suicide as well as feeling guilty or worthless.

However the same document is very emphatic on the point that there are other similar conditions that may seem to mimic any of the above but may not be considered as such. These may include: firstly, presentations of depressive mood after a significant life stressor (in any form) even if it is for a short time when the person(s) is not able to adjust smoothly (this may be found under adjustment disorders, DSM-5); secondly, in cases where, a previous manic episodes oscillates into a depressive episode (as in bipolar disorders) and lastly, when the person(s) episodes could be better accounted for by another diagnostic category. In such cases the other category supersedes MDD; examples could be the case of bipolar disorder or schizoaffective disorder.

2.4 Psychopathology: an African perspective

There has always been a debate on whether psychological abnormalities could be considered universal or culturally specific. For instance Toldson and Toldson (2001) are of the view that the basic yardstick for labeling or diagnoses and perhaps treatment in psychopathology theory stem from clinical and general psychology and must therefore be placed in context of the individual within a cultural setting even though in the broader idea of its universalistic nature. This position could later be inferred by Tseng (2006) with the argument based on what could be classified as psychopathology which must be the sum of the symptoms that make up a clinical condition (Tseng, 2006). It would be therefore vital to contextually understand that symptoms constituent of a condition that is evidenced by the patient in the context of his/her culture. However social scientists think that inasmuch as every culture is unique, it will still find itself in the light of other cultures. This may be due to interpersonal, intergroup, international-relations, economic, political, and subjective dynamics (Draguns, 2000). In this light Tseng (2006) may soften his position by agreeing to the fact that culture-related disorders is always in the sea of a cross-cultural psychopathology; hence contemporary transcultural psychiatry is attuned to appreciate this position (Tseng, 2006). However scholars like Bird (1996) on the other hand think that there is no way in which a distinction between conduct behaviors that are symptoms of an internal mental or psychological dysfunction from those that exhibit a negative environmental or socio-cultural context; thus arguing for a rather universality of mental disorders or psychopathology.

2.5 Culture and diagnoses

From the above arguments it may be quite reasonable to say that defining, diagnosing and even treating of psychopathologies could not be effective unless it is linked to cultural and contextual factors. This is in the backdrop of the fact that every society's culture influences how its members manifest, report symptoms and seek treatment. No wonder Sam and Moreira (2002) opine that culture and mental illness are more or less embedded in each other and that a good knowledge of the role of culture in mental health is crucial to comprehensive and accurate diagnoses and treatment of illnesses. This discourse seems to be supported by Kaplan and Sadock (2003) that "meanings, values and behavioural norms that are learned and transmitted in the dominant society and within its social groups culture powerfully influences cognition, feelings and self-concept as well as the diagnostic process and treatment decisions" Kaplan and Sadock (2003).

Earlier; Castillo (1997) had identified a couple of clues to consider when it comes to psychopathology or mental health. Among these were:

- I. the individual's own personal experience of the illness and associated symptoms;
- II. how the individual expresses his or her experience or symptoms within the context of their cultural norms;
- III. how the symptoms expressed are interpreted and thus diagnosed;
- IV. how the mental illness is treated and ultimately the outcome.

If all the above are anything to go by, then diagnoses of any mental disorder or psychopathology as well as its treatment should be culturally contextual. A term "*biopsychocultural*" was therefore coined as an approach by some scholars in the hope that it might offer the discipline, clinical

psychology, with knowledge of the importance of culture in the lives of people regarding mental health (Gurung, 2006; Gloria & Ho, 2003; Gloria & Rodriguez, 2000).

In 2007, a systematic review of hundred-and-two worldwide population-based studies of ADHD was done by a few psychologists (Polanczyk, Silva de Lima, Horta, Biederman, & Rhode, 2007). The results came to support the above that there were significant differences in the prevalence estimates found between North America, Africa and the Middle East. However, it was not so among North America, Europe, Asia, Oceania or South America. The researchers identified differences in instrumentation, methods and definitions used across studies (Polanczyk et al., 2007). This goes to suggest that even within the same society there might be a difficulty at a consensus as regards diagnosis among clinicians.

2.5 Culture and treatment from an African view

The inclusion of cultural considerations in diagnosis and management of psychiatric and psychological pathologies have being, in the past few decades, very crucial. However there are varying views from experts with regard to what extent this should be used and how it may be used. This idea seem to be strongly supported by the WHO (2001)'s Geneva report that a more sophisticated modern way to safely assume a near-to-accurate diagnosis is to actively consider cultural elements in the process.

In fact the normal practice in a regular psychiatry history of clients and patients do not cover only neuro-biological matters: they include the client's/patient's presenting complaints/symptoms, socio-cultural life, family history among others which is aimed at arriving at a comprehensive perspective of the patient's experience. It is only when this is achieved that a holistic treatment is earned or achieved. This practice has come to stay, as it were, ever since

Lewis-Fernández (2009) openly criticized the DSM-IV that it had ended up trivializing the issues of culture in diagnoses and rather sought to take the stance that difference and heterogeneity were superficial and unimportant when it came to diagnoses.

In fact there have being two schools of thought that argue from two angles on this topic. One is “cultural relativists” who are of the view that psychiatric/psychological pathologies cannot be considered separately from a person’s socio-cultural context. Supporting this stance, Fabrega (1992) defines culture in this context as, “. . . a system of meanings that is learned, that provides people with a distinctive sense of reality and which helps shape behavior and affective responses” (Fabrega, 1992, p. 91). This means therefore that the psychiatric psychological world view and reaction towards mental events depend on their cultural and social background. On the other hand the “universalists” hold that there is the physical/biological similarity that runs through humanity and this overrides culture. Patel, and Winston (1994) had taken the position that seem to suggest that “universality” in psychiatric/psychological diagnoses and treatment should be based on biological etiology. They opined that psychiatry, just like any medical matter, must seek their basic protocol on physiological or biological change. Interestingly both perspectives seem to acknowledge the role of socio-cultural dimensions; the difference, I believe is the level or prominence it takes.

On a deeper level, recent studies have revealed that socio-cultural factors do not just play one sided role in psychiatric/psychological pathologies. There are several interplaying roles that, according to experts, these socio-cultural factors play in mental pathologies. Tseng (2001) for instance found out at least six (6) interplaying roles that play herein: the first are the “pathogenic effects” he explains that culture is a direct causative factor in the prognosis of mental illness. The second are “patho-selective effects” which he thinks that reaction patterns of the brain can be

cultural and its negative resultant could be psychopathological. The next is “patho-plastic effect”. He explains that socio-cultural factors mold psychopathological symptoms. He also talked about “patho-elaborating effects”. This is where he believes socio-cultural factors explain how a person’s conditions could either be acutely exaggerated or tamed. The next was “patho-facilitative effects”. He thinks that relapses and frequencies of occurrence could be influenced by social or cultural factors. The final one is “patho-reactive effects”. He again explains how culture could influence perception and reaction of both patients and their caretakers which could in turn affect the whole cycle of the condition.

In brief if psychiatric or psychological pathologies could be defined and linked with psychosocial disabilities as well as functioning (Lopez, Mathers, Ezzati, Jamison, Murray & Washington, 2006), then it goes to say that socio-cultural factors cannot be underestimated. This leads us to consider the African and for that matter the traditional Ghanaian view on psychopathology and mental illness.

2.6 Psychopathology from the Ghanaian perspective.

Every culture has its unique way of seeing and interpreting life and its related matters. This is same in the Ghanaian culture and even further more vary from one community to the next. Oduro, Hennie, Nussbaum and Brain (2008) for instance think that “...there is an African way of understanding God ... in the same way, there is an African way of understanding the world, the visible world around us – the cattle, trees, people and cities as well as the unseen world, the supernatural world of spirits, powers, and diseases” (Oduro et al. 2008:9). Health and disease in Africa is a holistic thing. It “...consists of mental, physical, spiritual, and emotional stability [of]

oneself, family members, and community” (Omonzejele, 2008, p. 120). I believe that once the world view and understanding of prognosis of illnesses of a group of people are understood; prevention, diagnoses and treatment would be purposeful.

2.6.1 Causes of psychopathology

The view of health and disease in African is an integrative one. This is based on their unitary view of reality (Omonzejele, 2008). This means that disease and illness are not just as a result of organic factors but mental state, spiritual stability of both the individual as well as the community.

In Africa, to be sick and more seriously if its mental or psychological could be as a result of either an inappropriate behavior to self (as an individual or collective), against the values and norms of the traditions of society (Iroegbu, 2005) or a breach of cordial relationship or balance between the mundane and the supernatural (Setswe, 1999).

Mbiti (1990) in this regard asserts that:

Only in terms of the other people does individual become conscious of his own being ...
When he suffers, he does not suffer alone but with the corporate group ... Whatever happens to the individual happens to the whole group, and whatever happens to [the] whole group happens to the individual. The individual can only say: I am because we are, and since we are, therefore I am. (pp 108–109)

From the above we can safely say that in the world view; diseases and poor health can result from attacks by evil or bad spirits when they are offended or when person(s) do not relate well with their ancestors. However due to the same reason the ancestors themselves can punish the

persons(s) when they are not treated well. (Westerlund, 2006). Nyamiti (1984) supports this view by suggesting that it is “when ancestors are neglected or forgotten by their relatives [that] they are said to be angry with them and to send them misfortunes as punishment” (Nyamiti, 1984. p16). In addition, it is believed that disobeying taboos and rules can be a major cause of illness (Gyekye, 1995). On the day-to-day modus-operandi, spell-casting, curses in the name of the river deity, witchcraft, among others are the usual direct causes of sickness. Olupona (2004) believes that these are normally done by wicked men or women with evil powers who may be aggrieved.

If these are the causes of sickness then the WHO (2000) definition for its diagnoses, and management termed “*traditional medicine/health care*” comes in handy as “...the total combination of knowledge and practice, whether explicable or not, used in diagnosing, preventing or eliminating physical, mental and social diseases” (WHO, 2000:1; Kofi-Tsekpo, 2004). This type of health care was earlier on noted to have come from, according to Helms and Cook (1999), some naturally selected and helpful beliefs and practices cultures/societies in their quest to treat or manage their indigenes in their ailments.

2.6.2 Traditional practitioners in mental and psychological health in Ghana.

In the traditional setting, mental health service is solely offered by persons who have been strictly chosen by the gods and ancestors to carry out such duties. These are greatly revered and feared by the community; and are persons with the solemn vocation centering on the choice of ‘abosom’ (the gods). Among the ATHs, for a person to be chosen as a traditional priest, there must be some rules and criteria for measuring a genuine call into priesthood. Ekem (2008) reveals that essentially a sign of possession by a particular deity/god who inhabits the individual must be

evident. In such events an experienced priest in the field may be called upon to determine the originality or otherwise. Normally these go through thorough training: that is after they have been called to that service by the gods, ghosts, ancestors or dwarfs. The training generally are either in the context of residency with a seasoned practitioner or in solitude in a forest by the dwarfs or spirits. They go through rituals, tuition, practice, meditation and/or self-discipline. These trainings, according to Ekem (2008:48), could range between periods of “six months to four years or more, depending mainly on the trainee’s submissiveness and ability to learn.”

Appiah-Opoku, (2007) opined that

...entry into the ranks of training lasts three years or more under tutelage of a senior priest or priestess. The training process is described as quite arduous, rigorous and lengthy. The novice is charged with learning the character, songs, dances, and loads of information about their personal deity as well as other known deities. Other pertinent information such as family and community rituals, medicines and protocols are taught. They become the repositories of Akan history, community knowledge and traditions, customs and taboos that are revealed during this period of training. Most of the information is privileged information and shared only on a need to know basis, perhaps not on the same level as other ‘*akɔmfɔɔ*’. Every ‘*ɔkɔmfɔɔ*’ has the opportunity to acquire knowledge of traditional medicine, use of herbs, roots, and other items nature provides.

Owusu-Ansah and Donnir (2017), reveal that the traditional practitioners for mental health may include the ‘*odunsemi*’ (herbalist), the ‘*ɔkɔmfɔɔ*’ (priest), ‘*ɔsɔfo*’ (the pastor/spiritualist) or simply ‘*ɔpanin*’ (wise ‘elder’). The attention in this write-up will be on the “*ɔkɔmfɔɔ*”.

2.6.3 ɔkɔmfɔɔ

These are the main “priests” of the Akan culture and tradition. They are considered as the intermediaries between the spirit and the physical worlds; and thus considered ‘the eyes of the spirits’. They may also be known as traditional healers, African traditional priests, and herbalists (Sarpong, 2002). It may be summed up that the role of a traditional healer seems to be all round. The traditional healer among the Asante is a counsellor, consultant for every facet of life; including physical, psychological, spiritual, economic, moral, and sometimes legal matters (Asamoah-Gyadu, 2014).

2.6.4 Diagnosis

The underlying issue upon which ATHs base their processes of diagnosis is “divination”. Croucamp (2013) suggests that:

“...divination is a technology that is used to deliberately initiate a process of accessing and collecting information, through the use of randomly arranged symbols and then, using the brain’s capacity for analogical thinking, making associations that are ordinarily inaccessible. It is therefore a transpersonal field of information to gain healing knowledge”. (p. 4)

When this information is done, then they (he) will know whether to use either spiritual or physical and a combination of therapeutic processes.

2.6.5 The process of healing

If the above arguments of experts are anything to go by; that is the health issues of the African and Ghanaian for that matter is unitary and involves both mundane and spiritual matters, then the process of treatment and healing will not be different. Thorpe (1993) suggests therefore that the Ghanaian view of healing process is holistic. It would therefore include among others physical, psychological, spiritual and social ingredients. None of these can be left out, that is, spiritual and physical.

Truter (2007) suggests that:

“...traditional healing is intertwined with cultural and religious beliefs, and is holistic in nature. It does not focus only on the physical condition, but also on the psychological, spiritual and social aspects of individuals, families and communities”. (p. 57)

2.6.6 Spiritual process of healing

2.6.6.1 Spiritual protection:

Sometimes the ATHs may perceive the illness as coming from attack(s) from evil spirits or evil wishers. When this is the case, the ATHs would find some means of performing some rituals to protect the client first before any form of remedy is administered. These protective rituals

may include, among others, making of body marks, wearing of amulets, and spiritual bathing. According to Westerlund (2006), the rituals may drive off evil and dangerous powers, spirits or elements.

2.6.6.2 Appeasing the divine:

In situations where the illness is as a result of either an inappropriate behavior to self (as an individual or collective), against the values and norms of the traditions of society (Iroegbu, 2005) or a breach of cordial relationship or balance between the mundane and the supernatural (Setswe, 1999), the offended divine (gods, ancestors, spirits etc) is appeased. These could be cases caused by an invocation of a curse or violation of taboos among others. The nature of this process again depends on the severity of the case, by either sacrificing an animal or by pouring of libation. In most cases the cost is borne by the client or their caretakers. Some of the ritual items include; specific and spotless animals, schnapps, ‘akpeteshie’ [traditional liquor], calico (red, white or black) etc (Insoll 2010).

2.6.6.3 Sacrifices:

Normally, the first of the protocol needed to proceed with on traditional healing is the sacrificing of an item or two. These may range from less expensive and common items like schnapps, fowls, palm-wine to expensive and rare things items like goats, cattle, owls etc. It may be noted that these items may be at the request from the spirits, gods, and ancestors (Olupona, 2004). These are done to pave ways for the healing process, or in order to consecrate some herbs and sometimes as a way of spiritual connection between the priest and the spirits. This, they consider as basic and very necessary since they base their services on the sanctions of the divine and ancestral (Idowu, 1973).

2.6.6.4 Counselling

One very significant process during the therapy session is counselling and advice giving. Normally the sick person or their caretakers are advised on how to arrest the situation; these pieces of advice ranges from issues of life style, behaviours, rituals, through to the kind of food the person should or should not eat. This is mostly done when it is an issue of a violation of a taboo (Sundermeier, 1998). On a usual day when clients fail to follow these counsels it can happen that the ancestors or spirits dwarfs etc who may be protecting them may withdraw and the results could be a stalling or worsening of the already bad health condition of the client and can even open doors for other illnesses, deaths, as well as other misfortunes.

2.6.6.5 Exorcism:

It is a practice of expelling demons or evil spirits from people or places that are possessed, or are in danger of possession by them. Exorcism is usually performed by a person with special religious authority, such as a priest or shaman. The practice was common in ancient societies and was based on the practice of magic. Ancient Babylonian [civilisation], in what is now Iraq, had special priests who would destroy a clay or wax image of a demon in a ritual meant to destroy the actual demon. The ancient Egyptians and Greeks had similar rites. Many religions in various parts of the world continue the practice of exorcism. (Encarta, 2009)

Sometimes it could happen that the client may be suffering the ill-health as a result of some evil spirits or forces they may be possessing. This could be as a result of a curse or some behaviours that had invited these spirits. This process, according to (Avorgbedor, 2000) is most often

performed for those who are mentally challenged. They include processes like singing, drumming, dancing, the spraying of powder, bathing with blood of animals, washing of cloths in order to drive away the evil spirit by touching the body of the possessed person several times with the 'bodua' until the process is complete.

2.6.7 Physical process of healing

In case the healer thinks or perceives the mental illness as physical or having a physical source, they would normally prescribe the following:

2.6.7.1 Herbs and clays

Normally the healer and the prescriber first would consult the spirits who would show them specific single leaves, roots, backs, seeds, flowers or fruits of certain plants. Other times it might be so form of rocks or clays that are processed (Lartey, 1986), into forms like: concoctions, emulsions, ointments and powders. These would be pre-prepared or solely prepared by the healer who will give directions as to how it must be administered. Administration could be either by mouth, inhalations, and instillations into the nostrils, anus, sex organ, eyes and the ears. It could be combined with specific waters from specific water bodies or with alcohol, oils, honey, sap from other plants, bloods among others before it is applied (Ayim-Aboagye, 1993). Senah (1988) in agreement to this asserts these healers have the belief that every illness should have a corresponding plant or animal source remedy.

2.6.7.2 Surgery

Sometimes and again depending on the instructions from the consultations with the spirits the traditional doctors may perform surgeries. These could among others, include: circumcision,

bone setting, minor to major foreign material removal from the body, and scarifications. For instance in the treatment of certain diseases or illness, the healers may use knives to make incisions and insert medicine beneath the flesh. Occasions like this the healer can mix some fruits, seeds, herbs, roots and/or plants for the purpose of the healing. This could be considered antibiotics, hemostatic agents, anesthetics or purely spiritual use. There could be alcohol or water solvents to aid this or used as creams and/or powders.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This section discusses the research design, area of study, population/participants, sample of the population, sampling technique, and instrument for data collection, validation of the interviews, administration of the instrument and method of data analysis. According to Silverman (2006), it is important for the researcher to be mindful of every pertinent ethical issue at each stage of the research process, that is, from the research design stage through to writing of the report.

The following ethical issues were addressed:

A formal request and proposal for ethical approval was sent to the Ethics Committee for Humanities (ECH) of the University of Ghana, Legon. This was done in October, 2016. It was approved and cleared on 25th November following which data was gathered. Due to the researcher's relationship with most of the ATHs, there was no need for any formal introductory letter to be obtained from the Department of Psychology, University of Ghana, Legon, introducing the researcher and confirming the researcher's identity to all who may be involved. This was ascertained when pilot and initial contacts were made prior to the proposal stages that he could walk in at any time to get any information for the thesis. This did not change on the field and interaction was smooth. However, all protocol regarding consent was duly followed. All except two of the participant personally signed the consent form. The remaining two had it signed for them due to literacy reasons. Even these latter ones had everything explained to them before the

signing. Indeed all witnesses also signed their portions. Regarding the clients, all or their gradients signed after explanation was given and confidentiality was assured. For this reason none of these would be referred to in this write-up by name. With the consent of the ATHs, all agreed to have their names used in full.

Lastly all the necessary protocol at each shrine was observed. In all but one shrine, a bottle of schnapps and a token of fifty Ghana cedis were offered to the shrine as entry protocol. The (KK and OO) who were interviewed as a pair refused to accept the entry protocol on grounds that they feel ‘it is our duty to educate people about the gods, so we don’t and shouldn’t charge for such a noble course’ (KB).

3.1 Area and timing of study

The study concentrated in the Ashanti region of Ghana where all participants were interviewed between May 2017 and June 2017.

3.2 Sample and sampling

A good knowledge about who to sample out for information or data as well as right sampling techniques are crucial to improving the quality of research synthesis (Patton, 2002). It is in this light that Kemper, Stringfield and Teddlie (2003) identify a couple of principles that should inform researchers in their selection of samples. One of the principles is that the sample should be able to generate a thorough database on the type of phenomenon under study. In this study, for instance on ATHs’ role in mental health, where not much data already exist, such a thorough data from “experts” and right sources would increase the reliability of its findings. They (Kemper et

al, 2003) also talk about the fact that apart from ethical standards, efficiency and how feasible the data gathering could be, the sample should at least allow the possibility of drawing clear inferences and credible explanations from the data which cannot be underestimated in this research. Other good reasons why issues on sampling are so important include the fact that a good sampling plan allows the researcher to transfer/generalize the conclusions of the study to other settings or populations; in this case mental health in Ghana.

It is in this regard that the sensitivity of expert views with regard to this topic will call for a purposeful sampling of Asante Traditional Priests as well as current/on-going clients from whom credible data could be gathered. This is consistent with Suri (2007) who suggested that a quality academic research or thesis is bound by the pragmatic constraints of time, resources and access to information and expertise; which may call for a purposeful sampling and reduced (as much as possible) sample size.

Eventually the population for my study included of all traditional priests within the Asante Kingdom. The sample was forty (40): fifteen (15) practitioners for the qualitative aspects and twenty-five (25) clients for the quantitative aspects. These twenty-five clients of the ATHs were sampled as a way of validity regarding the common mental disorders that the ATHs who were sampled claimed they usually handled: The breakdown and brief profile of the samples are provided below; for the sake of ethics and confidentiality all, apart from the Chief in charge of priests (Nana Nsumankwaa Hene), the president of the Asante Traditional Priests Association (Nana Duruwaa) and the Chief Executive Officer of the African Diaspora Clinic (Nana Kwame Subunu) whose authority would be needed and who agreed to have them interviewed on record; however the identities of all other respondents were presented in this report in alphabetical codes.

Nana Nsumankwaa Hene (personal communication, May 13, 2017)

He has been a Sub-Chief for the Asante Kingdom for 28years. The first 25years was as the “mpapahene” (a chief in charge of the fans that ventilate the Otumfoɔ and was elevated to the Nsumankwaa Hene (chief in charge of all traditional priests in the Asante Kingdom) in since 2012 by Otumfoɔ Osei-Tutu (II) with the stool name “Baffour Asabre Kogyawoansu III. He preferred to keep his age not mentioned. He is not a priest but is in charge of all priests. His work is to coordinate and manage all the affairs of the priests. He is the one who handles all issues concerning the gods, ancestors and all other foreign gods and priests that may have any relations with the Asante Kingdom. He also, on a daily bases handle all issues about curses mitted out to people and tries to settle these. He was interviewed in his home and palace at Kurofofrom; a suburb of Kumasi in the Ashanti Region of Ghana. This sets him as the main back bone of information in matters of the ATHs.

Nana Kwame Subunu (personal communication, May 15, 2017)

Nana Kwame Susunu is a 60year old man who has practiced as a priest for forty-seven (47) years. He is the CEO and the in-charge; African Diaspora Clinic (Abirem-Ashanti Region). This is a form of a ‘Westernized’ traditional healing centre. However it has professionally trained doctors and nurses that manages the biological conditions while he “...specialize in spiritual diseases. Spiritual diseases are caused by evil spirits or curses. Once you know about evil spirits and curses then you can treat spiritual diseases. We treat various spiritual ailments. The clinic also deals with Orthodox health care” (Nana Kwame Subunu, 2017). He (Nana Kwame Subunu) admits though that the number of times he treats cases of mental illnesses are minimal: “I treat mental cases too, but not too frequent. If the patient has been mad for long, I do not even admit him/her and attempt treatment because it won’t work. However, if is a fresh case say 3 months then it is easy to treat only if the cause is spiritual” he asserted.

His clinic was established as a result of his involvement with a patient who had convulsive episode in public and his ‘instant cure’ amazed some Americans who later offered to help him in this establishment. According to him

“Some time ago (he said he couldn’t remember exactly when but it is about ten years, from inference) some black Americans were here on a visit, when a child in a convulsion state was brought to me to be cured. I poured “*dudu*” (concoctions) on the child who recovered immediately. The black Americans inquired what I used to cure the child and I told them that it is herbs and once the convulsion is gone it won’t come back again. Because of what they saw, they supported me to set up this herbal clinic. They sent US\$6000. So I built the clinic and I started the herbal clinic but it was not progressing well. The people in this community preferred orthodox medicine so we had to convert to orthodox clinic. We now have a doctor, midwife and nurses working in the clinic. It is called African Diaspora Clinic because we got support from the Diaspora to build the clinic (Nana Kwame Subunu).

Nana Duruwaa (personal communication, May 14, 2017)

Nana Duruwaa is a 64year old woman. She has been a priestess for almost 43years. According to her “the gods called me at the age of fourteen years and was trained for seven years and was commissioned on 14th April 1973”. Since the past fifteen years, Nana Duruwaa says, the ATHs have tried to come together and work under one umbrella. She was selected to be the president of the Asante union of traditional priests in 2013, and has since been in that position. She was interviewed in Bomso a suburb of Kumasi at her shrine (Fofie shrine).

The rest of the seven leaders of the union

KB (personal communication, May 17, 2017) is a 32year of priest of the Onwi shrine. According to him he has been a priest for close to 15years now and deals with mental cases on a daily basis. He was interviewed at his shrine at Onwi with the 34year old OO (personal communication, May 17, 2017). He is a private traditional priest under the union. OO has been a priest for 15years and also deal with mental cases. He admits however that his is not as frequent as that of KB. Both are members of the leadership of the union. The next is NMA (personal communication, May 18, 2017) of the Tano Shrine in Fumesua (also a suburb of Kumasi, within the Ejisu district) NMA was the youngest member of the leadership with an age of 24years. He had been a priest, according to him, for a little over 8years now. He was interviewed at his shrine at Fumesua.

NT (personal communication, May 19, 2017) was also interviewed. She deals with mental cases. NK (personal communication, May 19, 2017) is a 57year old priestess who has practiced since infancy. According to her she was picked “up at 5 years and trained by the gods in the forest for 7years” and have since been a priestess. She therefore says she was trained purely by the gods and therefore has no master or god name. OYS (personal communication, May 19, 2017) is also a member of the leadership. She was 42years as of the time of the interview and had practiced as a priest for 25years. She was interviewed together with her linguist. OYS is the priestess at Aputogya, a village in the Sekyere East district of the Ashanti region.

A focus group of four was conducted on the remaining leaders since the researcher was fortunate to meet them together. Out of these, one was not part of the leadership but was

understudying these leaders and was in the area of mental health. They were: NAD (personal communication, May 20, 2017), a 74 year old priest who has been a priestess for 45years and serves the god of Maaban (the god of Maaban village; suburb of Kumasi). Her son was NB (personal communication, May 20, 2017), a 35year old priest who had been a priest for close to ten years after taking over from her mum who was now aging. He serves the same shrine. The other two were NKA (personal communication, May 20, 2017) and NKK (personal communication, May 20, 2017). NKA is a 40year old priestess who had ministered for just a year now. She was under studying NAD and her son. NKK is a 45year old priest who also deals with mental health and had been a priest for 15. He claimed and appeared to have much knowledge about ATHs and mental health.

Next was NAB (personal communication, June 1, 2017); he is the priest of the god of the Kune shrine at Kwanwoma, a village in the Ashanti Region of Ghana. He had been a priest for 8years even though he had studied and ministered for an earlier 20years under his mother who used to be the main priestess of Kune. He was interviewed with his linguist. His age will be taken out from this write up, at his request. The last but not the least was NFB (personal communication, June 1, 2017) who is also a priest for the Boame shrine in in Fumesua.

Below is a summary of the biodata for the ATHs who were interviewed (Excluding the Chief in charge of the ATHs):

3.2.1 Age –Sex Characteristics of Traditional Healers Interviewed.

Out of the 14 traditional healers surveyed, 5 were females whilst 9 were males. The average age was 47.8 years, with the youngest at 24 years and the oldest 74 years. Majority of the

respondents were above 35 years old, with no female below age 34. The details of the age-sex structure of the traditional herbalist interviewed are shown in Figure 1.1

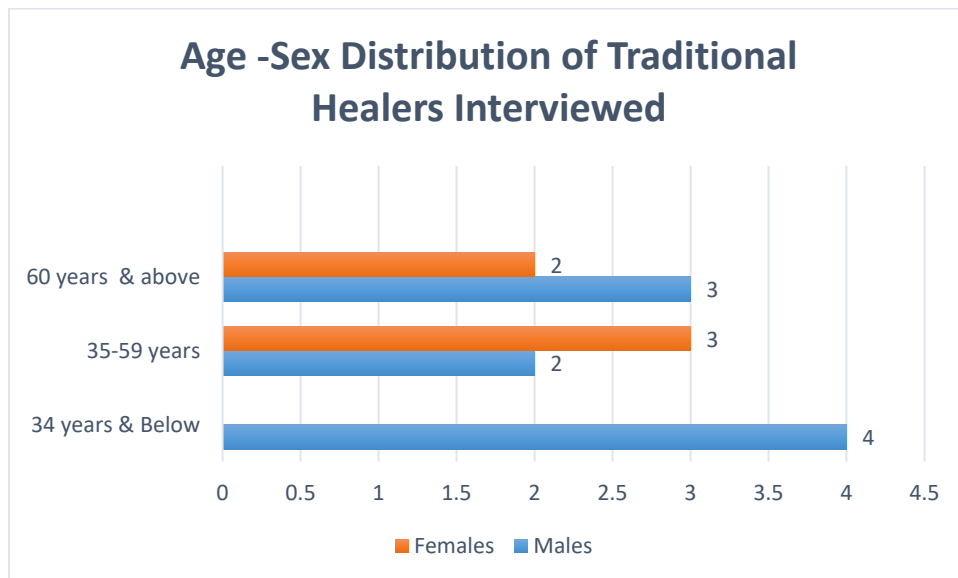


Figure 1: Age-sex distribution of ATHs interviewed

3.2.2 Years of Practice by Traditional Healers

The years of practicing traditional healing vary for different priest and priestess. The average year of practice recorded is 27 years. The longest serving healer has operated for 60 years whilst the least has operated for just a year. The distribution of years of practice by the traditional healers interviewed is presented in figure 1.2.

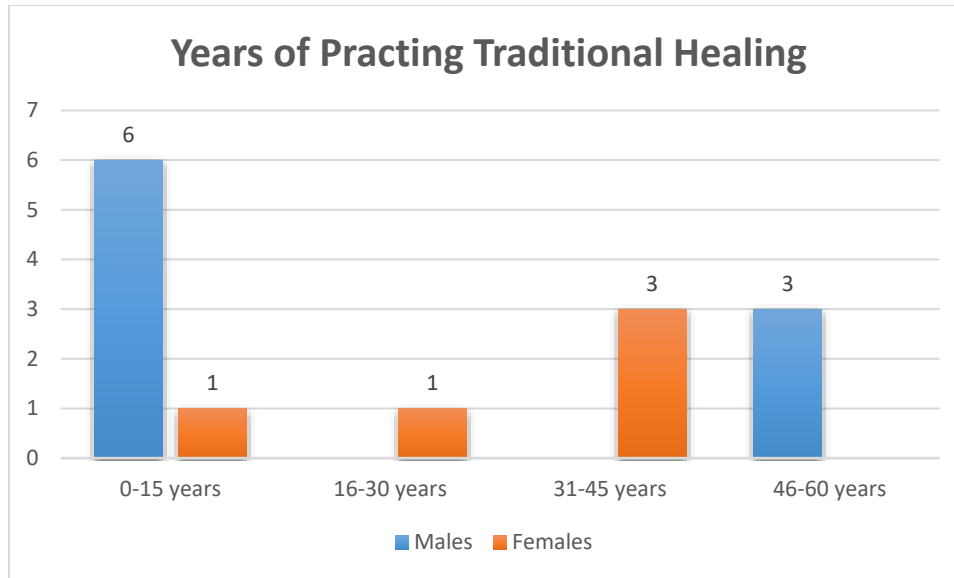


Figure 2: Years of Practice of ATHs interviewed.

Sampling process for the practitioners was a convenient purposeful (judgmental) sampling of these institutionalized leaders and authority manning the whole of the Asante sacred priesthood. An earlier contact with Nana Duruwaa (the president of the union) led us to the chief priest for the Asante kingdom and the rest were contacted. The researcher stopped at the number 15 which experts suggest that less than 20 participants in a qualitative study like this helps a researcher build and maintain a close relationship and thus improve the “open” and “frank” exchange of information (Crouch & McKenzie, 2006; Latham, 2013). This means that this sample size for the qualitative part of the study will be enough to provide data for this research.

Twenty-five clients of the five sampled priests who work mostly with mental cases.

For reasons of feasibility of data gathering and time bound research reporting; the thirty clients were to be selected through a two-stage sampling procedure. Out of these thirty clients, five (5) of them declined midway. Therefore twenty-five participants in this regard was used in this report. The total number of thirty (30) clients (of whom five declined) was arrived at because it was realized that the population of clients of ATHs with only mental issues may be too large and scattered for it to be practical to make a list of the entire population. A background check showed from Nana Duruwaa revealed that there are about five priests/healers who normally handle clients with mental or psychological issues. For the remainder of the ATHs, they may occasionally have clients. In view of this the following steps were taken at getting the thirty clients:

Stage one

The total population of clients with suspected mental disorders would be put into two (2) purposeful clusters; those who sort attention from general ATHs and those who seek attention from the ATHs who mainly deal with mental issues.

Stage two

The cluster representing the healers who deal with mental cases would be conveniently selected. This cluster would be divided according to the number of practitioners therein and quotas given per the total number (30) aimed at (even proportion). The *stratified sampling* was used, that is, sample was obtained by taking samples from each stratum according to their quotas. That is the number of healers in this cluster divides thirty and the number gained would be the number of cases selected from the camp of that practitioner.

3.3 Data collection

The main instruments for gathering data in this research report were interviews and questionnaire. A general interview guide was developed to ensure that the same general areas of information were collected from each interviewee (Patton, 2002). However a modified version, yet similar one, was used for Nana Nsumankwaa Hene (the chief priest). This was because he himself is not a priest but a chief in charge of priests. He may not be able to answer directly how the priests come up with their diagnoses and treatments. However, he has an overview of what goes on and the protocols they follow.

The researcher used a semi-structured-open-ended interview. This provided a more focused data than the conversational approach, but still allowed a degree of freedom and adaptability in getting the information from the participants. It was useful because even though there is a general protocol as found in this report, there were slight differences regarding each priest and shrine. These open ended interviews thus, helped with the rich data found herein this report.

It must be noted with importance here that history taking as well as Mental Status Examination (MSE) are considered the most important diagnostic tools in both psychiatry and psychology. They are the standard ways of obtaining information towards accurate diagnosis. Even though these have been standardized, in actual practice, they remain basically subjective with regard to how clinicians go about this process. Most often, if not always, the history taking and Mental Status Examination (MSE) are in the forms of verbal questioning and observations based on laid down checklists from manuals that are internationally accepted; namely, the DMS-5 and ICD-10. A questionnaire was therefore generated from prescriptions and indicators from the aforementioned manuals.

This generated questionnaire was used as a form of basic screening for various psychological/psychiatric conditions. The results were later used to triangulate the data gained from the interviews with regard to the common psychiatric conditions claimed to be handled by the practitioners. This basic screening was, as mentioned above generated to cross check with their clients to see if there were any traces of conditions.

The following format was followed:

- a. All the clients that ATHs claimed to be having psychiatric issues were noted
- b. These selected clients from this group were taken through the history taking and SME (following the questionnaire)
- c. The results were scored to ascertain the above claims as to whether there were traces of psychiatric/psychological challenges.

In doing this, the researcher used the aid of three research assistants to facilitate the pace of gathering data. They assisted with the interviewing of participants. Specifically they helped with the recording kits and supported in jotting notes as the main researcher led the interviews. Each assistant took particular identified practitioners and administered the questionnaires to his/her clients. The researcher took two each from the ATHs' clients thus numbering the five sampled clustered clients; each to the ATH sample practitioner.

All including the main researcher employed the following tools in gathering the data:

- Pens and note books
- Digital audio recorders

3.3.1 Supporting scale

Depression Anxiety Stress Scale (DASS; Lovibond & Lovibond, 1995) is a self-report measure, which consist of 42 items comprising 3 subscales namely depression, anxiety and stress. Each subscale is made up of 14 items. Items in the scale refer to an individual's expression of the above emotions over the past week. Each item is rated on a 4 point Likert scale from 0 which means "did not apply to me at all" to 3 "applied to me very much or most of the time".

The Depression subscale utilizes items which largely assess dysphoria, anhedonia, hopelessness, devaluation of life and inertia; The Anxiety subscale assesses acute responses of fear as well as somatic and subjective symptoms of anxiety, and the Stress subscale contains items which measure tension, agitation, irritability and difficulty in relaxing (Lovibond & Lovibond, 1995). These scales are considered to approximate various faces of psychopathologies such as presented in the domains of depression scale for mood disorders, as well as the anxiety scales for panic disorders (Brown, Chorpita, Korotitsch & Barlow, 1997). In the light of the above arguments and the facts in line with scope of this work; namely schizophrenia, depression, manic depressive psychosis, substance abuse and alcohol dependency syndrome, the items chosen served as a good ground for basic screening for all except for schizophrenia and substance use. In the latter cases, the other history taking protocol was used as found in the questionnaire.

There is strong empirical support for the use of DASS-42 amongst clinical and non-clinical populations (Lovibond & Lovibond, 1995). For example, Lovibond and Lovibond (1995b), using a large non-clinical sample ($n = 2914$) reported the internal consistency of the Depression Anxiety Stress Scales as 0.91, 0.84 and 0.90, respectively. These values are similar to those reported from clinical populations in studies by Brown et al., 1997 and Antony et al., 1998. Again this justifies

the use of items from this scale because the setting and procedure and the cases were not all purely clinical.

3.5 Data analysis

A conventional content analysis was employed in analyzing data. This is because the data collected was in verbal electronic form which, was obtained from narrative responses and/or open-ended interviews, reviewed related literature as well as observations from the researcher and research assistants as recommended by Kondracki & Wellman (2002). The researcher therefore delved into details and specifics of the data to discover important patterns, themes, and inter-relationships. The researcher deemed this form of qualitative design as fitting because it is usually appropriate when existing theory or research literature on a phenomenon is limited, as in this case. It may be noted however, that there is a fair level of literature on related areas but not on specifics to the objectives of this research. To avoid, using preconceived categories (Kondracki & Wellman, 2002), the researcher allowed the categories and names for categories to flow from the data. It may be noted that there was not a separation between data collection and analysis since the two overlapped. During data collection the researcher did a form of a thorough interim analysis-ongoing and iterative (nonlinear) process (Bazeley, 2009). This means that a mental analysis of whatever information or data that was being gathered was done in order to make it easy to code them during the after-data-collection analysis (Anderson & Kanuka, 2003). From the above, the following systematic procedure was followed:

3.5.1 Documentation

The first formal analytical step is documentation. The various contacts, interviews, literature review, memos were saved and transcribed appropriately. This documentation is critical to qualitative research for several reasons (Anderson & Kanuka, 2003). According to Anderson and Kanuka (2003), it is essential for keeping track of what will be a rapidly growing volume of material gathered (notes, tapes, and documents). This also provided a way of developing and outlining the analytic process; and will encourage ongoing conceptualizing and strategizing about the data gathered.

3.5.2 Priori coding and coding

Some form of “a priori coding” (Miles, 1994) was be done: these already codes were developed from literature review and earlier interaction with few experts and general knowledge of situation on the ground before the actual examination of the collected data was done. During this process the researcher put down memos in a note book; “memoing” as Bazeley (2009) puts it, “recording reflective notes about what is being learnt from your data”. Meanwhile all data and memos from interviews, observational notes, memos, etc was transcribed and saved both in hard and soft formats/copies with Word Processing Documents (MS Office Word). It was these transcriptions that the researcher later analyzed.

3.5.3 Developing Category Systems, discussions and conclusions

The researcher agrees with Miles (1994) that coding and developing category systems are major stages of any qualitative data analysis and are aimed at bringing meaning to any data collected. From the above raw data in MS word, labeling for emerging codes was done directly from the text and used as next step of coding scheme. These codes were be sorted into categories

based on how different codes are related and linked from both literature and data from field. The emergent categories were used to organize and group codes into meaningful clusters (Patton, 2002). The next step was to define each category, subcategory, and code that came up. This was done with objectives and research questions for this research in mind (Patton, 2002). It was after these systematic procedures that discussion of findings and conclusions were drawn to conclude the research report.

CHAPTER FOUR

FINDINGS AND DISCUSSIONS

4.0 Introduction and structuring

This chapter contains discussions on important materials and findings from data that the researcher was able to gather on the field: these include mainly, materials from interviews and questionnaires. It will also include pictures gathered from the field as well as tables, charts and other illustrative matters that have been generated from the data which are appropriate to this section. In order to make reading and comprehension easier, findings would be structured to follow directly the pattern of the research questions as stated in Chapter One. It would also be more topical and discursive. All respondents were introduced and described in detail (included were; when and how I met them) as found in Chapter Three in order to make the discussions flow well. Therefore, such names would be mentioned directly in the narrations in this and the next Chapter by the Researcher.

It may be worth noting that this and the next chapters would be structured on the modelling of research thesis by Murrison and Webb (1991). They, proposing the following such models means that it is possible, for the sake of clarity, to structure thesis report to suit the context.

Model 1	Model 2	Model 3
Results	Results and Discussion	Results
Discussion		Discussion and Conclusion
Conclusion	Conclusion	

Table 3: Source: Murrison and Webb (1991).

Based on the above, this and the next chapters would be structured as summed in the next table. This means in order to make this particular report meaningful and clearer, the whole work from this Chapter (Chapter Four) to Chapter five can be viewed within the context of this structure; without prejudice to the rules for graduate research report writing of School of Graduate Studies of the University of Ghana.

CONTEXTUAL MODEL		
CHAPTER FOUR	Part one	Issues regarding: 1. the common mental disorders that the ATHs handle; and 2. diagnosis
	Part two	Issues regarding treatment
	Part three	Issues regarding successes and challenges
CHAPTER FIVE	Summaries Conclusions	CLOSING
	Recommendation	

Table 4: Contextually created structured model; by researcher for chapters 4 & 5 (based on above model)

PART ONE

Nota Bene

In this and the next chapters with their sections some few traditional words would be used.

They are:

Abosomfie

This is the Asante-Twi word for shrine. Literally it is a two worded term, Abosom (plural for god) and fie (house); that is house of the god. These are houses, caves and/or sheds built purposely to serve as the spiritual home of a particular god.

Suman

This is a terminology used by some to represent the Asante-Twi word for god. It is considered as a minor deity who could mediate between a mortal being and the supreme God which they call 'Nyame'. Other synonyms for this word are: *abosom* (stone worship-singular is bosom), *nananom* (elderly ones, a respectful way of referring to the gods), *mpanimfoɔ* (older ones, another respectful way of referring to the gods), among others. Because these terms are used interchangeably in the language, they would be treated as such in this research report. In this case when an ATH mentions any of them, it will be reported just as such.

4.1 COMMON MENTAL DISORDERS OR PSYCHOPATHOLOGIES

The ATHs, from the data gathered suggest that they have in mind; almost all, if not all of, the psychopathologies or mental disorders stated in the World Health Organization (WHO, 2007)

country summary series on Ghana. From their (WHO, 2007) report as stated earlier, there are prevalence of schizophrenia, substance abuse, and depression in Ghana. Others in this regard included hypomania, acute organic brain syndrome, manic depressive psychosis, schizo-affective psychosis, alcohol dependency syndrome, epilepsy and finally dementia (Asare, 2003); being the top ten prevalent mental cases in the country. The main problem was that, the ATHs did not seem to have different vocabulary to qualify these different pathologies but put all into “adwene mu asem, or adwene mu yareε” (matters of the brain or mental disease). In fact majority of the disorders spelt out in the DMS-5 and ICD-10 are equally seen as disorders within the world view of the Asante tradition. Nana Nsumankwaa Hene summed these up in the following words when interviewed:

Every human behavior like ‘gossip, cheating, backbiting, hording/selfishness, sexual disorders like fornication, alcohol misuse, etc are all sicknesses... and... especially **if it is difficult to control it is a disease.** Uncontrolled stealing (kleptomaniac) which **cannot be stopped even if they are prayed for** are all ‘adwene mu yareε’..., some behaviors make someone want to be nicked and unkempt, walk without control, talk plenty, are just the minority of ‘adwene mu yareε’. There are others that are more of mental disease than these; but because the others they don’t appear tattered, people do not consider them as mental illness. Any behavior that **does not befit ones status or defies someone’s social expectation** that the person cannot stop is adwene mu yareε....

From the above it seems clear that issues that are even complicated as found in other manuals like the DSM-5 and ICD-10 are considered pathological by the ATHs. For instance the

issue of conditions which are nuisance to the person and society and usually having more negative impact on quality of life like; “**if it is difficult to control, it is a disease..., cannot be stopped even if they are prayed for ..., (and) does not benefit ones status or defies someone’s social expectation...**” (as highlighted above); are considered pathological by the ATHs (Hybels, Blazer, Pieper, Landerman, & Steffens, 2009).

From another perspective Trull (2005) presented three basic areas as checklists in this regard. This idea had been drawn from existing concepts. All these three dimensions were alluded to by the ATHs as per the data gathered. They are as follows:

Conformity to norms

This is when the individual’s behavior becomes deviant, outrageous, or otherwise non-conforming (whether statistically or social behaviorally), then he/she is more likely to be categorized as abnormal; example from the data, “...any behavior that **does not benefit ones status or defies someone’s social expectation** that the person cannot stop is mental illness” (Nana Nsumankwaa Hene). Another example could be what Nana Serwaa cited saying that “...for some others, they are not so violent yet they behave strangely- they don’t mind urinating when they are facing you, these are all madness...”

Subjectivity distress

This is when the subjective feeling/sense of well-being becomes an indication of maladjustment. This was evident in a sample suggestion from Nana Nsumankwaa Hene that:

For instance there are people who cannot stand the surprise of scaring them from behind even jokingly; they react so violently to a level of killing when it was just a joke. Again someone can be insulted as ‘stupid’ this will set him/her thinking for unreasonably long

time: he/she just can't understand why that insult and lead to loggerheads and will always remember when he/she sees you.

OYS adds another sample that "...in the spiritual realms or it could be *yare paa*...these ones can make the person very flat in affect and it keeps worsening as the individual grows." These are samples to support this point that the wellbeing of the individual becomes challenged.

Disability or dysfunction

This is where the psychological conditions become impairments and causes social and/or occupational problems. OYS stated that "...some people give birth and they become very flat and quiet that they cannot take care of their children: we give them medicine too." This could be a good example of social impairments in that the said person (with post-partum depression) is not able to function as expected of a mother.

All the above discussions are grounds showing from the data gathered that the ATHs have ideas, to some extent, about psychopathology. For the sake and limits of this write-up, however, I concentrate on schizophrenia, depression, manic depressive psychosis and substance abuse. However before that the following are data for the frequency of clients seeking help, gender ratio as well as age frequency of clients who seek help from respondents as gathered in this research.

Frequency of Mental Disorder Cases Recorded by Traditional Healers

All the traditional healers interviewed responded positively to ever treating patients with mental disorders. However, most of them, with the exception of two priests stated that treatment of mental disorder cases was not frequent. The number of cases handled by a priest or priestess

within a month differed. Those who asserted there was low turnout of mental disorder patients, reported receiving between 1 to 4 patients in a month or even less than 3 cases in a year. Nonetheless the priests who treat mental disorders frequently reported dealing with about 5 to 6 cases or more within a month. A priest attributed his reception of lots of mental cases to patients dislike for orthodox treatment methods such as giving of injections. In a discussion he asserted the following; “I get lots of them (mental disorder patients) every a day. It is because they don’t want to be injected when they go to the hospital so they come here”.

Gender of Mental Disorder Patients treated by Traditional Healers

In relation to the gender of people who mostly seek attention from ATHs, the respondents had different views on the gender of most of their patients. However majority, which is 9 out of 14 respondents, reported that the mental disorder cases reported to them mostly affected females than males. One priest stated that the ratio of female to male mental disorder cases treated by him was 8:2. The traditional healers further explained that women are susceptible to relationship problems and tend to think too much about men which affects them mentally. Those who thought incidence of mental disorder in males was more than that of females reported to them also attributed it to that abuse of drugs by men.

Age of Mental Disorder Patients treated by Traditional Healers

In terms of the age of mental disorder patients, 9 out of the 14 traditional healers recounted treating mostly adults rather than children. The age of the patients that are mostly treated is above

20 years. A priest pointed out that children rarely suffer mental disorder rather children are brought to his shrine for treatment of epilepsy.

4.1.1 Schizophrenia

This spectrum disorder have common symptoms that may affect the persons' sense of "what is real" and also affects how he or she thinks, feels, and acts (APA, 2013). All ATHs interviewed called it "adwene mu yares". Literature had revealed that the main presenting symptoms include among others; catatonic, disorganized, paranoid, residual, and undifferentiated. It is argued that there is considerable evidence of a genetic predisposition to develop schizophrenia. Again empirical evidence prove that elevated levels of dopamine are related to symptoms of schizophrenia. These could manifest themselves positively or negatively (Copolov, Mackinnon, & Trauer, 2004). Data from this research did not reveal detailed distinctions between and among these symptoms, as described by the ATHs. However allusions did not exclude any of the features described by scholars. Cross checking with the general screening of selected clients from the ATHs within the time specified it came out, as in the table below, that 76% of population showed an indication of having a schizophrenic symptoms, with 4% showing a strong indication of having schizophrenic symptoms.

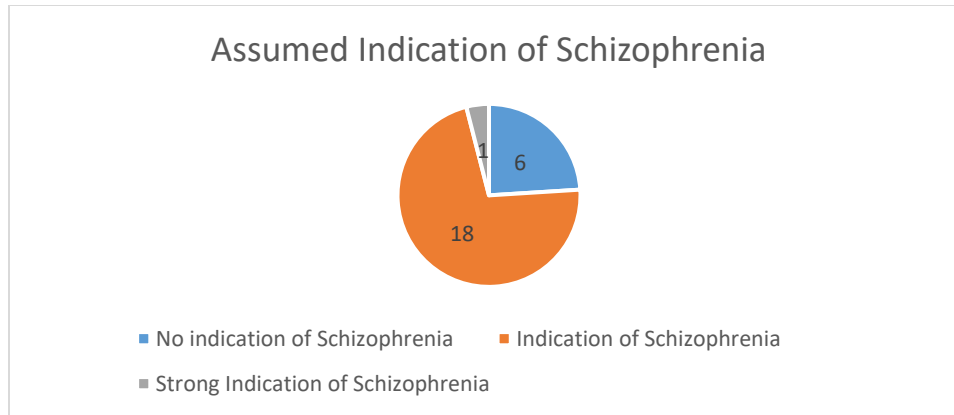


Figure 3: Chart of the assumed indication for schizophrenia

Themes arising from interviews from the ATHs regarding check lists with which they diagnosis persons are as follows:

Positive symptoms

When it comes to positive symptoms, Nana Duruwaa talked about somatic and/or catatonic symptoms by describing conditions where the person “...will cling his hands..., will be rigid bodily and the eyes drooping..., I look at the dressing and smell the odor etc. sometimes you can see the person panting for breath or feel the heart beating very fast and appearing very aggressive. All these say a lot”. In terms of paranoid signs Nana Nsumankwaa Hene said “...another is serious suspicious ideas. Example somebody dreams about you and will keep that as the gospel truth and will label you a witch anytime he/she sees you and will always be angry and suspicious...” Nana Nsumankwaa Hene again described situations where “...others see ‘totties wearing caps, rats wearing skirts’ and other plenty hallucinations; that will make someone frown or laugh unreasonably..., these tell us that mental illnesses are in several different forms....” This is a clear description of visual hallucinations. Such comments support literature that schizophrenia could

manifest itself in somatic and cognitive experiences as well as behavioral expressions which are in contrast to reality (Copolov, Mackinnon, & Trauer, 2004).

In this way other comments from Nana Nsumankwaa Hene suggested other manifestations of schizophrenia which are more contextual in terms of culture

...There are individuals; you will try to explain a simple fact for a long time till even the next day and he will conclude 'I will not understand'. Someone gets so angry so much that he can even commit murder... so any such behavior of a person is 'sickness'. But the main ones are those persons who react by wanting to commit murder. For instance there are people who cannot stand the surprise of scaring them from behind even jokingly-when they react so violently to the level of killing when it was just a joke. Again someone can be insulted as 'stupid' this will set him/her thinking for unreasonably long time: he/she just can't understand why that insult and lead to loggerheads and will always remember when he/she sees you...,

In this case the assertion of Sam & Moreira (2002) that culture and mental illness are more or less embedded in each other comes to play. This leads us to the general recommendation that a good knowledge of the role of culture in mental health is crucial to comprehensive and accurate diagnoses and treatment of illnesses. The idea that meanings, values and behavioral norms that are learned and transmitted in the dominant society and within its social groups, can powerfully influence cognition, feelings and self-concept as well as the diagnostic process and treatment decisions would fit in here perfectly (Kaplan & Sadock, 2003).

Negative symptoms

As stated above diminution of thoughts, feelings, or behaviors which should have been present in any person at a given time and condition (Breier, Berg, Thakore, Naber, Gattaz, Cavazzoni, Walker, Roychowdhury & Kane, 2005), were also alluded to. Nana Nsumankwaahene says "...Others include uncontrolled isolation, and refusal of food... moodiness...." Nana Duruwaa continues by saying "...We look at some things: like you say open your eyes and he will not mind you..., or the person is too quiet." In this way we realise that even though they may not be using the terminologies and commonly used axioms like reduced propensity of speech, anhedonia, apathy, psychomotor retardation (Greden & Tandon, 1991); they still consider these as mental disorders or psychopathologies.

4.1.2 Depression and manic depressive psychosis

The participants did not use any word in the Asante Twi that suggested depression or manic depressive psychosis. However some of the above symptoms and some few others suggested the existence of such a condition. If for instance the descriptions from Waraich, Goldner, Somers, & Hsu (2004) that common symptoms like feelings of sadness, anhedonia, as well as abnormal increase or decrease in sleep and eating patterns as well as feelings of worthlessness, and at the extreme suicidal ideations or even attempts are associated with depression then we can consider the following by the ATHs as symptoms of depression too:

...sometimes to I look at the texture of the eye balls and if it not strong or looking back I know there is something wrong...or if I realize he is sighing inappropriately

then I know..., and the eyes drooping and be laughing inappropriately..., marriage or something..., when they say things like ‘so why did you do that to me? You will never marry another woman’ and things like that I will quickly know it is marital issue...

This could easily depict any of the clusters of depression and the psychotic aspects of it. A general screening of selected clients from the ATHs within the time specified it came out in this regard. It came out, as could be seen in the table below, that there is an indication that all respondents showed some level of depression; however they were all in the minimum.

Depression

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 1	25	100.0	100.0	100.0

Table 5: Assumed indication for depression

This was not surprising as DMS-5 (APA, 2013) suggests that other similar conditions could arise that may seem to suggest depression but may not be so. The document included presentations of depressive mood after a significant life stressor. For instance Nana Duruwaa saying after all the suggestive symptoms that “...I will quickly know it is marital issue....,” could exclude this situation as indicative of depression. Data gathered could not find even a mention of situations where these symptoms and signs were in isolation on its own. In all these cases they (ATHs) were not be sure if there were previous manic episode oscillating into a depressive episode (as in bipolar disorders). This thus cannot there be a surety to the diagnosis of depression. However for the ATHs once the gods have spoken they are clear it is, in this case depression or depressive psychosis.

4.1.3 Substance abuse and substance dependency syndrome

The next theme/topic was substance abuse and substance dependency syndrome. It must be worth noting that all the ATHs mentioned “use of drugs” or “madness due to substance abuse”. This may not come as a surprise since research from scholars like Mueser, Yarnold, and Bellack (1992) revealed that epidemiological surveys suggested that most persons with psychiatric disorders usually abuse substances or are having some level of substance dependency linked to its cause and often too have an increased risk for alcohol and drug abuse.

It was therefore difficult, for the ATHs to differentiate between the actual conditions; that is whether the substance abuse or dependency syndrome stood alone or the substance abuse was triggering the psychotic conditions or it was the psychotic conditions that is making the person abuse the drugs.

Data from the interviews could not come as way over rated since the general screening revealed that 40% showed an indication of having a substance abuse disorder, with 20 percent showing a strong indication of having a substance abuse disorder. This was quite so much as found in the following table and chart.

Substance Abuse Variable

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 0	15	60.0	60.0	60.0
1	5	20.0	20.0	80.0
2	5	20.0	20.0	100.0
Total	25	100.0	100.0	

Table 6: Assumed indication for substance abuse

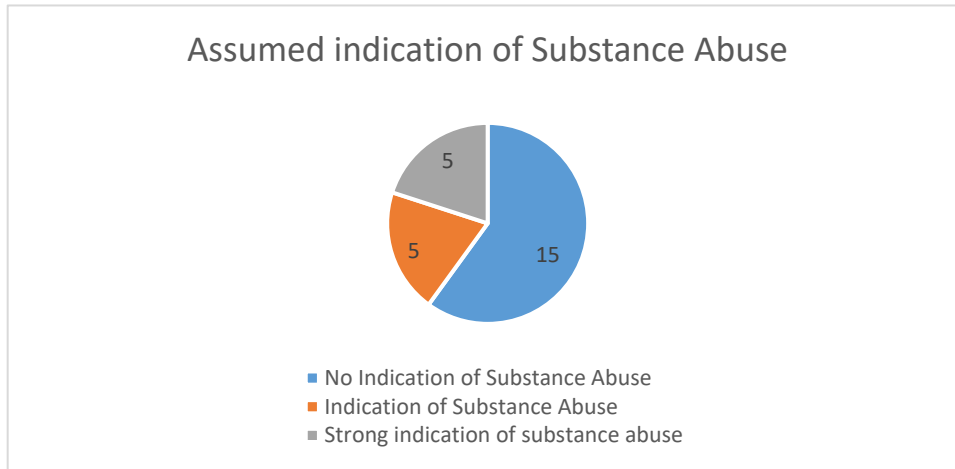


Figure 4: A Chart for assumed indication for Substance Abuse

NT sets the tone that "...the others are as a results of smoking weed, these normally happens to the intellectuals. They smoke a lot and when they are advised and they refuse to stop and they get mad..." Whether this is the case or not Nana Duruwaa gives out some of the symptoms and signs that "...Sometimes they smell either or unkempt life, they will not bath and all, or of the weed..., I look at the eye ball. The unrelaxed body or too tight muscles. I look at the dressing and smell the odor etc. sometimes you can see the person panting for breath or feel the heart beating very fast and appearing very aggressive." NFB continued in this direction that "...The patients who are mad as a result of smoking weed mostly talk to themselves or laugh continuously. Some persons become too rigid or very slow, whilst others are restless..."

Generally it seem to be that mostly the reliance on divination reduces that physical and behavioral assessments the ATHs use in classifying this disorder NK in narrating how he diagnosed and treated a client with substance induced psychosis said "...the first was the one with the substance abuse; I first of all went in to my shrine with the family. They put all before it. Even

though the persons had smoked secretly, it came out that it was as a result of this smoking and drinking...” This thus reduces the information about the disorders in terms of symptoms and signs.

Concluding part-one, the data gathered from the questionnaire revealed that truly the ATHs may be meeting persons with clear psychopathologies and/or mental disorders. The table below sums this assertion that almost all who were screened had one form or the other of a pathology. From the table below, 32% of respondents showed high levels of substance abuse. 24% of these showed high levels of schizophrenia while 12% showed that of anxiety. The remainder, that is, depression was at 32%; totaling a 100%.

	Frequency	Percent	Valid Percent	Cumulative Percent
substance abuse	8	32.0	32.0	32.0
Schizophrenic	6	24.0	24.0	56.0
Anxiety	3	12.0	12.0	68.0
Depression	8	32.0	32.0	100.0
Total	25	100.0	100.0	

Table 8: Percentage summary of various disorders screened

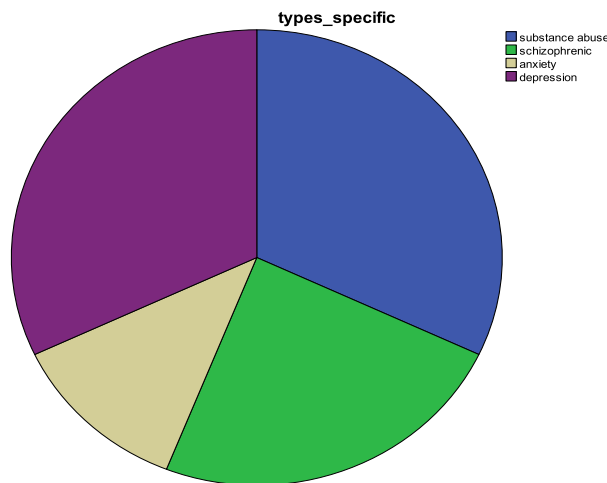


Figure 5: A chart of the percentages for the different assumed disorders screened

4.2 DIAGNOSIS

4.2.1 How do you get to know that the patient has a mental illness?

Data gathered from the interview with all 14 ATHs on diagnosis revealed one key word, ‘divination’. All the practitioners made allusion to the gods as the pivot to and the underlying factor to achieving any meaningful diagnosis. This confirms the ideology expressed through scholars like Croucamp (2013) that:

“...divination is a technology that is used to deliberately initiate a process of accessing and collecting information, through the use of randomly arranged symbols and then, using the brain’s capacity for analogical thinking, making associations that are ordinarily inaccessible. It is therefore a transpersonal field of information to gain healing knowledge”.

(p. 4)

NFB puts it subtly that they (ATHs) are “...only human but when we call “suman” and it comes, it is able to tell us the cause of the madness, whether it is caused by curses or evil spirits or addiction to drugs or by birth”. It seem to be the same thing that was said by NB when he responded that

“You know we are mortal men and we owe ourselves to the gods. So when you come we welcome and ask your mission as we did for you, we go behind to the gods to find out about what and what has happened to this person. They will in turn explain to us what may have happened. Then we move from there”.

This was also confirmed by Nana Kwame Subun they always "...go to the "Abosomfie" to ask the "suman".

All these come to confirm the place of divination and the gods in the life of the traditional African. It was earlier seen in review of literature that the world view of health and disease in African is an integrative one. This unitary view of reality (Omonzejele 2008) would perhaps inform the ATHs on the idea that disease and illness are not just as a results of organic factors but spiritual as well; in this case divination cannot, in anyway, be left of the diagnosis and treatment processes.

In Africa, to be sick and more seriously if its mental or psychological could be as a result of either an inappropriate behavior to self (as an individual or collective), against the values and norms of the traditions of society (Iroegbu, 2005) or a breach of cordial relationship or balance between the mundane and the supernatural (Setswe, 1999). In this way Nana Kwame Subun would put it that "...when we call "suman" and it comes, it is able to tell us the cause of the madness, whether it is caused by curses or evil spirits or addiction to drugs or by birth".

Once this undertone is established the researcher went on to find out the actual processes in traditional diagnosis. The first theme that arose obviously was the 'spiritual processes'.

4.2.2 The Spiritual process or divination during diagnosis

'You do not just start attending to the client. You call nananom' (NK). This seems to run through the process of diagnosis by the ATHs. All 14 members of ATHs made this assertion. For instance OKB stated that "...well we need to go to the shrine and ask the shrine about the problem. And the gods will tell us about the whole thing about what is going on". Words like "go to",

“invoke”, “consult” and “call on” were used for this process. OKB for instance would put it as “...we invoke the spirits and we consult them”, while Nana Boame would say “...I consult nananom about what caused the disease”. NK said “...I go to the gods and pray...” It was realized that all these terms were being used interchangeably to mean the same thing. The difference was the approach. Different approaches and procedures were expressed by the individual priests and priestesses. The main blocks of approach found were as follows:

Prayer and libation

Nana Duruwaa puts it straight by saying “I pray to the gods who come upon me and they will tell what the situation is.” In doing so, the priests or priestesses may either use only verbal incantations or a combination of this with the pouring of libation. NB confirms this by saying “...we invoke the spirits and we consult them. We take eggs and schnapps. We use the drinks to pray, as in libation: during this time we chant with the schnapps and tell nananom that they have visitors. So they should come.” Others like NMA said “...In consulting the elders “nananom” we use schnapps..., the schnapp is used for praying before we consult nananom.”

Three, out of the fourteen, priests interviewed would use prayers and libation in invoking the gods to act. This supports the findings of Insoll (2010) that some of the ritual items include; schnapps, ‘akpeteshie’ [traditional liquor]. There was a deviation by NAD who refuse alcoholic beverages as all the others say; “...for me I don’t like hard drinks so all I need is malt drink. So when I take the malt drink and I whisk the tale I get all that the gods want me to know.” This was the only priest who deviated from the norm.

Bell ringing and sound making

NK said "...I go to the gods and pray with my small metal bells. When the bells are sounded the god will know we are calling it so it will come..." NB on the other and said he would "...invoke the spirits and we consult them..., during this time we chant with the schnapps and tell nananom that they have visitors. So they should come." This brought out one of the ways by which some of the ATHs invoke the link between the mundane and the divine in order to diagnose any form of disease.



Figure 6: A picture of the metal rattle held by an ATH

Item offering

Sometimes in order to invoke the spirits or gods some items may have to be offered to the gods. Insoll (2010) stated that most often the traditional priests may use some 'ritual items' which include among others; specific and spotless animals, money, schnapps, calico (red, white or black), eggs and cola. In fact the list seem endless; "Sometimes the gods can request for knives and cutlasses and even guns..., the gods will use to defeat those who are causing the illness if that is the case..." OYS would say. These latter items however was explained further by Nana Duruwa that "...the rest like the whisk and the sward and the knives and the rest all not directly used by us, they are the tools or weapons of the gods that they themselves us for their processes like healing, fighting against the enemy and the rest."

The data gathered here supported this. NK said "I take two-hundred Ghana cedis and I go to the gods and pray with my small metal bells"; whiles Nana Serwaa will consider using "... alcohol and chicken and sacrifice on the gods and tell them that I have a case". In all these the impression is that there seem to be the idea of item collection and sacrificial rituals that run through all; yet they vary from one shrine to shrine.

4.2.3 The process of divination and arrival at diagnosis

Now, after all these items are gathered, the main issue is how divination is done to arrive at a diagnosis. Running through the interviews three main procedures seem to pop up: the rapport or initial session, actual spiritual consultation and the interpretation.

Rapport/initial session

The underlying issue is that almost if not all the priests and priestesses rely solely on the gods through divination, Croucamp (2013). Therefore the initial or rapport session is just the normal traditional welcoming and “mission finding” [asking of why person(s) came to the shrine]. It may be noted that traditionally there is always a consultation fee of a sought whenever one enters the shrine. Therefore after the traditional welcoming “I interact with the patient’s family when they arrive to find out what has brought them here. The people then tell me what their problem is...” as NT would have it. Nana Subun subtly puts it that just when clients come “On arrival, patients are given card at GH5 and consultation fee GH5. This is paid before we interact with the client. We assess the condition of the patient to find the problem before we take it to the “Bosom panin”. This particular could be so perhaps because his shrine is fused with the diaspora clinic so things are done to mimic the orthodox hospitals. Nana Kunadu Tiwaa will “take 200gh”; KB puts it that “...for me you give me schnapps. Nana Duruwaa says “You bring an egg; then you say all you problems on it”. In summary the initial rapport session involves welcoming and the settlement of consultation fees.

Actual spiritual consultation

After the initial rituals are done the next is to consult the gods. This starts with the personal preparation of the priest. NK says “But before is go I wear my spiritual smock and that is it.” It is after this that the prayers, incantations, rituals and others are done. For NK: “I sometimes take schnapps and cola. For the cola is mash it and use it to mark myself with it before going in to see nananom..., ...first you pour the schnapps on the gods and ring the rattles then instantly they come.

For KB, "...you give me schnapps..., you pour at my back. Then you give me cola for a ritual. Then I will also use the same eggs to speak back the issues to you with interpretation".

Others like NAD "...use horse whisky and misbaha/tasbih for the Muslims. But for me I don't like alcoholic drinks so all I need is malt drink. So when I take the malt drink and I whisk the tale I get all that the gods want me to know.

For Nana Duruwaa, the client will "...bring an egg; then you say all your problems on it. After that you cast the egg on the gods and the gods will let us know everything. Somethings I use cowries. This you cast on a mat; it will display particular pattern and this pattern will be interpreted. Others use cola. But as for me, I mostly use the eggs. Other items like the whisk and the sword and the knives and the rest are not directly used by us, they are the tools or weapons of the gods that they themselves use for their processes like healing, fighting against the enemy and the rest."

Interpretation

It is after rituals such as these that there is a connection between the mundane and the spiritual. When this connection is done, then the "gods will reveal everything". This may be done in countless ways: it could either be a direct insight from the gods through specific means of communication.

Nana Kunadu Tiwaa puts it this way;

...when it comes it has its own things it does and will just reveal how and why and what is happening; like this and that and that is what has happened to you. The god will actually have somethings like incense that is burns. As the smoke comes out it will ask you the client or your caregivers to speak onto an item it will give you. After that this item will be taken from you and dipped into the smoke. When this is

done flames will spark from the smoke and all of a sudden the gods will speak out all that is happening

Nana Subunu rather talks about the channeling of the information through the spirit of the client by saying "...the gods, by this, will pull along the spirit of the client to search through it and now tell us what is going on." This seem to be the same thing others also said. For instance KB says "...the client or their care-takers take the eggs in their hands and speak their problems onto it then you throw it against the gods. Immediately after the gods will speak for us to know what the problem is, how is came about and what must be done." When these are done well, he KB continues to say "...the gods will tell us about the whole thing about what is going on." There are other times that this insight come through either an interpretation by the linguists or interpretation of some signs by the priest or priestess themselves.

Nana Duruwaa explains with sample items:

"...however like the eggs when you throw it and it cracks you will notice two things: either it cracks 'facing up' meaning you are innocent of any spiritual disease so we go ahead and cure you only on herbs, or the two halves will face down meaning there is something hidden that must be investigated. The principle is similar in the cases of the cola or cowries and the rest. Example if we use a chicken; and we need to know everything, we ask the gods to accept the chicken. We say if all we know or you have said is all we need to know the gods should accept. Then we slash the throat of the chicken. If you have said everything truthfully the chicken will die facing up- that is, the gods have accepted. If it dies facing down it means the gods have rejected. In this later case it means there is something more to be said

or you are hiding some information or lying to us. Then we ask further questions and repeat the process until we are satisfied.”

OYS affirms this procedure with a similar sample cases:

“...the gods will tell what it is and what to do. Whether it is real sickness or spiritual. If the killed chicken faces up then it is normal real sickness if it dies facing down then there is serious case, normally spiritual; then the gods will tell us what to do.”

This is the type where the priest or priestess is the one interpreting the signs. But most of the priests agreed that most often than not the ATHs may be in trance: in this case they have linguists who will do the interpretations. NMA clearly states that

“...In the spiritual realm my physical body is overpowered and the “mpaninfo” (gods) talk with my spirit.... When possessed I am not in control and do not know what happens but my linguist is able to interpret what I say. The spirits talk through me. My linguist tells me what transpired in the spiritual realm, explaining what the cause of the diseases is.”

This was confirmed by NK that “...however things inside the shrine, it is only the linguists who can tell what happens since we are always in trance....”

Physical and behavioral considerations of diagnosis by ATHs

The next considerations of ATHs regarding diagnoses are physical and behavioral signs and symptoms. Setting the tone NFB states that “...I sometimes observe the behavior of the patient

and based on my experience, I am able to tell what is wrong with the patient as well as the cause of the illness. The madness caused by weed smoking can be easily seen...” This means that the ATHs do not just rely on divination. Nana Duruwaa will confirm this through her own practice by saying that “...I look at the eye ball. The unrelaxed body or too tight muscles. I look at the dressing and smell the odor etc. sometimes you can see the person panting for breath or feel the heart beating very fast and appearing very aggressive..., all these say a lot.” This may seem to flow with the scholars whose research have suggested that mostly, psychopathologies or mental disorders like schizophrenia may normally present itself in three main dimensions (Mueser, Curran & McHugo, 1997; Van den Bosch, Rombouts & Asma, 1993), namely; positive symptoms, like the aggression, improper dressing, “The unrelaxed body or too tight muscles” and others as stated by Nana Duruwaa; negative symptoms, like Nana Duruwaa would say “...like you say open your eyes and he will not mind..., or too quiet” and cognitive impairments, “...Sometimes when you are talking to him he will be saying different things, like ‘this my dress is nice’,’ my husband is wicked...” (Nana Duruwaa).

On issues of positive symptoms Nana Subunu says “...I sometimes observe the behavior of the patient and based on my experience, I am able to tell what is wrong with the patient as well as the cause of the illness..., some of the patience are restless...” on negative symptoms he (Nana Subun) continues “...others are motionless.” This will support the orthodox practices as by Copolov, Mackinnon, and Trauer, (2004) that suggests that the somatic and cognitive experiences as well as behavioral expressions that are in contrast to reality should be taken note of duration diagnosis of psychopathologies. These go to suggest that the ATHs do not just consider spiritual processes or divinations but they consider the manifestation on the physical and behavioral issues.

Other investigations

Just as found in most diagnostic manuals like DSM-5 and ICD-10, other investigations like duration of the condition, severity and frequency as well as other socio-cultural family histories are vital to arriving at a proper diagnosis. This may be so important because earlier literature suggested that psychopathology can be viewed not only as absent or present, but dimensionally, via measures such as frequency and severity that can assist in determining a therapeutic path (Kessler, 2002; Krueger et al. 2005; Saha et al., 2006).

NT talked about these when he asserted that:

...I ask how long the symptoms have lasted. Whether they have taken the patient to the hospital before? Whether the patient has ever been taken to a traditional priest or a pastor before and the situation still persists? I do all these before if I add my knowledge in addition to what the spirits “nananom” will say about the patient in order to give out treatment. I ask about the family background of the patient, i.e. which town they are coming from, their family details, address and how we will contact them in case of anything, promises of thanksgiving items when the patient gets well. All these information is written in a notebook. We do this because we work with a lot of clients so I can forget the things they promised as thanksgiving items. So even after 100 years the records will still be there as evidence of our dealings with the patient...

It may be noted that due to heavy reliance on the gods most of these investigations may not be necessary because the gods may reveal almost everything to the priests.

PART TWO

4.3 TREATMENT MODALITIES OF THE ATHS

The next big block in this research write-up is treatment. Research prove how important culture and sociological factors is to treatment with regard to psychopathological conditions are. On his reflection on culture as a response to cultural diversity psychotherapy process, multicultural psychotherapy, Nezu, (2010) said:

Be aware that any difference, especially one that existed during one's development, is potentially important, be it large ears, sexual orientation, or ethnic diversity. However, certain differences are more culturally bound, steeped in an historical context, and more pervasively influential. I have found Hays' (2001) acronym, "ADDRESSING," to be an effective way of reminding me to inquire about all the salient diversity characteristics (A-Age and generational influences; D/D-Developmental or acquired Disabilities; R-Religion and spiritual orientation; E-Ethnicity; S-Socioeconomic status; S-Sexual orientation; I-Indigenous heritage; N-National origin; G- Gender). Such information can provide for a more rich, comprehensive, and accurate picture of one's clients.

The World Health Organization (WHO, 2002) acknowledges traditional medicine and forms of therapy. It asserts that this form of therapy or medicine involves a totality of the knowledge, skills and practices anchored on the belief systems as well as the experiences which is indigenous to the specific traditions/cultures in question. Using traditional or cultural means to the diagnosis and treatment can thus be based on the culture and beliefs dominant in a particular

community. It may not be considered as ineffective whether it works efficiently outside its jurisdiction/context or not (Koon, 1999).

Established earlier in this chapter, the main considerations when it comes to mental disorders are the spiritual and physical causes, diagnosis and treatment. OYS sets the tone by asserting that there are two main domains to causes of illness in the Asante cosmology (all other ATHs participants affirmed this), namely; for “...some the brain itself is injured called “yare paa” (actual madness)..., others are spiritual matters.” Nana Duruwaa says a similar thing in different words that “...there are some people are who under a spiritual attack and this could cause spiritual madness and manifest physically. Others too have marital issues that could disturb them till they are mad. In that casual case we let them go to the hospital or get mediators to settle the case and they would be well.” Assertions such as these support literature that health and disease in Africa is a holistic thing. It “...consists of mental, physical, spiritual, and emotional stability [of] oneself, family members, and community” (Omonzejele, 2008, p. 120). Nana Nsumankwaa Hene sums this as “...So our traditional healers consider its diagnosis and treatment as holistic and cannot treat one and leave others.”

From the above the research herein teases out and will develop the following themes as they emerged from the data; namely spiritual and physical modes of treatments.

4.3.1 Spiritual mode of treatment

There seem to be several ways to spiritually treat mental disorders among the ATHs. The following were themes that developed from the data collected.

Sacrifices

Normally, the first of the protocol needed to proceed with on traditional healing is the sacrificing of an item or two. Sacrifice can continue on with the diagnosis, and treatment and even termination. Nana Duruwaa puts it "...As I said everything depends on the gods when they come. They will say we should use herbs or this or that." At any stage it could involve items ranging from less expensive and common items like schnapps, fowls, palm-wine to expensive and rare things items like goats, cattle, owls etc. It may be noted that these items may be at the request from the spirits, gods, and ancestors (Olupona 2004). Affirming this point of Olupona (2004), NFB asserts "the 'bosompanin' can even charge the patient the amount to pay when cured. We give the patient time to pay for the treatment cost say about 2 years although some even get healed after about 3 months on treatment here. After 2 years if the madness does not come again then the patient comes to pay the money." NMA sums it all by saying "...all the interventions are directed by the nananom..."

As to exactly how these sacrifices are done, it depends on the particular shrine's protocol and the presenting compliant; as NFB would put it "...is based on the disease and what the 'bosom' prescribes." However these sacrifices generally involve casting the items (whole and entire, squeezing out its sap or blood etc) on the gods, leaving or burying them at designated places, giving them out as charity or even applying some of the items on the patient. Nana Duruwaa cites an example that "...Sometimes if it's a curse or spiritual illness the gods can recommend you pay

something like a goat or chicken or cat or something. We sacrifice it to the gods and cleanse you and after which we fortify you again by re-bathing you with our herbs. Some of the herbs are ‘kuokuo nsuo’, ‘konkroma nhini’ etc we mix them, boil and use them for bathing or drinking....” These are done to augment the healing process; either by consecrating the herbs or as a way of spiritual connection between the priest and the spirits. This, they consider as basic and very necessary since they base their services on the sanctions of the divine and ancestral (Idowu, 1973).

Pacification

KB sets the tone that

You know it is not every disease that is physical, some are spiritual. In that case nananom will tell us exactly what to do and what to do to help the person..., some may be under a curse. They have done something wrong against the gods. So we pacify them. Like the gods don’t like weed this will make you mad because the gods of the land do not like that. In this case the gods will show us what to do to pacify him

This seem to affirm the assertions of Iroegbu (2005) that in situations like this it is a matter of actions (as an individual or collective), against the values and norms of the traditions of society (Iroegbu, 2005) or a discord between the mundane and the supernatural (Setswe, 1999), which is offensive to the divine (gods, ancestors, spirits etc). Both scholars revealed that the gods be appeased.

For instance NT gives a scenario

...majority of the people I treated were suffering from mental diseases that occurred through spiritual manipulations. For some of the patients, they wronged someone

and the one who was offended took them somewhere to make them mad. Others also stole people's things and their offenders made them mad. The mental cases I treat are mostly spiritual in nature..., like somebody cheats on the spouse and is cursed to be mad.

Nana Duruwaa also added that "...someone may have offended someone else and have been cursed, like stealing somebody's item." These and other similar cases are what Insoll (2010) says must call for pacification. The nature and extent of this cleansing ritual will depend on the extent of the offense. In most cases the cost is borne by the client or their caretakers. Some of the ritual items include; specific and spotless animals, schnapps, 'akpeteshie' [traditional liquor], calico (red, white or black) etc (Insoll 2010). OYS affirms this that "...Schnapps, chicken and or eggs...and somethings money..., sometimes the gods will demand even lizards, frogs, bullets, or even pepper. And they will determine how to use it. The god will tell you everything."

Exorcism

Sometimes it could happen that the client may be suffering the ill health as a result of some evil spirits or forces they may be possessing. This assertion was supported by Nana Duruwaa when she opined that "...There are some people are who under a spiritual attack and this could cause spiritual madness and manifest physically." This could be as a result of a curse or some behaviours that had invited these spirits. NMA gives examples of these as "...For some of the patients, they wronged someone and the one who was offended took them somewhere to make them mad. Others also stole people's things and their offenders made them mad. The mental cases I treat are mostly spiritual in nature." It is in such cases that as Avorgbedor (2000) suggests a form of cleansing or

exorcism is often performed for those who are mentally challenged. These may include processes like singing, drumming, dancing, the spraying of powder, bathing with blood of animals, washing of cloths in order to drive away the evil spirit by touching the body of the possessed person several times with the 'bodua' (horse tail whisk) until the process is complete. Nana Duruwaa gives the example that "... there is a plant called 'dunum' we mix with water and other things. You will use this to bath and we give you other drugs to take. This makes you sleep very deep for some days. By the time you are awake you will be fine."

In effect this happens when the ATHs think the cause is from a breach of spirit harmony; either by the persons fault or from a curse: for example, OYS says

"...for others the madness is given to them at birth and it gradually develops as he/she grows, it could be the midwife, in the spiritual realms or it could be yare paa...these ones can make the person very flat in affect and it keeps worsening as the individual grows. So when the person is old that is where everybody will know that that is what happened to him/her. So it is nananom who will tell us how to exorcise.

A case was cited by OYS in this regard:

It is the gods who will attend to the spiritual side while we do the physical. For instance a man was brought from abroad who was mentally ill and could not recall anything. He was about fifty years. When they brought him, at first I thought it was normal aging however we consulted the gods. It was found out that the man was an ambitious and had too much plans. So his family bought the illness for him and wanted to destroy him. So he was forgetful, flat affect, wouldn't have anything to

do with women. His mother was a queen mother and this was an attempt to dis-stool the mother. When the gods revealed to us and instructed us, we exorcised him and now he is fine and even has three children with the wife. It is by the grace of almighty and the gods.

Counselling

One very significant process during the therapy session is counselling and advice giving. Normally the sick person or their care takers are advised on how to arrest the situation; these pieces of advice range from issues of life style, behaviours, rituals, through to the kind of food the person should or should not eat.

Nana Duruwaa speaks to this by saying "...others too have marital issues that could disturb them till they are mad..., in that..., we..., get mediators to settle the case and they would be well." These are moments when these types of counselling services are offered. The most common of these counseling services are those linked to dosages and treatments, as well as those that are linked to spiritual attacks and curses. These are managed with strict compliance Sundermeier (1998). On a usual day when clients fail to follow these counsels it can happen that the ancestors or spirits dwarfs etc who may be protecting them may withdraw and the results could be a stalling or worsening of the already bad health condition of the client and can even open doors for other illnesses, deaths, as well as other misfortunes. Nana Duruwaa sums it that "normally and generally all go well. Once you follow the gods it is easy..." and these gods speak through the ATHs.

4.3.2 Physical process of healing

Material/medication:

As said earlier, "...there are some people are who under a spiritual attack and this could cause spiritual madness and manifest physically" (Nana Duruwaa). In cases like this the ATHs could apply any or a combination of the following:

Herbs and clays

Normally the healer and the prescriber first would consult the spirits who would show them specific single leaves, roots, backs, seeds, flowers or fruits of certain plants. Others include rocks or clays that are processed (Lartey 1986), into forms like: concoctions, emulsions, ointments and powders. This was supported by NK's assertion that "...the gods can direct us to use some herbs. As to how to use it; the gods will tell us whether to use the sap to drop in their nostrils or mix it with alcohol and let him drink so it goes into the brain and cures him. Or we can use these herbs to bath." These would be pre-prepared or solely prepared by the healer who will give directions as to how it must be administered, acting from instructions from the gods.

Nana Kwame Subunu described how the administration of these herbs could be done; "we can bathe you in herbs or drop some herbs into the nostrils and the person will sleep and later be fine. During which we give them foods like porridge. We can also use syringe to push medication through the anus into the colon to flash things from the abdomen..." this goes to support the literature of Ayim-Aboagye (1993) that the administration could be via the mouth, through inhalations, instillations into the nostrils, anus, sex organ, eyes and the ears.

Senah (1988) in agreement to this asserts that these healers have the belief that every illness should have a corresponding plant or animal source remedy. In terms of mental health all the participants talked about herbal bathing that is so sedative that the patient could sleep for a long time. For example Nana Duruwaa says they mix these herbs into water then they let you bath with it which sedates the patient “...by the time you are awake you will be fine..., we use these to pacify the gods and cleanse you and after which we fortify you again by re-bathing you with our herbs. All other ATHs but one mentioned these sedative herbal drinks and bathing. The only ATH who was a bit different even uses the drinks but may not bath the patient. He (KB) said “...we give them medicine to drink and they will calm down..., for me I use a cloth to wrap them and put them out in the open space and they will be healed.”

Surgery

Literature gathered earlier in this report suggested that sometimes some the traditional healers may perform surgeries. It was true to some extent but not in the case of mental health, just as NK puts it “as for mental cases we don’t perform any form of surgery. If it were other diseases, yes. But even then we only make minor cuts and insert herbs.” It was only one out of total fifteen ATHs interviewed who made assertions to that we can do it.

KB was emphatic that

“...if you like I will let you experience one, one day. [How do you do it?] ...like a person comes...we do it here. First I will consult the gods and they will tell me that there is something buried in the stomach or somewhere... I will remove it [as in

physically or spiritually?] physically! I will use a knife. And after that I will use a powder on the wound and you will not see the wounds again, just a small mark.”

Apart from him all the others said they do not do it. However they could make some incisions and insert some herbs to calm some people when they are in their manic episodes NK for instance said

...no we don't do any major surgery. The furthest we go is to prepare some mixture with burnt plants and roots. Then we create some abrasions on the body and insert the medication there. This will make the medication go into the person faster. This process has a dual purpose. It works directly on the body and secondly drives away evil spirits.

Nana Duruwaa was even more emphatic at denying its use within their profession “...no we don't. You see those who do these are magicians and they just want fame. They can even remove your intestines and all and replace it. It is not our style. For us we may, if we have to, make some marks on you and insert the herbs or drop the herbs in the nose or mouth.” Nana Kwame Subunu rather made a comment on avoiding risks, in support of what Nana Duruwaa said, that “...I don't perform surgery or incisions, in this era of diabetes, you may start up a wound on someone which can take forever to heal.”

4.3.3 Interaction/contact with clients and patients.

Detention

In the handling of psychiatric or psychopathological conditions detention sometimes become necessary. This becomes the option when the client or patient is considered lacking sufficient capacity to care for themselves or to defend their own. The Ghana Mental Health Act 846 (2012) supports this that

Where a psychiatrist or head of facility is of the opinion that the nature of the mental disorder of a person justifies admission and that there are adequate facilities for the treatment of the patient, the psychiatrist or head of the facility may admit that person as a voluntary patient. (40.1)

Despite the above, all the ATHs in the bid to manage cases of mental health admit that admissions are of last resort. Apart from three persons, all of the participants said 'no' to the question of admissions and twelve out of fifteen later add that when it really becomes necessary they may do so for just a few days. OO said, in this regard that "normally we don't. But if it becomes extremely important we do; especially if the person is very seriously sick and violent. I mean it is not every case we detain."

Nana Duruwaa expatiate this that

...no we don't, we perform all these and ask you to take them away. Some people come and the mental illness have made them weak through dehydration or anemia, so when we revive them we ask you to send them to the hospital for further treatment in the blood or something.

OYS affirms this in a similar fashion saying

...because I don't have enough rooms I don't. If I detect that the condition is too critical I would prefer they take him/her to the hospital and we see how we handle from here. So the doctors will do theirs and after that we do ours. It could be that it is a doctor's sickness; so he will do his first.

Those who affirmed that they detain patients were those who had their own compounds and could afford to do so. Nana Boame for instance states that "...we detain people here. Some even spend about 6 months here. We take care of the patient till he/she is fine then we discharge him/her. After which they come to give thanks." This was same with NK and Nana Kwame Subun with similar assertions and working conditions.

Duration

In terms of duration, all the ATHs admitted that it takes a while but on the average, the maximum was two to three weeks; unless there was an outlier which could take longer. NK for instance suggests that "...it depends, it doesn't take too many days. Once all has been done it wouldn't take long. We have other medications we administer after this..., once these medications as well as the spiritual interventions are done you would be ready to go home. The maximum is two weeks." This was affirmed by Nana Duruwaa that "...it depends sometimes on the situation..., ...but most often it could be about a day or two or few weeks."

The outlier was from NAD who suggests that "...it depends on the type. Some can spend one month and through the gods the person will be well."

OYS explains this outlier with the assertion that

It depends, however once the spirits request is done it would not take long. On the other hand if this has not been done you can work on it for ten years but no results will be achieved. Just doing all the gods will say is the important thing. Normally it is forty days.

Nana Kwame Subunu also gives another illustration to the outliners that

For instance if it is as a result of a curse, we overturn the curse. But if the patient is unable to identify or locate the one who cursed him/her then it takes a long time. Because the “bosom” has to work on the case. Immediately the curse is reversed the patient gets well. After the curse is reversed it takes about 2 to 3 months for the patient to return to a normal state. Such healing doesn’t have a specific period. Some even take 1 year to recover. What we do is to administer the herbs and also plead with the gods to heal the patient.

This means that none of the claims of the ATHs on duration of treatment or even admissions if need be is against the laws of the country on the surface level. The Ghana Mental Health Act (846, 2012) suggest that the “period of the prolonged treatment order shall not exceed twelve months at a time. An order for prolonged treatment of up to twelve months shall be reviewed at six months by the Tribunal” (47.1, 2).

Evaluation and termination

Moore (1998) in his study about discharge and discharge procedures from an acute psychiatric ward had hoped to find out whether this is normally planned to support improvement of symptoms and prevent future relapse. Results were scanty but revealed that it wasn’t always the case of diligence. This section is present the findings and

discussions on what the ATHs consider before discharge and termination of treatment procedures. There were varying responses even though they were all related. The main theme was a consideration of the initial presenting symptoms and comparing with the desired goal. The second is how they (the ATHs) conduct the actual evaluation. However, both are done concurrent and not in isolation. The last and yet the most important issue in this regard is consultation with the gods.

NAD starts clearly by saying

“...you see, the person comes in with certain behaviors and signs. Some cannot even get up to pick one thing or the other. However after about two weeks onwards you may begin to notice that you can let him go and perform certain tasks, he can go and fetch water and even bath well on his own. You could also realize that the person can sit with you and chat appropriately. When it was bad, he couldn't do these, but now you can see its better; when you see these positive signs know should know it is better now.

Nana Duruwaa continues in a similar direction that

when we realized you are calm and you appear normal, you eat well, bath well, sleep well and all we know you are well. Sometimes you realize the eye balls are appearing bright. Again we engage them in conversations and we will determine there is improvement. We can ask them to perform simple tasks or errands like sending them to buy some items. If they are able, those all is well. If not them we know there is much more we need to do. Some come in, looking so lean and wasted, so if they are now getting better it will show.

This was the similar thing Nana Kwame Subunu suggested; he said

We assess the patient based on observations made when he arrived and after giving treatment. Changes are observed in the behavior of the patient, the way he walks, eats, talks and conduct himself and so on. We monitor the patient for a while before we declare him fit..., some even remove their cloths when they come but after treatment, the patient becomes conscious of himself and wears clothes and is even able to bath, dress and travel to Kumasi and back. Such a person is back to normal.

NK said the same thing “...well we look at the condition with which you came. If for instance you can now go and fetch water to bath on your own; or you can go on errands and even cook and all then we know you are ok.”

So it is realized that the ATHs use the simple technique of observing the initial presenting conditions then they compare it to the desired goal for the treatment and make the judgement if that desired goal is achieved. By this procedure they observe their functioning by giving the clients simple tasks: these range from general daily functioning and self keeps of the patients, simple tasking like conversations, errand achievements, orientations, insight among others. According to this data, it means that when these observations are satisfactory then they are on course for discharge or termination of treatment. NFB however brings in another dimension. This is when the client/patient requests for discharge.

He (NFB) says “the patient tells the priest when they feel that they are healed and the disease is gone.” These requests and/or the other observations are not conclusive yet until the gods are finally consulted. NFB says “...but when the patient says he is healed, I inform the ‘bosom’ about it for confirmation. If the ‘bosom’ confirms that he is healed they I discharge the patient.

When the patient gets well we have to inform the ‘bosom’ on behalf of the patient and to ask permission for the patient to be released since the patient is now under their care.

NK affirms this when he says

On the surface and human level, we observe the condition they present on their first day; like the way they talk and behave will let you know they have mental problem. So after the administration of medication, if there is improvement, you will see that the talking and behavior is better. When we see these we go back to the gods to ask and they will confirm or not. Then we can discharge

NAD continues in the same direction that “...after observing the signs and behaviors we go back to consult nananom. They will be the ones to grant the go ahead for termination or discharge. In this case the family is free to take their ward away without fear of relapse.”

On the sidelines however NFB suggest a form of ‘thanksgiving’ to the gods before they are finally let go. He says “...the patient pays a token before we take care of him just as consultation fee is paid in the hospital. Some also make promises to give items out to the “bosom” say a sheep or an amount of money when they are healed. So when they are healed and the thanksgiving gift is ready, they bring it.”

It is after all these that as NK puts it “...we can let you go.”

PART THREE

4.4 CHALLENGES

This section discusses some of the challenges the ATHs face in their management of psychopathologies and/or mental disorders. This is in the light of Omonzejele (2003)'s assertion that inasmuch as there are challenges regarding the African Traditional Medicine (ATM) the people of Africa will put itself at a disadvantage if they should look down on traditional ways of therapy.

The themes arising from the interviews with the ATHs on the challenges they face at the different stages of the therapeutic process of healing patients with mental disorder ranged from issues regarding compliance, infrastructure, and stigma as well as other social challenges.

4.4.1 Compliance to directives by the gods

As stated earlier, the gods are always consulted before anything or action is done. In so doing certain sacred items are demanded by the gods for pacification and treatment. Inability of the family members of the patient to provide these items tends to drag the treatment and healing process. It may be noted that in Africa, to be as a result of an inappropriate behaviour to self (as an individual or collective), as suggested by Iroegbu (2005) and Setswe (1999). This will mean that if there is any form of physical manifestation in terms of the illness it shouldn't be seen in that surface level. This means therefore that anything short of all recommended requests from the gods would impede the treatment and healing process. NAD for instance says

Sometimes, you see, you have offended the gods and they have punished you with madness. If the gods say you should do this or that or bring something it becomes difficult when the family will pretend and say yes in front of you, yet when they leave they will never come back. When this happens it prolongs the process and we can't do anything about it.

Nana Duruwaa continues in the same direction but this time suggests delay rather than non-compliance.

Other times the family members will delay when you have asked them to provide certain things. It can take them like a month to return. When these things happen it makes the work difficult or even worsens the initial condition. Sometimes they do these things because they think that the priest just wants the goat or sheep for his/her own food. But honestly these things after the sacrifices nobody even wants to touch them let alone use them

Apart from non-compliance and delays some patients do not adhere to the instructions and directions that are given to augment their healing hence the deterioration of their conditions. This is what OYS bluntly puts it that "there are others who will not follow instructions; like add pepper to this or that and they will not do it as instructed. This causes challenges. But it does not normally happen. They will mostly follow. After all, these days, they have our telephone numbers; they can call when there is any uncertainty". It may be noted that because of the unitary nature of health in the Asante cosmology, failure to follow the instructions also has spiritual repercussions and can lead to relapse. OYS explains that it could be lack of faith. She illustrates that

...other times some people come without faith in what we do. In this case they may not be corporative and it makes it difficult. Like we can tell someone who is healed not to do this or that other than that this or that will happen to you on such and such a day; if you don't follow you can relapse or something bad will happen to you.

Another twist to this issue regarding lack of faith has to do with the cosmology of the Asante culture. Treatment by traditional healers is highly dependent on the patient's faith and belief in all the treatment procedure and in the ability and powers of the gods to deliver the patient from spiritual forces and to cause total healing from mental disorders. This goes to affirm the findings that "traditional healing is intertwined with cultural and religious beliefs, and is holistic in nature. It does not focus only on the physical conditions, but also the psychological, spiritual and social aspects of the individuals, families and communities" (Truter, 2007: p. 57). It therefore goes to say that the spiritual nature of the treatment process requires absolute believe in the efficacy of the gods to set patients free from the spiritual bandage underlying the manifestation of mental illness in the patients. Patients' unbelief and display of doubt therefore serves as an impediment in the treatment process. Another issue is unbelieving family members who bring patients for healing. Such relatives of the patients can sometimes question the diagnosis and treatment method which does not augur well for effective healing therapy. OO affirms in a rather indirect way that

Mostly the families challenge us when we tell them of the causes and what must be done. They will do many crazy stuff against us that can get me angry and sack them to go wherever they want to go. So sometimes you need to calm down and know your left and right. If you follow such people you cannot even take good care of them person.

NT however admits that it is not always that it is the fault of the clients and/or their caretakers. She says that “sometimes people come without money so it is difficult to continue or it is difficult for them to get the items needed. This makes it a bit difficult to continue. However, for me, I will start with the little you have and sometimes pre-finance until you are well then you come to pay back.”

4.4.2 Lack of needed tools, skills, and infrastructure

Another setback in the practice of traditional mental healing is the lack of the requisite tools, skills and personnel to carry out intravenous therapy and surgery which is sometimes needed by patients. This brings to mind the findings of Owusu-Ansah and Donnir (2017), that the traditional practitioners for mental health may include the ‘odunsemi’ (herbalist), the ‘akomfo’ (priest), ‘asfo’ (the pastor/spiritualist) or simply ‘apanin’ (wise ‘elder’). It would be an understatement therefore to say that they (‘akomfo’) are only trained for either or both “specialties” of herbalists and spiritualists. Most of the respondents herein admit this limitation. NK for instance asserts that

“Well the only one that I faced the difficulty was the one who was cursed. The curse sent a warm into his brain. So how to get the medication into the brain was the problem..., surgery could have helped..., but in that case the gods may recommend that they send them to the hospital”.

Whiles others like NAD also puts it that

“if it is a spiritual disease or it has a spiritual under-tone; then we are very confident..., you see a case like spiritual curses can never be solved by the hospital, in the same way we are confident of cure here except doctor’s disease.”

This shows some difficulties and limitations when it comes to expertise in the handling of psychopathologies by ATHs. Perhaps the underlying issues are their lack of training outside the realms of spiritual and herbal matters. In this case patients whose treatments require such intervention are referred to other treatment centers with such capacity as alluded above.

There was a general admittance to lack of infrastructure. All but one shared their lack of this facility. The exception was NK who for his establishment of the diaspora clinic have the capacity to detain clients comfortably for long term treatment which require constant monitoring and observation. It was realised therefore that comments like the immediate one below affirms this challenge:

...we don’t, we perform all these and ask you to take them away. Normally if its severe we will finish all rituals and ask you to send them to the hospital. You see it is not all of us who even have places that are decent to live. Some of us even stay in our family houses, so we can’t not detain. (Nana Duruwaa)

Nana Serwaa and others like NMA affirm this challenge with statements like “...where I am operating is a family house and I don’t have any facility to detain people here for treatment. If the madness is serious, I rather move to patient’s house to treat him/her for about 1 week” (NMA) and “...no. because I don’t have enough rooms I don’t. If I detect that the condition is too critical I would prefer they take him/her to the hospital and we see how we handle from here. So the

doctors will do theirs and after that we do ours. It could be that there is a doctor's sickness, so he will do his first." (OYS)

The comment that really painted the issue of accommodation so graphic was from the Chief priest Nana Nsumankwaa Hene who lamented that

...again, where these our traditional priests operate, they do not have places to admit their clients for proper treatment and observation... normally they give their dilapidated rooms to clients and say stay here like that. But that is not right. They are left in the cold, sometimes no doors, windows or roofs and no toilet facilities. Sometimes mosquitoes and other bad animals harm their clients causing more problems.

In terms of tools and skills NKA puts it straight that

You see again we don't have machines here for blood transfusion and all so when the sickness has manifested too much in the body and the person now needs blood or water, we can't do much than to refer. They can also give some drugs to help..., but the reality is that it is difficult."

Inasmuch as scholars like Senah (1988) suggest the ATHs have the belief that every illness should have a corresponding plant or animal source remedy. The main issue has to do with how refined their medication can be and how it could march to some level of standard. Nana Nsumankwaa Hene explains this further saying

Some..., priests find it difficult to keep particular qualities and dosages even if it works once. For example, have measured the medication that will sedate the client? Will it be too much or too little? Or just take till you are ok? We should go about it

with regulations like the others in foreign countries do...,aside that, some of the medications are not processed well, those that are used as nasal sprays for instance; are they smooth enough so not to chock he person? Again is it diluted or concentrated? These are problems.

The chief priest continued that this could be as a result of over reliance on the deities, just as Lartey (1986) had earlier suggested; these concoctions, emulsions, ointments and powders would be pre-prepared or solely prepared by the healer as directed by the gods who will give directions as to how it must be administered.

4.4.3 Spiritual Attacks

According to some respondents, in the course of treating patients some ATHs could be attacked by spiritual forces who may be against their clients of the healing process. The spiritual forces may be from the family of the patient. The literature gathered seems to support this finding. Olupona (2004) had suggested that in the African belief system, on a daily basis, people come in contact with spell-casting, curses in the name of the river deity, witchcraft, among others. He (Olupona, 2004) suggests that these are normally done by wicked men or women with evil powers who may be aggrieved. This may be the underlying factors why in the course of relieving the sick, if the cause is from these wicked forces, they (ATHs) get attacked. OO suggests that

Sometimes it may be within them family. So if you are healing such people their families will be working against you from another source. They come in the night to fight us. If they don't succeed they come physically and attack and to deride you.

And you might send the client away; meanwhile may be you are the only one destined to cure him.

Sometimes too the spiritual forces are sent just to challenge the powers of the priest or priestess. Nana Durowaa in her submission attested to the occurrence of spiritual attack sometimes in the process of treating a client but also added the ability of the gods to detect and address such situations.

Again some other people can spiritually impede the process and worsen the plight of the client. However, for these latter situations, the gods can gradually find out and arrest the situation and cause the enemy to confess

4.4.4 Safety of Patients and Healers

Some of the respondents admit that some clients could exhibit violent behaviours, putting the healer, attendants and patients themselves at risks of injury. The intensity of the violence sometimes scares off the priests from getting close to administer treatment. Research suggests how sometimes some psychopathologies could lead to violent behaviours. These could include psychotic conditions due to substance abuse, schizophrenia, and even depression (Swanson, Holzer, Ganju, & Jono, 1990; Monahan et al., 2001; Dean, Scott & Rogers, 2006). Persons with such conditions are normally seen as violent or otherwise dangerous. In containing such violent behaviours of their clients, some of the ATHs resort to counter violent actions like chaining or instant sedation; even though they admit these could be inhumane and illegal making some priests unenthused about admitting and managing such clients. In this light some healers would rather liaise with nearby hospitals and clinics to help in this regard. OO affirms this that

There are many challenges, like some people will come they are so violent and cannot be controlled, so if you are not careful they can harm us and our personnel. Again if you don't exercise patience you might have to chain them... which we know is not good and can harm them. When that happens, you need to get their families to tame him before we come in.

Supporting this was NMA who continues that "...sometimes the patient may be very violent which may serve as an impediment to us in diagnosing and even treating the patient. You have to be patient at that stage."

Whiles Nana Kwame Subunu admits that

Putting the patient in chains is also challenging. You cannot chain a patient and put in indoors. Neither does the law permit that you chain a patient outside leaving him at the mercy of rain, sunshine and insects and mosquitoes. It really worries us. If we have a big safer space, then it would have been good for the patient. Because our land is small we even decided not to admit mental cases again. Some are calm but others are very violent and have to be chained. The issue is of worry to us. We have been communicating with the Psychiatric health officers in Mampong. We can even call on them to give injections to the patients to calm them down. But we don't also want to mix spiritual and orthodox medicine. If is spiritual, it must be totally spiritual.

Aside the mainstream violent behaviours, there is the tendency for the client to abscond. This causes a big challenge to most of the ATHs; since security is an issue. They (ATHs) normally will rely on the care takers of the clients in such cases. However, there are instances where family members leave patients in the traditional healers' home and never return to check on them. Some of the family members leave under the pretense of going to raise money to provide items needed for rituals and never return. It came out that detaining patients in the shrine without a family member to take care of them could delay the healing process.

Nana Kwame Subunu illustrates this, saying that;

the treatment stage is difficult. You cannot detain a patient here without a family member who comes along to take care of him. If there is no one to monitor the patient, he can even run away from here. If the patient runs away, you have to go search for him and bring him back here to start the treatment all over again which delays the process. But when there is a family member here to support the patient it makes the healing process easier and faster.

4.5 Success rates

The last thing this report wanted to look at was some of the success stories. It was noted from the literature that the diagnosis and management of mental disorders or psychopathologies could be more efficient if cultural considerations are not neglected. The WHO (2001)'s Geneva report supports this view that a more modern and near-to-accurate diagnosis and management of psychopathologies/mental disorders cannot but consider cultural elements. The main finding/theme in this research is the strong reliance on 'the divine'. This, according to the ATHs

interviewed revealed that so long as the cause of the disorder is believed to have spiritual undertone, the diagnosis and management is sure. This idea seems to be strongly supported by NB, NKA and NAD (interviewed together); who believe strongly that:

(NB) if it is a spiritual disease or it has a spiritual under-tone; then we are very confident. (NKA)...I have been serving under my mother for several years. It has never happened that someone came and went back without complete cure. As for me..., I have never seen that before. (NAD) you see a case like spiritual curses can never be solved by the hospital, in the same way we are confident of cure here except doctor's disease.

Others like NK support this stance using years of experience and practice and the backing from 'nananom' that "...I am so confident, you know... because my many years in the forest as a child trainee, the gods normally come to directly show me the herbs to use. Sometimes before I even get out of my room the medication would be at my door post. So I am so confident. Another priest, NMA says "...I am confident of my ability to cure madness. This is based on my experience. With nananom's support I am able to cure madness. Except if the source of the madness is from God. Once the madness was contracted on this earth, I am able to cure.

Nana Duruwaa affirms this, yet from another humbling statement that

It is true I am confident, but there is a saying that 'one medications augment the other'. So I am confident yet when it becomes necessary I can consult for reinforcement. This will not kill me or reduce my powers. If you know you cannot, why don't you refer to others if you know you cannot handle it. When it even requires that it needs a hospital or herbalist who is not a priest I will refer.

NFB supports this confidence in referral. He asserted that "...I believe I don't have all the knowledge, when I get a case that I cannot handle I take it to another priest. As priests, we do not challenge ourselves we love ourselves."

Another twist to the confidence and success belief was based on the originality of the priest and his/her calling. Ekem (2008) reveals that essentially a sign of possession by a particular deity/god who inhabits the individual must be evident. Once this is ascertained there is a surety that diagnosis and management may not fail. KB revealed that it can never fail for "...the truth is some priest are not real and they come in because of money. But for us the real ones we are confident." This could be, as Ekem (2008) would suggest that these ATHs go through thorough training: that is after they have been called to that service by the gods, ghosts, ancestors or dwarfs. Opoku (2009) in the same vein opined that "...the training process is described as quite arduous, rigorous and lengthy."

This may be why OYS may be saying that "...it can never happen that you are here and you follow the instructions of the gods..., there is no way you will not be well. Therefore I am very confident. Since all is about the gods. Once you follow everything of the gods not even other spirits can stop us. OO sums everything saying "once the gods speak and we follow; it is final".

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

This Chapter is structured into five parts; namely, a recap of the whole report, limitations encountered and how it was resolved, discussions on validity and reliability. It will also cover some conclusions and generalisations of the main themes emerging from this research and finally suggest some recommendations arising from this work.

5.1 A recap of the report

With the increase in population coupled with insufficient access to mental health care in Ghana (Van den Boom, Nsowah-Nuamah & Overbosch (2004), the role of traditional healers in Ghana could be considered as a strong alternative to making up for the demands for health care in this direction. However little is known about them and little effort have been made to write about them leading to standardizing their activities and empowering them if necessary. This research therefore was done to gather and document the role of traditional healers in the handling of mental/psychological disorders in Ghana. It was limited to Asante Traditional Healers (ATHs). The report sought to find out the common mental disorders handled by the Asante Traditional healers, the diagnostic criteria with which they conduct their mental health service, their ways of treatment as well as their evaluative plans. It went further to find out the challenges they go through as well as highlight their positive sides. This was to satisfy calls by many like Abdallah and Prinz,

(2009) who calls for a careful re-look at and a restructuring of traditional approach to mental care in African countries as a preferred alternative to orthodox medicine.

In the bid to achieving this aim: interviews were conducted on purposefully selected ATHs as well as the chief in charge of their services in the Asante Kingdom. Again thirty sampled clients of these priests were screened to be sure they were actually or possibly having the psychopathologies for which they or their caretakers sought help from the priests in question. With these data, compared and weaved with already existing literature, this report stands to answer many of the questions raised from the objectives of this thesis.

5.2 Limitations

Limitations, according to Silverman (2005), are conditions that restrict the scope of the study or may have affected the outcome of a study and could not have been controlled by the researcher. Access to information is one of the main limitations encountered. This was mainly from the participants. It was realized that some participants, for the mere reason that some sensitive information about them would come out, could not say all there was to be known. This was mainly in the area of what actually happens in the process of divination and treatment modalities. For instance KB made a disclaimer when asked what happens inside the divination chambers; he said “You know what? As for what we do there I can’t tell you because it is my secret..., let me give you a gist, what happens is that when the person comes, the linguist will go and ask of their mission and say he says I have a problem...” Despite this challenge, a form of triangulation was done and bits and pieces were put together from all the other respondents and this research report may not

be too scanty with regard to information. Another side to this limitation was the fact that almost all respondents who are ATHs admitted that during moments of divination they are mostly in trance and there could not give every detailed accounts. However due to months of training, they are able to infer and give honest accounts. Nana Duruwaa spoke on record that “during that time it is the spirit that has come; my body itself will no longer be active. It is the spirit that has taken over. When power comes, like you can see me today with white powder all over me because today is a ‘wukudee’ (Wednesday of spiritual visitation); they say everything to me. Therefore when the spirits leave I am very much informed by my linguists.” This means that the information herein may not be necessarily inefficient but enough to ascertain what needs to be known.

The next limitation had to do with language. Even though the proficiency in Asante-Twi of the researcher was average, it could not be interpreted to mean translating the language into English could be hundred percent accurate. “When dealing with translation, we firmly believe that this need is even stronger. Proficiency in two languages, the source one and the target one, is obviously not sufficient to become a competent translator” (Manfredi, 2008; Hatim and Munday, 2006). It will be recalled from above that all interviews except one were done in Asante-Twi, translations done and transcribed in English. With the help of one of the research assistants (who was purposely picked for this particular foreseen challenge), cross checks triangulations were done to ensure that the final report was near-accurate. Another side to this limitation was the lack of vocabulary to express matters of faith and spirits. Some participants either lacked the vocabulary to explain matters arising in terms of emotional and aesthetical dimensions or simply were not able to express some vital “spiritual” underpinnings about their diagnosis and treatment. Nevertheless, a diligent cross check was done, as spelled out in the next section under validity and reliability.

5.3 Validity and reliability

Validity in such a qualitative research like this particular one could be dicey. However using classical definitions as a venture that ‘concerns the interpretation of the observations whether or not the researcher is calling what is measured by the right name’ (Kirk and Miller, 1986: 69) or the ‘integrity of the conclusions that are generated from a piece of research’ (Bryman, 2008: 31): this research report was carefully executed to ensure that the concerns of what is sought to measure as well as its integrity are not compromised.

To achieve this, there was no manipulation whatsoever in this report, suggestive to this regard that; ‘qualitative researchers try to achieve validity not through manipulation of variables but rather through their orientation towards, and the study of, the empirical world’ (Bulmer, 1979: 49). All quotations were as close to literal and contextual translations as possible.

However, besides the above issue on non-manipulation of data, there was a conscious effort at triangulation. This was a way at cross-checking multiple data sources from the participants herein. It would be recalled that fourteen different priests from the same kingdom were interviewed. All these had similar questioning from the same interview guide. This was to help the evaluation of the extent to which all evidence converged. Again data from all the ATHs stood together as one and was compared to that of the chief in-charge of priests in the same kingdom just as a way of cross checking facts. Lastly the quantitative screening of their clients was a way to check where the cases coming to them were actually mental disorders or psychopathologies. This was a deliberate effort at ensuring that information being gathered from these different sources corroborated and thus were actually converging evidence. Finally it was realized that there seem to have been a point when it was obvious that saturation point had been hit; that is, the point

during data collection that became clear that additional data from other sources were just confirming the emerging themes and information. For instance almost all the priests kept recounting similar procedures of divination, treatment and challenges; evident in the findings.

The next, regarding validity and reliability for this report, was the conscious effort to avoid biases. This was evident in the great quantities of direct quotations from the interviews done to gather data as reported herein this thesis. It would be recalled that an attempt was made at recounting and reporting even the slightest discrepancies that were noted in data gathering and there was no point shelving them. This was to ensure confirmability/objectivity/neutrality.

5.4 Conclusions and generalisations

The aim of this research was to find out (as seen in chapter one); the common mental disorders handled by ATH, examine the diagnostic tools they use and to describe their treatment modalities. It was to also try to tease out the success rates of the treatment processes of the ATHs as well as to identify the challenges of the treatment processes.

It came out that:

5.4.1 The common mental disorders handled by ATHs

The ATHs come face to face with most, if not all noticeable psychopathological cases or mental disorders as suggest by the WHO country summary series on Ghana. These included and yet may not be limited to, hypomania, acute organic brain syndrome, manic depressive psychosis, schizo-affective psychosis, alcohol dependency syndrome, epilepsy and finally dementia (Asare,

2003). It came out that the ATHs did not use different vocabulary to qualify these different pathologies but put all into “adwene mu asɩm, or adwene mu yareɛ” (matters of the brain or mental disease).

5.4.2 The diagnostic tools used by the ATHs

All ATHs use two main tools in their diagnostic procedures; namely, spiritual and physical means. Spiritually they used prayer and libation, bell ringing and sound making and item offering. In this process they use three main procedures. These are: the developing of rapport or initial formalities/session, actual spiritual consultation with the gods and interpretation of information they get from the consultation to make sense or meaning to their clients.

On the physical level their main tools are: behavioral observations or physical signs and symptoms as well as interviews. The latter however is not too elaborate since the reliance on divination makes up for this. The interviews thus come in when the clients and/or their caretakers seem to want to hide certain vital information which the gods may want to know or made known in order to facilitate their healing process. These are similar to the mental state exams that are done in a regular psychiatric/psychological clinic.

5.4.3 The treatment modalities of the ATHs

It was established that the main considerations when it comes to mental disorders is the dual process; namely, spiritual and physical. This seem to have its bases on the cosmology regarding the causes of illness of the traditional African. Spiritually it was found out that there are several ways to spiritually treat mental disorders among the ATHs. These processes included, among others, sacrifices which seem to run through every stage of the process. This could involve offering of items ranging from less expensive and common items like schnapps, fowls, palm-wine

to expensive and rare things items like owls and lizards; others include goats, cattle, etc. Regarding how these sacrifices are actually done, it came out that it varied from shrine to shrine and case to case.

Other modes of spiritual treatment intervention emerging from data gathered were pacification and exorcism. The former mode is used in situations when it is assumed that the cause of the illness is on matters of improper actions against the values and norms of the traditions of society or the gods as suggested by Iroegbu (2005). Exorcism on the other hand is normally used when it is revealed by the gods that the client could be suffering an ill health resulting from some evil spirits or forces he/she may be possessing. Just like the other spiritual modes, the actual process depends on the gods, shrines and case. These styles of treatment include processes such as singing, drumming, dancing, spraying of powder, bathing with blood of animals, washing of cloths in order to drive away the evil spirit and touching the bodies of the possessed persons several times with the 'bodu' (horse tail whisk) until the process is complete.

Normally in any of these separate or combined spiritual processes there is a conscious effort at counselling the clients and/or their caretakers regarding treatment, issues of life style, behaviours, rituals, through to the kind of food the person should or should not eat. All these are aimed at preventing the condition from happening again as well as augmenting the treatment process.

On the other side of treatment is the physical intervention. This is also done in different ways depending on the case, shrine and/or god in charge. However, there seem to be some themes that seem to run through all: they included, the application of medication which are mostly, if not always, herbal. These are normally from leaves, roots, backs, seeds, flowers or fruits of certain plants. The medications are mostly in forms like; concoctions, emulsions, ointments and powders.

They are normally administered orally, through inhalations, instillations into the nostrils, anus, sex organ, eyes and/or the ears.

Another physical intervention that came out is treatment with surgery. This however was not general. It was only one out of the fourteen priests who admitted using this procedure. The rest seemed to frown upon it and saw it as magical tricks. The farthest the ATHs go in this regard, as evident in the data is create some abrasions on the body and insert the medication there. This according to them is to allow work faster.

In the process of treatment or management of psychiatric and psychopathological conditions all participants admit to the usefulness of detention. However it was only few who are able to do so. I came out that apart from Nana Kwame Subunu all the rest had no form of accommodation for their clients. For this reason almost every one of the ATHs preferred treatment on an outpatient basis or if necessary detaining for some few hours or days and discharging. One person also admitted this situation and said he would administer treatment by going to the clients home if it becomes necessary.

In terms of the duration for treatment the data showed a range between a minimum of a day to a maximum of a few months. They admitted however that there could be outliers that could stretch to a year or more especially in cases which involved curses.

When the healing process seem complete there were procedures the ATHs follow in order to discharge or terminate the healing relationship. They all admitted to reassessing the client before termination. The assessment, here again, is based on both divination and behavioural observations. They first of all return to the gods to consult before any decision is made. However all ATHs interviewed admitted their simple technique of observing the initial presenting conditions then

they compare it to the desired goal for the treatment and make the judgement if that desired goal is achieved. By this procedure they observe their functioning by giving the clients simple tasks: these range from general daily functioning and self keeps of the patients, simple tasking like conversations, errand achievements, orientations, insight among others. According to this data, it means that when these observations are satisfactory then they are on course for discharge or termination of treatment.

5.4.4 The success rates of the treatment processes of the ATHs

Based on the WHO (2001)'s Geneva report on Ghana, two main three main issues popped out. They are strong reliance on socio-cultural factors leading to diagnosis, management and prevention, reliance on faith (gods) as a way of therapy and readiness to collaborate with other trained health personnel for a holistic management of mental disorders. It could be recalled that The WHO (2001)'s Geneva report reiterated that a more modern and near-to-accurate diagnosis and management of psychopathologies/mental disorders cannot but consider cultural elements.

It goes therefore to say that these three factors mentioned and particularly anchored by the 'faith-factor' sets the confidence level of the ATHs so high. Further still, this level of confidence coupled with the years of practice and some evidence of successful treatment seem to put the management of mental disorders by ATHs on a neck and neck to high success rate. It was therefore not surprising that, for instance OO may be saying "...once the gods speak and we follow it is final...and we are sure it will work."

5.4.5 The challenges of the treatment processes of the ATHs

There had been an observation by Omonzejele (2003)'s that there are some few challenges regarding the African Traditional Medicine (ATM). Data gathered supported this assertion. There

were quite a number of these challenges that came out of this research. They included, and definitely not limited to; matters of compliance on the part of their clients, lack of needed tools, skills, and infrastructure. Others include spiritual attacks on the part of the practitioners, safety of patients and the helping hands of the healers.

5.5 Recommendations for Research

The following recommendations are offered for related research in the field of technology education.

1. Given the seemingly rich cultural material the ATHs display and viewing matters in the lenses of most universal diagnostic manuals for mental disorders that call for a relook at cultural dimensions to diagnosis and treatments measures of mental disorders/psychopathologies: I recommend an in-depth longitudinal study on cases handled by traditional priests. This could include measuring of and ascertaining of the condition (by trained psychiatrists and clinical psychologists), a careful follow of events leading to diagnosis, management and treatment of the condition and a re-evaluation of the case. This could aid with well documented material leading to a form of knowledge and standardization of the services of traditional priests.
2. With the claims of the ATHs on some form of herbs that is indicated for soothing and curing mental disorders with its strong sedative ingredients; I suggest a further collaborative research with pharmacist and personnel from the department of herbal medicine as well as, if possible, the Standards Boards of Ghana to study the herbs and if

found potent lead to a locally manufactured medication for the treatment of mental disorders.

3. Finally, I recommend a study into the perception of psychiatrists and clinical psychologists about Traditional faith healers in the light of mental health. This suggestion comes from the findings in this research about the readiness of the ATHs to refer cases to the medical centers to augment healing. However little is known about the other way round; that is, even if it will happen.

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APPENDIX I

Images of some of the “suman” (gods)

Source: pictures taken by researcher on the field (May, 2017)



APPENDIX II

Items for spiritual cleansing/sedation (upper) and prepared concoctions “kuokuo nsuo” for that purpose (lower)

Source: pictures taken by researcher on the field (May, 2017)



APPENDIX III

Some items that are offered to the gods on display

Source: pictures taken by researcher on the field (May, 2017)



APPENDIX IV

Images of the African Diaspora Clinic

Source: pictures taken by researcher on the field (May, 2017)



APENDIX V

Interview guide: semi-structured (administered to the ATHs participants)

Demographics

1. How old are you?
2. How long have being practicing as a priest?

Common mental/psychological disorders handled by Asante Traditional Healers

3. Have you being handling clients with mental disorders?
 - a. If yes how is the statistics like in terms of
 - i. Frequency
 - ii. Gender
 - iii. Ages and
 - iv. Numbers?
 - b. What are the type of cases and conditions that often come to you as a priest for treatment?

Diagnostic criteria for mental disorders by the Asante Traditional Healers

4. How do you get to know that the patient has a mental illness?
 - a. Spiritually, how do you arrive at a decision?
 - b. Physically, what do you observe?
 - c. Behaviorally, what do look out for?
 - d. What others do you ask for or investigate?
 - e. How are you able to differentiate the different types of these disorders?
5. What are the instruments and or tools with which you make your diagnosis?
 - a. How is each of them used?
 - b. How do you arrive at the results (interpreting results)?

Treatment procedures normally used by Asante Traditional Healers and their evaluation

6. What goes into to the treatment plan for mental disorders after the diagnosis is completed?

- a. Intervention
 - i. Spiritual
 - ii. Material/medication
 - iii. Surgery
 - b. Interaction
 - i. Detention
 - ii. Duration
 - iii. Contact times
 - c. Evaluation
 - d. Termination
7. How long does it take to treat a person with such disorders; and what goes into the determination of the duration?
8. In terms of the entire process; what are some of the difficulties you face as a practitioner?
- a. How well do your diagnosis and treatment come out?
 - b. Do you face some difficulties at any stage of your therapeutic process?
 - c. Based on “c”; if YES, what are they?
9. How confident are you about the therapies you give out?

APENDIX VI

Questionnaire for basic screening for psychopathologies

(SELECTED MENTAL/PSYCHOLOGICAL DISORDERS

FOR 25 CLIENTS OF THE ATHs)

Please tick where applicable: for each question you have four (4) spaces available 0, 1, 2, and 3.

No, not at all	0
Yes, slightly	1
Yes, moderately	2
Yes, definitely	3

Feel free to and sincerely tick the one which is applicable to you. Note that is purely for academic purpose and your confidentiality is very much assured. Again note that this is not to diagnosis but to generally screen the likely condition that could be happening to you.

Item	Question	0	1	2	3
DEPRESSION					
1	I am using a drug or substance regularly without the doctor's prescription (e.g. drugs, alcohol, medications)				
2	The use or nonuse of the drugs cause me to feel sick				
3	I have being diagnosed with a medical illness that can make me feel down				
4	I have lost a dear on in recent past that				
5	My mood changes often without cause				
6	I feel like staying away from friends and family when I feel down				
7	When I feel down I can't study, nor rest, nor work				

8	I easily lose interest in my normal daily activities				
9	Others around me normally complain my attitudinal change if too obvious				
10	I easily feel tearful and empty				
11	I over eat to get me happy				
12	I under eat to feel good				
13	I wish I was dead				
ANXIETY					
14	I normally feel apprehensive				
15	I worry a lot without a just cause				
16	I am mostly afraid of what I don't know or I think can happen				
17	I am on the edge most often without cause				
18	I easily get angry over minor issues				
19	My muscles and other parts of my body easily get tenses without just reasons				
20	I am afraid to sleep				
21	I have a terrible flashbacks that keeps scaring me				
SCHIZOPHRENIA					
22	Your ward exhibits extreme beliefs that is abnormal				
23	Your ward resists any move to convince him/her to change that belief or behavior				
24	He/she talks to another person or other people that nobody else can hear				
25	he/she appears to be seeing another person(s) or things that nobody else can hear				
26	he/she finds it difficult to get a hold of thought-patterns and express issues weirdly				
27	he/she has trouble speaking the words he/she want to say, or is he/she able to speak but incoherently				

28	he/she sometimes feels completely unresponsive emotionally, as if he/she don't feel anything				
29	he/she have difficulty getting organized to complete any kind of daily activity, or personal hygiene				
30	Will you attribute some of the experiences above to the use of alcohol, or drugs, or taken prescription medications which could alter mood or behaviour?				
SUBSTANCE/ALCOHOL ABUSE or DEPENDENCY					
<i>Tick where applicable</i>					
Are you regularly or frequently using any drug or substance which is not prescribed by a medical personnel for medical reasons? []					
Alcohol []					
Other substance []					
31	I mostly end up drinking/taking the substance more, or longer, than I intend to				
32	I have tried a couple of times to reduce or stop drinking/taking the substance, but I couldn't				
33	Drinking alcohol/taking the substance get you sick and gives me other aftereffects				
34	I would wish to drink/take the substance so badly that I cannot think of anything else				
35	Drinking/taking the substance affects and interferes with my taking care of your home or family, or caused job troubles, or school problems				
36	Drinking/taking the substance makes me vulnerable when driving, swimming, using machinery, walking in a dangerous area, or having unsafe sex etc.				
37	To get the same effect I have to drink/take the substance much more than previously				
38	When I try to stop I get troubles in one of or a combination of the following: sleeping, shakiness,				

	restlessness, nausea, sweating, increased heart rate, or a seizure				
39	I think I have given up trying to stop				
40	I know alcohol/this substance is not good for my wellbeing.				
SCORES	DEPRESSION				
	ANXIETY				
	SCHIZOPHRENIA				
	SUBSTANCE/ALCOHOL ABUSE or DEPENDENCY SYNDROME				

Scoring

Depression

This have thirteen items on the scales 0, 1, 2, and 3. The lowest score would be 0 and the highest 39. Since it is not to diagnose but to screen, any score lesser or equal to 10% (≈ 4) would be considered negligible and ≤ 4 to ≤ 39 would be assumed indicative of depression.

Anxiety

This have eight items on the scales 0, 1, 2, and 3. The lowest score would be 0 and the highest 24. Since it is not to diagnose but to screen, any score lesser or equal to 10% (≈ 2) would be considered negligible and ≤ 2 to ≤ 24 would be assumed indicative of anxiety

Schizophrenia

This have eight items on the scales 0, 1, 2, and 3. The lowest score would be 0 and the highest 24. Since it is not to diagnose but to screen, any score lesser or equal to 10% (≈ 2) would be considered negligible and ≤ 2 to ≤ 24 would be assumed indicative of schizophrenia.

Substance/alcohol abuse or dependency syndrome

This have 10 items on the scales 0, 1, 2, and 3. The lowest score would be 0 and the highest 30. Since it is not to diagnose but to screen, any score lesser or equal to 10% (3) would be considered negligible and ≤ 3 to ≤ 24 would be assumed indicative of Substance/alcohol abuse or dependency syndrome.

APENDIX VI

A scanned copy of Ethics Committee of Humanities' approval letter.

