AN EVALUATION OF VARIOUS CONTRIBUTIONS OF THE NATION'S CLINICAL PSYCHOLOGISTS TO HEALTH CARE IN GHANA FROM 1972-2005.

BY

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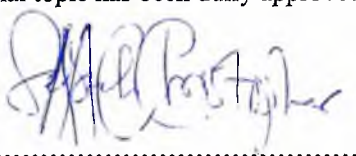
DECLARATION AND APPROVAL

I, Christopher Mensah-Sarbah do hereby declare that this dissertation was my own novel invention and that all references have been duly acknowledged. The area of study and final topic has been dully approved.



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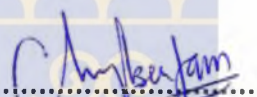

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DEDICATION

This dissertation is lovingly dedicated to the **four** most important people in my life:

The source of my life and destiny, **GOD ALMIGHTY**,

My Family, Mr. & Mrs Albert Mensah-Sarbah, Alberta, Andy, Harriett, Irene and Chris,

My Students, who are ever increasing and keep informing me of my influence on them

and

My Clients who seem to respond to my therapy and show appreciation for it.

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Apart from granting me the interview on three occasions, Dr Araba Sefah Dedeh also instructed me on the minimum length of sessions of psychotherapy I should adopt for my clients among other things. Dr Angela Ofori-Ata granted me an interview and provided me with objective criticism. She also read through four chapters of the script, edited them and offered good suggestions to be considered. Mrs Sarah Ado was kind and gracious in offering her candid opinions about the facts regarding the genesis of the Clinical Psychology graduate training programme. Interviewing her was intriguing.

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ABSTRACT

The study focussed on assessing the role and impact that Clinical Psychology as a profession has made on the delivery of health in Ghana since its inception in 1972. In order to achieve this objective, both quantitative and qualitative research methods were employed. The qualitative technique involving interviews and archival research helped reviewed the nature of health delivery that existed before 1972 when Clinical Psychology was not yet introduced, and the contribution it brought to bear on health provision after its introduction. To buttress the unique contribution of Clinical Psychology on health delivery, a pretest-posttest experimental design to investigate the impact of psychotherapy on neurosis was conducted with a sample of 42 patients of Pantang Hospital. Sample characteristics are mean age 31.04 years, SD=9.84 and gender distribution 24 to 18 male and female respectively. Psychotherapy, which is the main treatment approach used by Clinical Psychology was used to intervene with the experimental group. Statistical analysis using the Independent Samples t test revealed significant differences between experimental and control groups. The results showed a drastic reduction in the level of neurosis (anxiety, stress and depression) of the patients who were taken through psychotherapy. Furthermore, comprehensive interviews and archival research conducted reveals that more patients respond better when psychotherapy is integrated with chemotherapy. In conclusion, psychotherapy which was introduced to the health care landscape since 1972 by Clinical Psychology is still potent and valid as when it was first introduced. This finding makes it logical to have Psychologists working hand in hand with Medical Doctors, Psychiatrists, Social Workers and even Nutritionists in hospitals and other health centres as prescribed by the Biopsychosocial model.

CHAPTER ONE

INTRODUCTION

In Ghana, traditional health delivery system was predominantly the services provided by Physicians or Medical Doctors, Psychiatrists, Community Health Nurses as well as the non orthodox approaches of Traditional Healers until 1972. By 1971, S.A. Danquah had become the first Clinical Psychologist on the West Coast of Africa and in the following year he started both the practice and teaching of the discipline at the University of Ghana Medical School.

Through persistence in practice and the training of more human resources to continue the work, it is becoming clear the distinct role and the actual impact Clinical Psychology is having on the health delivery system in Ghana. Health is a multidimensional factor that includes physical, social and psychological wellbeing. Clinical psychology which essentially deals with the assessment, diagnosis and treatment (psychotherapy) of psychologically related health problems has succeeded in showing the significant relationship between mental or psychological health and physical health.

DISTINCTION BETWEEN CLINICAL PSYCHOLOGY AND PSYCHIATRY

Every day survey shows that most lay people are uncertain about what difference there is among Clinical Psychologists and Psychiatrists and some times even a Social Worker. This makes it difficult for them to know specifically who to seek a specific mental health need from.

A Clinical Psychologist is a person who has been trained some times up to doctorial degree in psychology with specialisation in the areas of psychopathology, diagnostic evaluation and treatment of people with psychologically related health problems. This degree entails about up to 10 years of academic training including hundreds of hours of practical training and internship experience. The breakdown of the training include four years of undergraduate training, additional three or more years in post graduate training for doctorate degree. During the graduate training, the Clinical Psychologist works in treatment settings such as hospitals and clinics under the supervision of more experience Psychologists. At this point, he/she may seek to be licensed to offer services on an independent basis.

A Psychiatrist on the other hand is a Physician who has decided to specialise in the treatment of people suffering from psychiatric and emotional disturbances. The Psychiatrist complete up to six or seven years of medical school training and generally a three or four year psychiatry residency. As a resident the Psychiatrist serves on the staff of a hospital or clinic and receives additional training and supervision in the treatment of emotional problems.

In terms of rigour and extensiveness of their training, both Clinical Psychologist and Psychiatrist have essentially equivalent background and both training programmes are highly competitive and requires higher degree of ability and diligent to complete. In most of their routine practices Psychiatrist and Psychologist function very similarly. The main difference however is, because their backgrounds differ, they do bring difference

skills to bear on a situation. The Physician is highly trained in the physical functioning of the body and is licensed to prescribe drugs. On the other hand the Psychologist is more highly trained in psychological functioning, personality theory, psychological diagnostic testing and research. Despite these distinctions, in many settings psychologists and psychiatrists work together in teams to capitalise on the unique skills of each and blend different models of practice (the Biopsychosocial model) (Walker, 1990).

In a typical relationship, a patient may first complain to a medical doctor when faced with any health problem. A medical doctor's natural inclination is to prescribe medicine in an attempt to cure the problem. When the patient's condition refuse to respond to the medication, the medical doctor may suspect that the condition may have more to it than mere bodily disease and may refer the case to the psychiatrist. The psychiatrist who is also pharmacologically oriented may continue with psychotropic medication until the case is eventually referred to the psychologist for assessment to determine the main cause of the condition and continue with psychological intervention.

Another adjunctive and effective mental health service provider is the Social Worker. To become a Social Worker one must complete four years of undergraduate training and two years of graduate training in Social Work. This leads to a Master of Social Work (MSW) degree. While it is possible to get a doctoral degree in social work, the MSW is considered the terminal degree for clinical practice while doctoria degree is more for research and academic social workers.

As indicated already, Clinical Psychology had been preceded by the main stream medical practice in Ghana (which involved physicians or medical doctors, psychiatrists and nurses) whose main mode of treatment is chemotherapy or pharmacotherapy, the use of drugs to treat health problems. Medical history in Ghana dates back to as early as the colonial days. The medical profession involves physicians who are trained to diagnose and give treatment to physical health conditions. Psychiatry on the other hand is part of Medicine which specialises in the study of etiology and treatment of mental illness. Since Psychiatry is a branch of Medicine, it uses medical modalities for its operation.

For instance both Medical doctors and Psychiatrists use the Biomedical Model as the main model for conceptualizing the etiology, cause and treatment of all disorders including psychological ones.

THE MAIN MODEL OF THE PHYSICIANS

The Biomedical Model

The Biomedical model is the view that all kinds of disorders or health problems have a biochemical or physiological basis and therefore the mode of treating such conditions should be essentially and primarily through the use of chemicals, pharmaceuticals or drugs intended to alter the malfunctioning of the physiological system. While this model is not new, recent research in neuroscience is proving the biochemical basis of many diseases, as well as the genetic factors involved in the variety of disorders.

This model is not new in the sense that it was the Greeks who were among the earliest civilizations to identify the role of bodily functioning (physiological system) in health

and illness. Rather than ascribing illness to evil spirit, they developed a humoral theory of illness that was first proposed by Hippocrates (Ca. 460-377 BC) and later expanded by Galen (AD129-199). According to this view diseases or disorders arise when the four circulation fluids of the body- blood, black bile, yellow bile, and phlegm- are out of balance. The function of treatment is to restore balance among the humours. Specific personality types were believed to be associated with bodily temperaments in which one of the four humours predominated (Taylor, 1995).

However from the beginning of the Renaissance, great strides have been made in the technological basis of medical practice. Most notable among these were Anton Van Leeuwenhoek's (1632-1723) work in microscopy and Giovanni Morpagn's (1682-1771) contribution to autopsy, both of which laid the groundwork for refuting the humoural theory of illness. The humoural theory of cellular pathology, maintains that all disease is disease of the cell rather than a matter of fluid imbalance (Taylor, 1995).

Just about a century ago, another view began to emerge with the rise of modern psychology, in particular with Sigmund Freud's (1856-1939) early work on conversion disorder. This is the Psychoanalytic model. Subsequently, other models evolved

THEORETICAL MODELS IN CLINICAL PSYCHOLOGY

The Psychoanalytic Model

This is the view, developed by Freud, that psychological disorders result from unresolved unconscious conflicts, usually traceable to childhood experiences and treatable by

helping the person to uncover the unconscious source of their problems. According to Freud, specific unconscious conflicts can produce particular physical disturbances that symbolise the repressed psychological conflicts. In conversion hysteria for example, Freud explains that the patient converts the conflicts into a symptom via the voluntary nervous system and becomes relatively free of the anxiety the conflict would otherwise have produced. Later the idea that specific illnesses are produced by internal conflict was perpetuated in the work of Flanders Dunbar in the 1930s (Dunbar, 1943) and Franz Alexander in the 1940s (Alexander, 1950) which shaped the emerging field of psychosomatic medicine. Another important model that evolved is the cognitive Behavioural model.

Cognitive-Behavioural Model

This is the view that psychological disorders result from learning maladaptive patterns of thinking and behaving and can be treated by learning new but, more adaptive patterns. This model emanated from the views of Skinner, Wolpe and Eysenck who focus on overt behaviours as the targets of clinical assessment and treatment and social learning theorists such as Albert Bandura, Walter Mischel, Julian Rotter who theorised about the ways cognitive activities contribute to learning. Today, the majority of clinical Psychology faculty at U.S universities are cognitive- behavioural in their orientation (Sayette & Mayne, 1990) using methods derived from behaviourist and cognitive approaches to learning. Cognitive-behavioural therapists begin with a careful behavioural analysis examining the symptom and the stimuli or thoughts associated with it. They then tailor procedures to address problematic behaviours, cognitions and emotional responses. The

effectiveness of cognitive behavioural therapies lies in their ability to target specific psychological processes

Diathesis- Stress Model

The diathesis–stress model is the view that people who are biologically predisposed to mental disorder (they have particular diathesis) will tend to exhibit that disorder when they are affected by stress. The diathesis- stress model provides an increasing popular way of integrating biological concepts into psychological models. This perspective views many mental disorders as the result of an interaction between a biological predisposition or risk of a disorder and an environmental trauma or life stress.

The final model which has evolved and has a lot of present relevance is the Biopsychosocial model.

The Bio-Psychosocial Model

The Biopsychosocial Model is the view that biological, psychological and social risk factors combine to produce emotional disorders. The approach is also known as the system's model. The Biopsychosocial model is a modern concept which is being strongly advocated by the World Health Organisation (WHO) to be the most valid means of diagnosing and treating illness and diseases. The Biopsychosocial model uses a multidisciplinary approach to diagnosing and treating illness or disease. In this case, the mind and body is seen as an inseparable entity and as such views disease as a result of multiple factors comprising biological, psychological and social which produce multiple effect requiring an interdisciplinary approach to diagnosis and carry out treatment

(Danquah, 2000). There must therefore be a team working together made up of Psychiatrists, Physicians, Nurses, Nutritionist, Clinical Psychologist, Environmental Officers, Social Workers etc. (Danquah, 2001).

The idea of the inseparability of the mind and body can also be traced to Ancient Greek civilisation when medical practice progressed by the theory of cellular pathology, a notion that illness is a result caused by pathogens to the cell, making Physicians to become the guardians of the body (i.e., the Biological Model) while Philosophers and Theologians became the care takers of the mind.

Because the Biomedical Model failed to see the true relationship between the mind and body, and rather construed them as separate entities, it led to several difficult implications. According to Taylor (1995), firstly, it was a *reductionistic* model. That is, it reduces illness to low level processes such as disordered cells and chemical imbalances rather than recognising the role of more social and psychological processes. Secondly, the biomedical model is essentially a single factor model of illness. That is, it explains illness in terms of biological malfunction rather than recognising other factors some of which are biological responsible for the development of the illness. Finally, the biomedical model clearly emphasises illness over health. By this, it focuses on aberrations that lead to illness rather than on the conditions that might promote health.

Consequently, some obvious problems with the biomedical model include difficulty in accounting for why a particular set of somatic conditions need not inevitably lead to

illness. In effect the social and psychological conditions that influence the development of the illness are ignored by the biomedical model. Moreover, even with the most competent of diagnosis and treatment, the practitioner–patient relationship substantially influences the therapeutic outcome.

All these difficulties with the biomedical model make it scientifically and clinically inadequate in explaining and treating health problems, hence the new emphasis of the World Health Organisation (WHO) is the Biopsychosocial Model.

In this regard, the Biopsychosocial model of health and illness overcomes the disadvantages of the biomedical model by the use of the *systems theory* approach, which maintains that all levels of organisation in any entity are linked to each other hierarchically, and that change in any one level will effect change in the other levels. This means that micro level processes (such as cellular changes) are nested within the macro level processes (such as societal values), and that changes on the micro level can have macro level effects (and vice versa) (Taylor, 1995). The Biopsychosocial model maintains that health and illness are caused by multiple factors and produce multiple effects. The model maintains that the mind and body cannot be distinguished in matters of health and illness because both so clearly influence an individual's state of health.

Apart from these five main models of conceptualisation and treating illness and diseases, there is one model that is worthy of mentioning which was and is still notable in Ghana. This as mentioned above is referred to by others as the non orthodox traditional healings.

TRADITIONAL HEALING MODEL

Under this model, a number of sub disciplines apply. There is the **Traditional Herbal, Traditional Spiritual** and a blend of the two. The traditional spiritual can also be categorised into two: ***the Native Spiritual Centres*** that are mainly attached to a particular shrine and deity and ***the Christian Spiritual Centres*** that are mainly practiced in Churches and Prayer Camps. However, the two have something in common. They both seem to express strong faith in deities. The strict traditional herbal may either express faith in a deity or the ancestors or sometimes even both *(Personal Communication, 2005*).

The Traditional Herbal Model

This model is similar to what is now termed Modern Medicine. The traditional herbal approach also holds the view that diseases and sicknesses are caused by the malfunctioning of the physical body. As a result it uses herbs which are either brewed for drinking or merely applied to affected parts as in the case of any medication. As alluded to earlier, some of the Herbalists blended the herbal medication with other beliefs and practices which may be termed as faith healing *(Personal Communication, 2005*)

The Traditional Spiritual (Native Spiritual Centres)

This model is quite broad as it views disease and illness from a mystical and demonological perspective. In other words, traditional native spiritual centre views diseases and illness as caused by other spirits and/ or the enemies of the victim who has used another spiritual medium or their own witchcraft to cast a spell on the sufferer.

Therefore, they believe the victim should be cured by using a counter technique to reverse the trend and invoke it with curses to the source *(Personal Communication, 2005)*

The Christian Spiritual Centres

This model conceptualises the etiology, cause and treatment of diseases and sicknesses from both supernatural and natural sources. In other words, the Christian Spiritual Faith healing believes that diseases and sicknesses are sometimes caused by wrong doing (or sin) against the teachings of the Christian faith as enshrined in the Holy Bible. Secondly, illness can also be caused by natural events such as the outbreak of a particular disease as in an epidemic or pandemic or health problems can also be caused by poor health hygiene. As a result of this conceptualisation, the Christian faith uses both supernatural means such as prayers as treatment approach as well as seeking medical care from orthodox health institutions such as clinics and hospitals or resort to their own herbal concoctions. *(Personal Communication,2005)*

As indicated earlier, it is within the context of the biomedical and the traditional healing models that Clinical Psychology with an emphasis on the Biopsychosocial model was introduced into the Ghana Health Delivery System. However, at the first instance the Biopsychosocial model was not introduced in name even though the approach was actually that. It was in 1997 when the pioneer of the profession in Ghana (Danquah 2001) with the help of a number of the Clinical Psychologists such as Araba Sefah Dedeh, Angela Ofori Atta, and Psychiatrists such as J.J. Lamptey, Dr. Asare, Prof Turksa, Dr. Ohene officially established emphasized and practised the Biopsychosocial approach to

health care *(Personal Communication with Professor S.A Danquah, 2005, Dept. of Psychology, Legon).*

This means they operated as a team of experts dealing with health problems looking at the medical, psychological social and even nutritional, referring cases to each other consulting with each other and sharing from a bigger chemistry of expertise in order to have effective and more lasting results. These professionals did not only refer and consult with one another; the psychiatrists helped the training of clinical psychology students. Consulting with other Medical professionals existed among themselves in few instances before, but in 1997 it was concretised and expanded to include all variety of health service providers and it became the main operating system introduced by the Psychologists which was more pronounced than ever in the history of health delivery in Ghana.

The first clinical psychology technique to be introduced was the Behaviour Therapy which was essentially a psychological treatment approaches in Ghana by 1972. It was located at the Department of Psychiatry of the University of Ghana Medical School, Korle – Bu. After three decades, of persistent practice and training of more human resource to continue the good works, it is becoming more and more evident, the distinct role and actual impact that clinical psychology is having on the health delivery system in Ghana.

On the basis of the above premises, a comprehensive review of the discipline is to be pursued. The form includes both interviews with the pioneers of the practice in the country and other significant stakeholders, health professionals as well as collating their clinical successes published. As part of the impact assessment an additional clinical research has been conducted during the author's one year of clinical practicum.

The historical records of Clinical Psychology as practised in the clinic and taught in the classrooms seem to lead to a logical prediction that the profession's services will increase the rate of recovery among patients with health problems. Secondly, the profession affords patients with preventive techniques that disallow the recurrence of health problems in patients. Ultimately, clinical psychology makes the individual the controller of their own health since they are taught responsible behaviours that promote health.

STATEMENT OF THE PROBLEM

A considerable number of important problems has been identified which is motivating this current study. The main issues and problems are being outlined in order to attempt to answer them with the research. The important questions include; is there any distinct role of Clinical Psychology in the delivery of health care in Ghana; or is it merely a duplication of the work of Psychiatry? If it has a clearly distinct professional role different from Psychiatry, why is it not integrated into the Ghana Health Service? Furthermore, there seems to be a misrepresentation of the profession among the lay people of the street in terms of what it is and what it does. For instance, Clinical Psychology seems to be viewed as synonymous with Counselling among many

Ghanaians. This is perhaps due to the fact that it is a relatively young profession in the country compared to other health providers in the Medical field such as Medical Doctors and Psychiatrists. Apart from that, it is being practiced by very few qualified practitioners in the country. This is part of the problem. In order to find conclusive or convincing solutions to these issues, and to attempt an evaluation of the possible impact of the profession on health provision, an approach of the historical development of the profession would be engaged for the purpose.

AIMS AND OBJECTIVES OF THE STUDY

1. The study would investigate various contributions of Clinical Psychologists on the delivery of health in Ghana.
2. The study will explore the *distinctive but complementary role*, played by Clinical Psychology alongside mainstream Medicine and Psychiatry in health delivery.
3. Also, there would be a research to review the systematic historical development of Clinical Psychology in Ghana and West Africa.
4. To reveal the nature and scope of Clinical Psychology as a broader science, a fragmentary aspect of which is counselling. (NB. *Counsellors may not do any psychological testing and assessment, an important diagnostic technique which is essential to Clinical Psychology*).
5. To conduct an experiment to demonstrate the efficacy and validity of Psychotherapy in solving neurotic problems as compared with Chemotherapy alone used for treatment.

RELEVANCE OF THE STUDY

Every new enterprise or project that has already commenced needs to be evaluated after some time in order to determine its efficacy in the mission or purpose it set to achieve. If the evaluation reveals that the new enterprise or project is being efficacious in achieving its purposes and goals, then it is maintained and even streamlined to boost its success. On the otherhand if it is discovered that the new enterprise has been unable to achieve the goals and objectives it was meant to achieve, then a comprehensive analysis to find out the causes and reasons of the failure could be kickstarted and the necessary changes made to bring the enterprise back on track.

In this light, the study evaluates the possible contributions of the practice of Clinical Psychology on total health delivery system in Ghana. It is expected that the true nature and state of the profession as it stands today will be examined in the study and relevant recommendations made to specific areas which is deemed to require change in order to boost the efficiency of the profession.

In essence this research work can serve as an impact assessment data to the profession. Additionally, it can become a resource material of reference for the developing Ghana Psychological Association (G.P.A.) especially its Clinical Psychology wing. Potentially, the hard core facts from the study can generate further research and more articles to be published which could be used to educate people about the activities of Clinical Psychologists, their role in health delivery and the actual contributions for the past three

decades. This can help eliminate the unnecessary public misperceptions that currently exist among some.

Also, the material can be used to help the Ministry of Health in influencing policy direction after taking a critical look at the health service structure and help include Clinical Psychologists in the Ghana Health System structurally. It will also inform Government why they should help in the training of more Clinical Psychologists by committing funds to the Educational Institutions responsible for training. Furthermore, pursuit of a methodical and systematic attempt to review literature concerning the historical development of Clinical Psychology in Ghana from 1972 to 2004, will afford the profession a written history helping it to learn from its past, correcting its short falls and forging ahead with its strength. In this case, an accurate and comprehensive historical record of the origin, the present status and standing as well as the future prospects is being looked at. The study is therefore of immense importance and relevance since it will afford us the opportunity to review the profession in the right perspective, correct erroneous public perceptions and do adequate strategizing for the future.

CHAPTER TWO

LITERATURE REVIEW

Historical/Theoretical Framework

A lot of impact assessment, efficacy of psychotherapy for that matter the actual impact of clinical psychology as a profession has been achieved. However, these recorded achievements of a profession in terms of discharging its duties and role in health delivery has been focussed in the West where clinical psychology was birthed. An examination of the profession in the African Cultural context from the perspective of Ghana is considered a virgin research field for pioneer exploration, in the light of the fact that no comprehensive historical review of the impact of the profession has been done.

In the past three decades, a sizeable amount of clinical practice and researches have been conducted which reveals the impact of psychotherapy in treating health problems ranging from the so called traditional medical problems such as malaria and diabetes to pure psychological problems such as phobia and low self – esteem. Over the years, it is becoming abundantly clear the multiple but distinct roles that clinical psychologists play in the discharge of quality health to patients. These roles which include diagnosis, assessment, treatment and rehabilitation, referral, psychological testing, research, teaching, psychoeducation, consultation, and administration and management has become a major contribution to quality health delivery in the country of which a good number of medical doctors and psychiatrists well appreciate.

For the first time, we are beginning to see medical doctors and psychiatrists refer patients whom they consider have problems that can better be handled by clinical psychology to Clinical Psychologists. Clinical psychologists also refer patients to the physicians when they discover that the problem of a patient is outside their competence and will be better handled by the physicians. It is because of this healthy collaborative development that trained Clinical Psychologists are gradually being attached to a good number of the country's general hospitals. For example, there are Clinical Psychologists and clinical psychology units attached to Korle–Bu Teaching Hospital, 37 Military Hospital, Okomfo Anokye Teaching Hospital, Sunyani Regional Hospital, Kintampo Health Research Unit headed by Bright and Dr. Doku and recently Koforidua Regional Hospital manned by Sarfo Acheampong apart from the private practice Clinicians who are attached to other privately owned health centres.

In order to have a complete picture of the systematic historical development of the profession, it is better to consider original genesis of clinical psychology as a profession.

THE BIRTH OF CLINICAL PSYCHOLOGY AS A PROFESSION

In March 1896, a school teacher named Margaret Maguire asked Witmer to help one of her students who was a "chronic bad speller". When Witmer took the case, he became the first clinical psychologist and began an enterprise that became the world's first psychological clinic (Nietzel, Bernstein, & Milich, 1994). The willingness of the first clinical psychologist Lighter Witmer to work with a child's scholastic problem may not now seem significant enough to mark the founding of a profession, but it must be noted

that until this point, psychology had dealt with people only to study their behaviour in general, not to become concerned about them as individuals.

Although psychologists had began to apply scientific methods to the study of individual differences as early as 1879 when Wilhelm Wundth established the first psychology laboratory in Leipzig, Germany; and Sigmund Freud's dynamic approach to behaviour disorder was opening vast new areas of subject matter for psychologists interested in understanding deviance, the American Lighter Witmer is credited with being the father of Clinical Psychology when he applied the principles of the discipline to successfully treat his patients.

Several aspects of his new clinic which later came to characterise clinical practice were; he only made recommendations after adequate diagnostic assessment, teaming up with various professions in order to consult and collaborate on a given case. Moreover, his main interest was preventing future problems though early diagnosis and remediation. Witmer also offered a course of child psychology and this made him attracted to many teachers concerned about their students. It can be seen that these basic tenets of Witmer's clinical practice can still be traced in today's Clinical Psychology, School Psychology and Child Psychology. The most important of all is the team approach he used, which is now the Biopsychological model for which the World Health Organisation (WHO) is advocating.

Over the years, the birth of Clinical Psychology in the west particularly in the US has grown and developed into many countries and different cultures. On this basis it is important to review the genesis and development of clinical psychology in Ghana since that is the main focus of this study.

CLINICAL PSYCHOLOGY COMES TO GHANA

In 1968, the first Pan – African Psychiatry Congress was held in Dakar, Senegal and it indicated that there were no clinical psychologist/behaviour therapists in sub – Saharan Africa (Foster, 1968). At the time that clinical psychology was fast developing in both the Americas and Europe, S. A. Danquah was pursuing graduate education at McGill and Wales, at which time he studied under famous psychology theorists such as Hebb, Mezack, McDonald, Hans Eyesenck, a personality theorist and a British psychologist and later the famous South African Behaviour Therapist, Joseph Wolpe. Danquah also studied with Edna Foah at the Temple Medical School of Psychiatry where he completed his Post-Doctoral training in Behaviour Medicine *(Personal Communication with Professor Samuel Danquah, 2005, Dept. of Psychology, Legon).*

After the training and brief practice he proceeded to Ghana where he became the first clinical psychologist in Ghana and in West Africa in 1971. Clinical Psychology using behaviour therapy was first introduced to Ghana in 1971 as a unit within the Department of Psychiatry of the University of Ghana Medical School. As a result, undergraduate medical and dental students were taught theoretical concepts as well as practical training in clinical psychology at the unit.

TRAINING OF CLINICAL PSYCHOLOGISTS

Over the years, birth of clinical psychology in the West particularly in the U.S has grown and developed into several parts of the U.S itself, many other countries and even different cultures. It is important to have a thorough review of how clinical psychology training programmes developed, the principle and models and course structure used in establishing them. Since the U.S was the pioneer of the discipline and continues to serve as the epicentre of clinical psychology today, a comprehensive review of how the programme was introduced in some of its state Universities needs to be emphasised.

THE CLINICAL PSYCHOLOGY TRAINING PROGRAMME (C.P.T.P) AT LOUISIANA STATE UNIVERSITY

The clinical psychology training programme (CPTP) at Louisiana State University (LSU) was establish and accredited by American Psychological Association in 1957. It subscribes to a "Scientist Practitioner" or "Boulder" model of clinical training. In other words the faculty believes that the optimal clinical psychologist should be both an accomplished clinician and a research scientist. The trainee is trained to directly access clinical procedures in a scientific fashion, evaluate the clinical literature from a scientist perspective, call upon a relevant empirical findings and principles in creation and/or application of clinical procedures (and test them accordingly). Consequently, the CPTP trains students to ultimately integrate basic and applied (clinical) psychology into a suitable sound and personal frame of reference.

The course work of the CPTP at LSU is such that during the first four semesters the student must pass graduate level qualifying core courses in Biological Bases of Behaviour, Cognitive Basis of Behaviour, Social Bases of Behaviour, History and Systems of Psychology and either Intermediate Statistics or Methodology and Research Design. By the end of eight semesters, the following clinical core courses must have been passed; (1) Psychological Assessment; (2) Psychotherapy and Behaviour Change; (3) Behaviour Therapy or Child Behaviour Therapy; (4) Advanced Psychopathology; (5) Developmental Disorders and Psychopathology of Children; (6) Measurement of Behaviour, and (7) Professional Considerations in Psychology.

In terms of research, since C.P.T.P at L.S.U is a doctoral programme, three research projects are required: a master's thesis, an intermediate project and a doctoral dissertation. The intermediate project is an unusual requirement and informally conducted publishable research investigation undertaken on a collegial basis with one of the clinical faculty. Student's select research advisers and minor professors according to their research and clinical interest, and may change their advisers as their research interest require.

In terms of clinical experience students go through a comprehensive and wide range of clinical practica. The practicum is 12 credit hour requirements where students spend more time with patients (clients) and have more responsibility for them as they progress in the training. With increased clinical experience a student may begin to take part in the supervision of less experienced students.

But the clinical psychological programme in Louisiana State University is adequately sponsored by the Federal/State government. Virtually, all clinical students who are eligible for financial aid and who request it receive financial aid in the first four years. First year students get teaching/research graduate assistantships or clinical externships (have-time), supervised clinical psychology assistance positions with state mental health agencies or area practitioners.

Another University that has another efficient psychology programme is University of Kentucky.

CLINICAL PSYCHOLOGY PROGRAMME AT UNIVERSITY OF KENTUCKY

The University of Kentucky was founded in 1865 as land-grant institution and it is perceived as the leading research University in the State (Baer, 1990). The clinical programme is also committed to the Boulder Scientist practitioner model. It provides students with intensive training in the broad range of clinical and research areas. Students are expected to become competent researchers and clinicians who can be successful in the variety of clinical and/or academic positions. At the same time the programme is sufficiently flexible to allow students to tailor their training to fix their individual interest. Faculty members represent a range of theoretical orientations including cognitive-behavioural, inter-personal and psychodynamic. The programme is committed to comprehensive training in diverse approaches. Students receive both clinical supervision and course instructions in a broad range of conceptual frame works.

The course work of the clinical programme in the University of Kentucky includes Personality, Psychopathology, Assessment, Clinical Interviewing, Statistics and Research Design, Systems of Psychotherapy and History of Psychology. As students progress through the programme, they choose from a variety of advanced clinical seminars including marital and family therapy, behaviour therapy, child psychopathology, behaviour medicine/health psychology, psychopharmacology, forensic psychology, ethics, psychophysiological assessment and addictive disorders among others. In addition students are expected to fulfil an off-campus practicum placement requirement at either a medical centre or a mental health centre. During their second semester students take one hour seminar in thesis preparation, which provides structure and guidance in the selection of a thesis committee and development of thesis proposal. Most thesis work is done in the second year after passing the qualifying exams.

THE CLINICAL PSYCHOLOGY PROGRAMME AT STATE UNIVERSITY IN NEW YORK (SUNY) -BINGHAMTON

The Clinical Psychology Programme at State University in New York (SUNY) – Binghamton is another APA – approved Clinical Programme that focuses on behavioural Training. The CPTP at State University in New York (SUNY) also uses the new model called the Boulder Model. That is the programme emphasises training in scientific and experimental method not merely to produce skilled researchers or future academic scholars but also producing professionals who will have the option of engaging predominantly in direct source with clients. The programme integrates scientific

traditions and social values together and inculcates its student with them. This objective is achieved by requiring students conduct research in their advisors laboratory and discussing both the methods used and the outcome with faculty. The final aspect of the school's requirement is the theses and dissertations students are expected to submit as their final work before completion of their training.

Some methods of applied research used in the CPTP at State University in New York (SUNY). One is carrying out research with clients or patients at the Psychological Research and Training Clinic an APA site. However, there is a concern that the clinic is more like a traditional mental health outpatient clinic in function than a specialty research clinic. Another research model is the use of microcomputers for assessments, treatment design, decision making and monitoring of progress. This makes the students to well represent the scientist-practitioner model, where the empirical clinician is to use date to guide and evaluate the clinical process. Although the CPTP at State University in New York (SUNY) is doing well, the faculty is pretty worried that there is little doubt that their model of clinical training is under systematic attack from various quarters especially professional guild interest whose approach to training seems to be a course in this clinical topic and another in that (Bruce, 1988).

The completion of programme requirement takes the students an average of 5years before the pre-doctoral internship although a significant number do finish within the 4 years around which the programme is designed.

THE CLINICAL STUDIES DUAL-SPECIALITY PROGRAMME AT THE UNIVERSITY OF HAWAII MANOA

The APA approach doctorial programme in Clinical Studies at the University of Hawaii, Department of Psychology introduces what is called Dual-Specialty Programme. The programme interprets various conceptual elements, beginning the view concerning the value of integrating the fields of psychology in understanding and treating the problems of human behaviour. Based also on the Boulder vision of the Scientist –Practitioner, the programme discuss additionally from the M.D. PhD training model that is provided in many medical schools for the preparation of researchers and academicians. The basic conception of this approach is that top flight researcher-academicians in years to come will require PhDs in areas of psychology other than clinical and that outstanding practitioners in clinical psychology will profit greatly from expertise in basic areas of psychology that are required to meet APA Standards. This is meant to make graduates of the programme acquire licences as clinical psychologist in most states as well as being prepared for academic research careers. This approach is to make the profession of clinical psychology rests basic areas in psychology in the manner that medicine rests on its basic sciences.

The dual-speciality model of clinical training in University of Hawaii at Manoa attempts to address issues in the science of psychology. According to Heiby (1988) an associate professor of Psychology Department University of Hawaii at Manoa, at various levels including the governance structure of the APA, the field of psychology is characterised by splits between clinical and non-clinical psychology. The training of many clinicians is

so specialised that it precludes intimate contact with fields of psychology basic to clinical, thus the schisms between clinical and non-clinical are fostered in training.

The dual-speciality options offered in clinical studies programme of the University of Hawaii, Manoa include joint specialties such as behavioural, behavioural neuroscience, community, cross cultural, developmental, health, social-personality and an individualised specialty option.

THE CENTRE FOR COGNITIVE THERAPY AT THE UNIVERSITY OF PENNSYLVANIA: EDUCATION AND TRAINING

The Centre for Cognitive Therapy (CCT) located at the University of Pennsylvania in Philadelphia, offers intensive, formal post doctorate training programme for psychologist, psychiatrists and clinical social workers. The main goal of the training programme at the Centre for Cognitive Therapy (CCT) is to produce clinicians who are skilled in basic psychotherapy and in the specific model of cognitive therapy. The Centre for Cognitive Therapy (CCT) is affiliated with the University of Pennsylvania's Department of Psychiatry and is under the direction of Aaron T. Beck, M.D. The history of the centre dates back to 1975 with the formation of the Mood Clinic at the Hospital of the University of Pennsylvania. Later, it was newly titled centre for "Cognitive Therapy" Official training of post-doctoral fellows and pre-doctoral interns began in 1980. One year after the publication of the Cognitive Therapy of Depression. However, informal training had been carried out since the inception of the Mood Clinic. Currently the centre has multiple functions including serving as an international training centre for

psychologists, psychiatrists and clinical social workers, providing direct clinical services, treating with rape of psychiatric problems, conducting research on anxiety disorders and providing information resources such as books, pamphlets, audiotapes and videotapes on cognitive therapy.

With recruitment of trainees, the centre serves as practician placement and internship site for both post doctoral patrons as well as giving clinical opportunities to graduates student. Acceptance to the centre is based on having completed an appropriate degree programme in psychology approved by APA. Selection factors taken into consideration include letters of recommendations, graduate GPA, clinical experience, publications, audiotaped or videotaped therapy sessions and a personal interview at the centre. Fellows entering the Centre for Cognitive Training Programmes are expected to obtain baseline data on their level of cognitive therapy knowledge and skills. In addition, a cognitive therapy written examination is used to measure their theoretical understanding about the model.

Some of the activities for trainee include fulfilling 150 supervision hours for a full year. Each student is assigned a mentor who functions as a clinical administrator, supervisor and advisor. During these supervision hours of requirement, trainees conduct diagnostic intake interviews. These interviews are to be comprehensive including full history, exploration of other diagnostic issues and a battery of psychological tests. Special feature was Dr. Beck, the founder of the Centre for Cognitive Therapy use to present a weekly seminar throughout the year, in which ongoing research is reviewed, professional

conference information is presented and summarised and new advances in the therapy discussed.

Another special feature of the Centre for Cognitive Therapy is its programme for visiting clinical scholars. Throughout the year a number of experienced clinicians from across the United States and abroad come to the centre periodically to observe and study. Visiting scholars may observe therapy sessions and intake interviews, sit in on supervisory sessions, view training and therapy video tapes and participate in regular formal education activities and research.

THE CLINICAL PSYCHOLOGY TRAINING PROGRAMME (CPTP) AT DEPARTMENT OF PSYCHOLOGY, UNIVERSITY OF GHANA (DPUG), LEGON

The training of clinical psychologists was commenced in 1974 at the Department of Psychology, University of Ghana, Legon. It was also patterned after the Boulder model. The architects of the programme had the objective of training students with scientific and experimental methods not only to produce skilled researchers or future academic scholars but also practitioners who will discharge services to meet the ever increasing needs of clients in the country. The trainees need a good first degree in Psychology before they could qualify to be enrolled in the master's degree programme in Clinical Psychology. The programme content includes Psychometrics, Statistics and Data Analysis, Research Methods, Systems and Theories in Psychology, Child and Adult Psychopathology and Systems of Psychotherapy. The others are Psychological Assessment, Principles and Ethics of Clinical/Counselling Psychology, Psychopharmacology, Family Stress-Biopsychosocial Approach and Seminar Presentation (1&2).

The second year of the training is devoted to theses writing and Clinical Practicum at a recognised Psychology Clinic which is either attached to a General Hospital, Psychiatric Hospital and sometimes relevant public institutions. Clinical Psychologists are attached to institutions and organisations such as the Prisons Service, the Police and even Research Centres like the one in Kintampo. Others are also holding lectureship positions in various universities in the country.

A trainee needs to meet a minimum amount of 72 credit hour academic requirement before he/she can graduate. In addition to this the programme of the CPTP of DPUG, Legon ensures that trainees undergo a 500 hour Clinical Practicum and Supervision, at which time trainees present the cases they are handling to their supervisors at weekly case conferences as well as writing of comprehensive reports about cases, assessments, diagnosis, intervention and evaluation of intervention. The supervisors therefore scrutinize, correct and coaches trainees on the appropriate clinical approaches. In addition to this, as part of licensing requirements, graduates of the MPhil programme are expected to complete a one year internship before they are awarded license by the Board of Examiners.

At the end of the second year students are required to submit their MPhil research thesis on Clinical Psychological topics before they are allowed to graduate. The variety of therapies available to clinicians for use during treatment are both taught and used to train students undergoing their 500 hour practicum experience.

These therapeutic techniques include Cognitive-Behaviour therapy, Progressive Muscular Relaxation, Breathing, Autogenics, Biofeedback, Exercises, Meditation, Visualization, Self Hypnotism, Thought Stopping, Cognitive Restructuring, Coping Skills, Assertiveness Training, Time Management, Job Stress Management, Brief Combination Techniques, Combating Distorted Thinking, Problem Solving, Systematic Desensitisation, Stress Inoculation, Covert Sensitization, Covert Assertion, Covert Reinforcements, Covert Modelling, Values Clarification, Paradoxical Intention, Orgasmic Reconditioning Nutrition etc. (Danquah, 2000). The wide range of therapeutic techniques has become very essential since the onset of the Biopsychosocial Approach to health Care which Clinical Psychologists spearheaded. Many of the above therapies are effective by altering various psycho-physiological aspects of conditions or illness.

These same trainees have engaged in a wide area of researches ranging from psychosomatic illnesses such as hypertension, stress of health care givers, and child abuse to standardization of psychological tests each of which is backed with follow-up interventions. From 1974 up to date, about seventy (70) students have gone through the full training with some having been awarded their degree while the rest are almost due for the award of the degree. In addition to the academic training and practicum, a one year internship is required from students before they are awarded a practicing licence. Currently, there are eleven students who are writing their theses as well as finishing up with their 500 hour clinical practicum. Also, there are about thirteen students of part one who have just ended the first year taught course *(Personal Communication with Professor Samuel Danquah, 2005, Dept. of Psychology, Legon).*

THE SPREAD OF CLINICAL PSYCHOLOGY TO OTHER WEST AFRICAN COUNTRIES

In consonance with the popular declaration made by the father of the nation, Kwame Nkrumah which says "the independence of Ghana is meaningless unless it is linked up with the total liberation of the African continent" (*Dr. Nkrumah's speech at Ghana's independence celebrations 1957, from BBC Sound Archives*), the Behaviour Therapy Unit had one important goal of exporting this modern technique of mental health and clinical psychotherapy to other African countries. Fortunately, by 1982, the goal was set in motion when S. A. Danquah was appointed (from Canada Memorial University) by the Nigerian Federal Government to go to the University of Calabar Medical School *(Personal Communication with Professor Samuel Danquah, 2005, Dept. of Psychology, Legon).* By 1982-1983 a Behaviour Science and Clinical Behaviour Therapy Department was first established at the College of Medicine, University of Calabar. This department was built and established on the platform and the pattern used in Ghana.

It is worth mentioning and should be acknowledged that there were other departments of clinical psychology in some of the Nigerian Universities, such as, Ibadan, Ife, and Lagos, offering clinical psychology. But the fact is that they pursued those subjects as a theoretical academic discipline but not as a clinical behaviour therapy until 1982-83 when S. A. Danquah established it there. Prior to the establishment of Clinical Behaviour Therapy in Nigeria, those departments at the Nigerian Universities were concerned with the traditional roles of psychological testing and measurements.

So when Behaviour Therapy was introduced there, it followed the pattern that was used in Ghana by Danquah where clinical psychology was integrated into multidisciplinary teams which shared clinical and therapeutic responsibilities, an approach currently termed the Biopsychosocial Approach to health care. On this score, clinical psychology which was termed then as Behaviour therapy in Ghana (spearheaded by S.A. Danquah and assisted by Araba Sefa Dede, Ofori Atta), became the epicentre to other clinical psychological practice in the rest of the West African countries, in conformation with Nkrumah's statement which was earlier alluded to.

CLINICAL PSYCHOLOGY UNDER ATTACK IN GHANA

Over the years there seemed to have been a contention between Physicians and Clinical Psychologists for that matter Chemotherapy and Psychotherapy. It is common knowledge that historically and even now, Physicians who comprise Medical Doctors and Psychiatrists use Chemotherapy or Medication as their main means of treatment of health problems in Ghana, although now few try to incorporate some psychological techniques such as psychoeducation and mental hygiene techniques to help their patients. This is as a result of the fusion and interaction surging between the two professions. Clinical Psychologist on the other hand has stuck to psychotherapy as its main mode of treatment and tackling heath problems although Clinicians endeavour to refer cases to the physicians that require more of their expertise.

In fact as a result of this interaction a number of Physicians are realising the crucial and distinct role of psychological interventions as it happened during the Freudian period and

are therefore enrolling in the CPTP at DPUG, Legon. Since then, about five Physicians have been trained.

Historically, the main attack on psychotherapy came from the physicians who claimed that it lacked scientific credibility. Even just about a decade ago several influential commentators and medical practitioners concluded that most of psychotherapy was unscientific and not significantly different from placebo. Perhaps this notion has been held particularly in Ghana and Africa due to the two major strands of psychotherapy that existed in history. Historically, there has been the empirical scientific form of psychotherapy which has more recent history dating back to not longer than the mid-eighteenth century, while the religio-magical form of psychotherapy is as old as human culture.

However, the religio-magical form is now largely outside of main stream of public health service in most countries. The psychotherapy which is now practiced within the orthodox health system is almost always the empirical-scientific form. As a result of these developments it is unlikely that such a view that psychotherapy is unscientific and merely a placebo would be accorded much credibility today as the scientific renaissance of psychotherapy is very well on its way.

In Ghana, the attack on clinical psychology has retarded the development of the profession although it is being perpetuated in a subtle fashion. Since the directors and important representatives of the Health Service in Ghana are Physicians who are

pharmacologically oriented, they have been very slack in adopting another health profession of comparable value like clinical psychology into the service. This lack of goodwill towards clinical psychologists by the physicians is not attributable to the doubt of Clinical Psychologists' role in health delivery. This is because clinical psychologists have been working with the physicians as far back the early 1970s in determining diagnosis and appropriate treatments *(Personal Communication with Dr Araba Sefa-Dedeh, 2005, University of Ghana Medical School, Legon).* A considerable number of proposals have been written to the health ministry and health service about integrating clinical psychology into the Health System but to no avail. As early as 1999, a comprehensive proposal explaining the training of clinical psychologists and its complementary role in health delivery was sent to the director of health services *(Personal Communication with Professor Samuel Danquah, 2005, Dept. of Psychology, Legon).* The document which was immediately met with lip services and rhetoric recommendations of more training of clinical psychologists to be sent to the hinterlands to help in health provision was later doctored and shelved *(Personal Communication with Professor Samuel Danquah, 2005, Dept. of Psychology, Legon).* Ironically, anytime there is a meeting to petition the ministry of health or the Health Service, the impression created is as if there is no knowledge of the role clinical psychology has been playing for the past three decades.

THE VALIDITY OF PSYCHOLOGICAL INTERVENTIONS

In recent years, task forces, especially the American Psychological Association task force on Psychological intervention Guidelines and the Task Force on Promotion and

Dissemination of Psychological Procedures have drawn up list of therapies which has been shown to be of poorer efficacy in relation to individual DSM diagnosis.(Task Force on Promotion and Dissemination of Psychological Procedures, 1995) These task forces have based their recommendations on empirically validated psychotherapies that are those kinds of psychotherapy for which there are research findings to support their efficacy.

Remarkably, the current indications show that psychotherapy has been effective in treating problems ranging from severe psychotic disorder to mild neurotic conditions. For example family education has been shown to reduce the risk of relapse in schizophrenic patients receiving medication, while a programme of cognitive behavioural technique help patients understand and cope better within their symptoms (Thase et al., 2005). It is now generally accepted that a combination of psychotherapy and pharmacotherapy is more efficacious than pharmacotherapy alone in treating mood disorders (Thase et al., 2005).

Studies have demonstrated the efficacy of adjunctive psychoeducation in reducing relapse rates in patients with bipolar disorders. Also anxiety disorders such a social phobia, generalised anxiety disorder, obsessive compulsive disorder and post traumatic stress disorder (PTSD) are deemed to respond better to cognitive behavioural techniques within interpersonal and dynamic methods while exposure procedures are the treatment of choice for panic attacks (Tarrier & Barrowclough, 1995).

Somatoform disorder such as somatization, hypochondriasis and pain disorder are also now commonly treated with methods which have strong cognitive components. Substance abuse and dependence require multiple psychotherapeutic methods. For example, supportive expressive psychotherapy and family therapy when used for substance abusers is more likely to yield positive results. When it comes to personality disorders, psychotherapeutic treatment of individuals remains challenging and complex because of the heterogeneity and the variable severity of these disorders, and the observation that personality traits and their corresponding disorders are resistant to change and very difficult to modify (Bateman & Fonagy, 2000)

REVIEW OF RELATED STUDIES

In order to look at the actual efficacy of psychotherapy, the main system of treatment employed by Clinical Psychologists, it is important to have a perspective look at impact assessments of psychotherapies. It was indeed thought in the past that psychotherapy and its outcomes were unmeasurable. However, it has now all changed. The earlier major attempts employed the use of meta-analysis (an assessment of treatment effectiveness through averaging and combining results across studies).

Meta-Analysis on the Efficacy of Psychotherapies

A landmark and first of such analysis was conducted by Smith and Glass (1977). They showed that psychotherapy was very effective by demonstrating a mean effect size of psychotherapy of 0.85 (that is, a change in Clinical condition that could be ascribed 85% to psychotherapeutic intervention).

Additionally, Smith and Glass (1977) also analysed the results of 375 controlled evaluations of psychotherapy and counselling which were coded and integrated statistically. The findings provide convincing evidence of the efficacy of psychotherapy. On the average the typical therapy client is better off than 75% of untreated individuals. Few important differences in effectiveness could be established among many quite different types of psychotherapy. More generally, virtually no difference in effectiveness was observed between the classes of all behavioural therapies. For example, (Systematic desensitization and behaviour modification) and the non-behavioural therapies, (example, Rogerian, psychodynamic, rational-emotive, and transactional analysis) (Smith & Glass 1977).

Applied meta-analysis to 475 studies of the effectiveness of psychotherapy and 112 studies of the comparative effects of psychotherapy and psychoactive drugs was conducted by Smith (1982). The studies' effect sizes were examined with the standard mean difference on the outcome variable between the treated group. Since many studies had more than 1 outcome variable, the 475 studies actually produced 1,766 effect sizes. Meta-analysis showed that psychotherapy is effective in enhancing psychological well-being, regardless of the way it is measured by researchers. The patient's age and diagnosis, the therapist's training and experience, and the duration and mode of therapy bear little relation to the psychotherapy's outcome. Behavioural therapies are somewhat more effective than verbal ones, and drug therapy, while combining well with psychotherapy, is not more effective than psychotherapy alone.

Due to Psychology's strong obsession for rigid compliance to scientific norms of data analysis, the quantitative technique of meta-analysis seems to have won the confidence researchers who desire to test the efficacy of numerous researches in the past. However, it is worth pointing out that, researchers may also need to consider other alternative approaches in future, since meta-analytic approach alone may not be enough for determining efficacy

Alan Kazdin (1985) explains that meta-analysis has been widely adopted as a quantitative approach to reviewing and evaluating a body of literature. The present article discusses the utility of meta-analysis in the context of the evaluation of psychotherapy. Benefits and limitations of meta-analysis are highlighted to identify essential characteristics of the approach as a methodological tool. The major focus is an exploration of meta-analysis in relation to alternative design and date evaluation strategies within clinical psychology. The unique contributions of meta-analysis are discussed. Fundamental issues and assumptions about psychotherapy research are identified to point to the need for critical (and qualitative) evaluation of existing meta-analyses.

Although he makes such proposal Kazdin (1986) also considers design and strategies by comparative outcome studies, including the conceptualisation, implementation, and evaluation of alternative treatments; assessment of treatment-specific processes and outcomes; and evaluation of the result. It is argued that addressing these and other issues may increase the yield from comparative outcome studies and may attenuate controversies regarding the adequacy of the demonstrations.

State- Sponsored Psychotherapy Researches

An important concern that emerged, discussed efforts made by the US Congress in the late 1970's and early 1980's to explore the extent to which those seeking psychotherapeutic services could be assured that the care they would receive would be beneficial. It is contended that psychology, psychiatry, and the mental health field have presented few summary statements to guide the educated consumer or enlightened third-party payers in decision making about mental health care. The mental health field is still young, and there has been insufficient time to evaluate the efficacy of all forms of therapy for all the problems for which patients/clients seek help. But the knowledge gained from clinical experience can be used in a tentative fashion to direct more rigorous empirical investigation. This concern continues to dwindle since there is constant evidence being revealed through countless research studies about the efficacy of psychotherapy.

In 1983, the Office of Technology Assessment (OTA), an agency of the US congress, which was established in 1972 to aid legislators in understanding the impacts of technology and provide science-based information on legislative problems, conducted assessments of psychotherapy. OTA's report on psychotherapy entitled 'The Efficacy and Cost-Effectiveness of Psychotherapy' concluded that psychotherapy is effective However, the report also indicated that the field of psychotherapy is relatively new and that only in recent years has substantial data been accumulated. (Banta & Saxe, 1983)

Belden et al. (1985) argues that the American Psychological Association's (APA, 1979) review of several studies on the cost-effectiveness of psychotherapy does not consider viable alternative interpretations or qualify findings in line with the studies' substantial limitation, (e.g., their lack of controls for regression or selection biases). It is suggested that in light of the financial contingencies surrounding conclusions about the effectiveness of psychotherapy, special care must be taken to ensure that psychology's special public stance on the value of psychotherapy contains the qualifications suggested by the scientific evidence. Public statements by the APA on the effectiveness of psychotherapy might be based on a review of the scientific merits of pertinent studies by an independent body of research methodologists.

In Ontario, there have been threats to restrict psychotherapy benefits. The Ontario Medical Association has rejected such restrictions and prepares an internal brief that was largely devoid of cost-benefit studies. Lesser (1979) reviews traditional psychotherapy outcome studies, which show that psychotherapy is more effective than placebo, long-term psychotherapy is as effective as brief, and limited hard data are available as to the effectiveness of the psychotherapies. Cost-benefit studies show that brief psychotherapy is cost effective, while long-term psychotherapy clearly reduces hospitalisation costs. Psychotherapy costs in Ontario pertaining to psychiatrists do not support any evidence of abuse by either consumer or provider. It is suggested that cost-benefit studies be instituted in Ontario and that peer review be considered.

While modern psychotherapies have often demonstrated a significant degree of effectiveness, in that they help clients overcome their presenting symptoms, their degree of 'efficiency' may not measure up to their 'effectiveness'. Efficiency in psychotherapy includes several issues that are often neglected in research on 'effectiveness'. These criteria include such ingredients as depth-centeredness, pervasiveness, extensiveness, thoroughgoingness, maintenance of therapeutic progress, preventive psychotherapy, and minimization of therapeutic harm and encouragement of scientific flexibility. It is contended that these aspects of psychotherapy are of profound importance to therapists and clients and that such aspects should be consciously included as values in psychotherapy, the main tool of treatment for Clinical Psychologists (Ellis,1980).

Psychological Treatment for Adolescents and Adults

Another study by Manos and Vasilopoulose (1984) examined the outcome of psychoanalytically oriented psychotherapy administered to 50 adolescents and adults ranging between15-54 year olds who presented with a variety of syndromes, including personality disorders, anxiety/somatoform disorders, psychotic disorders, psychosexual disorders, and bulimia. Subjects (Ss) and 16 non-treatment controls (aged 16-38 years) were evaluated 4 months postintake. MMPI scores, target symptoms, global evaluation, and other clinical evaluations were used as outcome measures. Findings show that subjects who underwent therapy improved significantly more than controls on subjective and objective parameters. The efficacy of psychotherapy and the relative spontaneous improvement of untreated Subjects are very evident confirming its potency as indicated in the study.

Chadwell and Howell (1979) hypothesized that outpatient psychotherapy in a mental health centre would result in an improvement rate of 65% or more, a spontaneous remission rate of 36% or less, and a difference of at least 29% from gain in improvement due to therapy. An analysis of 201 follow-up questionnaires completed by adult outpatients during 1967 and 1970 supported all 3 hypotheses. A 5-year follow-up questionnaire provided evidence for external validity in the form of a correlation between original improvement rate and subsequent need for outpatient treatment and inpatient treatment. Results are interpreted, as significant evidence for the efficacy of psychotherapy and for the validity the self-report method of measuring improvement and spontaneous remission.

Parloff et al. (1986) discuss research published between 1980 and 1984 regarding the treatment of adults by a range of individual psychosocial therapies. The contradiction between increased conceptual and methodological sophistication and increased scepticism regarding the scientific merit of positive research findings in the field of psychotherapy is examined. Efficacy research findings are discussed through a critique of global outcome surveys via meta-analysis and studies of particular therapies for specific problems/disorders according to Diagnostic and Statistical Manual of Mental Disorders (DSM-III) and behavioural medicine categories (e.g., depression, schizophrenia, anxiety, alcoholism). Issues and trends with regard to therapy manual, brief therapies, clinical trials, placebos and specificity of effects, theory development and integration, and koans are also discussed to the logical conclusion that psychological treatments improves the plight of patients (Parloff , London & Wolfe , 1986).

Tramontana (1981) looks at psychotherapy in relation to adolescents. In their work they describe and critically evaluate studies on individual, group, and family therapy that were published largely from 1967 through 1977. Of 33 independent investigations, 5 are judged as exemplary in methodological scope and rigor. Although methodological deficiencies abound, the greater weight of available evidence on adolescents does point toward the superiority of psychotherapy over no-therapy condition, with the median rate of positive outcome with psychotherapy being approximately 75%, compared with a rate of 39% without psychotherapy. Little is presently known, however, regarding the effects of specific patient, therapist, and process variables on adolescent therapy outcome.

One hundred and seventy-six (176) psychiatric inpatients were randomly assigned either to 1 of 3 group therapy programmes or to a no-treatment control group by Beutler and colleagues (1984). Patient diagnoses and initial level of psychological disturbance were included as potential predictor variables. Outcome was assessed by the SCL-90 (Revised) administered at the time of Subjects' admission, at discharge, and gain 10-18 months later and by ward ratings of patient behaviour and by discharge ratings. The 3 group therapy programmes were based on (1) an interactive, process-oriented group format; (2) an expressive-experiential-oriented group format; and (3) a behavioural oriented group format. Both group process and therapist compliance were closely monitored. Results suggest that after artifactual and milieu effects were accounted for, a systematic deterioration effect occurred among patients exposed to the expressive-experiential group. The process-oriented programme tended to produce the best results,

which were maintained at follow-up 13 month later. Results clearly portray the impact of a conscious psychotherapy programme.

Shapiro and colleagues (1982) also randomly assigned 44 outpatient enrolees of a Health Maintenance Organisation (HMO) to 1 of 3 treatment modalities: (1) a cognitive behaviour therapy group, (2) a traditional process-oriented interpersonal group, and (3) cognitive behaviour therapy in an individual format. All Subjects were referred by their physicians for treatment for anxiety and/or depression. The Beck Depression Inventory, the State-Trait Anxiety Inventory, and the adult Self-Expression Scale (an assertion measure) were administered pre-and post-treatment on the Hamilton Rating Scale of Depression. All 3 experimental groups significantly improved on all dependent measures from pre- to post-treatment, and no differential treatment effects were found.

Weissman et al. (1974) examined the effects of maintenance treatment on social adjustment in 150 25-60 year old female depressed outpatients randomly assigned to 8 months of amitriptyline hydrochloride, a placebo, or no pill, with or without psychotherapy, using a 2 X 3 factorial design. The Social Adjustment Scale was used as a change measure. Results for the 106 patients who completed the trial show a significant main effect for Psychotherapy apparent only after 6-8 week of treatment. Psychotherapy improved overall adjustment, work performance, and communication, and reduced friction and anxious rumination. There was not effect on the patients' social adjustment for amitriptyline, and there were no drug-psychotherapy interactions. Results support the value of weekly maintenance psychotherapy in recovering depressives. Since

amitriptyline reduced relapse and prevented symptom return, and psychotherapy enhanced adjustment, there is evidence for combined treatments.

Psychological Treatment with Children

It is not only adults who have shown marked improvement in the administration of psychological treatments. Children also respond significantly to a considerable number of psychological treatments with the exception of therapies requiring higher levels of cognition such as the cognitive therapies.

One study examined 75 studies, published between 1952 and 1983 by Rita and Jeffrey (1985) in which children who received psychotherapy were compared with controls or children receiving another form of treatment. Only those studies using Subjects younger than a mean age of 13 years at the time of treatment were included. Exceptions to the age limitation were made only if separate analyses for younger children were reported or if individual date from older Subjects could be eliminated. Results show that therapy with children was similar in effectiveness to therapy with adult; treated children achieved outcomes about two-thirds of a standard deviation better than untreated children. Although behavioural treatments appeared to be more effective than non-behavioural treatment, this apparent superiority was due largely to the types of outcome and target problems included in behavioural studies. No differences in outcome were found to result from other treatment characteristics such as the use of play in therapy or the administration of treatment individually or in groups. The evidence suggests that

previous doubts about the overall efficacy of psychotherapy with children can be laid to rest.

Arajarvi (1975) reports on the work of a 5-member clinic team who studied the effect of several forms of treatment of various psychiatric disorders of children. The sample of 151 Subjects (101 males and 50 females) did not include people living with psychosis or those of subnormal intelligence. The 40 most severely disordered as well as individuals with neurosis usually received individual therapy. Subjects with immature personalities often received group therapy. All patients also participated 'ward therapy'. Medication was used only for half of the most disturbed Subjects. Follow-up 1.5-2 years after termination of hospital treatment showed that 85% had clearly improved. The author's1973 report, which details methods used and factors affecting results, had found that the post-treatment environment had played the most significant role in maintaining improvement. The current study shows about equal improvement with individual and group treatment, while medication did not seem significant in terms of overall results.

Hampe et al. (1973) evaluated progress of 62 phobic children 1 and 2 years after termination of treatment or waiting period. 80% were either symptom free or significantly improve; only 7% still had a severe phobia. Successfully treated Subjects tended to remain symptom free and to be free from other deviant behaviours as well. 60% of the failures at termination continued to receive treatment and most were symptom free 2 years later. After 2 years, the effects of the original psychotherapy and reciprocal inhibition therapy no longer were related to outcome. However, age, status at the end of

treatment, and time were related to outcome. Results are discussed in terms of the nature of child phobia and implications for research.

Psychological Treatment for Neurotic Conditions

Ginsberg and colleagues (1984) did an intricate and revealing work important to this discussion presently at stake. They conducted a randomised, controlled trial in which 92 neurotic patients (mainly phobics and obsessive-compulsives) in primary care were assigned to behavioural psychotherapy from a nurse therapist (NT) or to routine care from their general practitioner (GP). 29 Subjects remained in the NT group and 37 in the GP group after 1 year. An economic questionnaire was returned by 22 NT Subjects and 28 GP Subjects. At the end of 1 year, clinical outcome was significantly better in Subjects cared for by the NT. Economic outcome to 1 year, compared with the year before entering the trial, showed a slight decrease in the use of resources by the NT group and an increase in resource usage in the GP-treated group that were mainly due to the latter's increased absence from work and more hospital treatment and drugs.

On the reasonably assumptions that NTs treat 46 patients a year and that such patient treated behaviourally maintain their gains for 2 years, the economic benefits to society from NTs treating such patients may outweigh the costs. This excludes any monetary value on the substantial clinic gains such as reduction in fear and anxiety. However, the numbers were small, few economic differences were significant, and many Subjects either did not complete the trial or waiting-list periods or they failed to return economic data. It is suggested that conclusions must be tempered with caution, even though pre-

treatment demographic and clinical data or non-returners were comparable with those of returners and the few dropouts who could be rated at 1 year had not improved.

In their work, the re-examined data of Smith et al. (1980) on the benefits of psychotherapy in 475 controlled studies, using only studies of patient seeking treatment for neurosis, true phobias, and emotional – somatic complaints, the results of 81 controlled trials were integrated statistically using the meta-analytic technique. The condition of the typical patient after treatment was better than that of 77% of untreated controlled measured at the same time, and the rate of relapse in the first two (2) years was small. Behaviour and psychodynamic verbal therapies appeared to be superior to other therapies. The relationship between severity of illness and choice of therapy is unknown and could account for some of the differential effects, but does not vitiate further evidence of the efficacy of psychotherapy.

Length of Psychotherapy

Howard et al. (1986) applied probit analysis to 15 sets of data to specify the relationship between length of treatment and patient benefit. Data were based on more than 2,400 patients, covering a period of over 30 years of research. The probit model resulted in a good fit to these data, and the results were consistent across the studies, allowing for a meta-analytic pooling that provided estimates of the expected benefits of specific 'doses' of psychotherapy. Analysis indicated that by 8 sessions approximately 50% of patients were measurably improved, and approximately 75% were improved by 26 sessions. Further analysis showed differential responsiveness for different diagnostic groups and

for different outcome criteria. Findings hold promise for establishing empirical guidelines for peer review and third-party financial support of psychotherapy.

Ginsberg et al. (1977) began a pilot study which reported the costs and benefits of behavioural psychotherapy by nurse-therapists for selected neurotic problems. Figures are based on the treatment of 42 neurotics (mainly phobics and obsessive-compulsives) who completed treatment with nurse-therapists in a mean of 9 sessions (16 hours).The year before and after treatment was studied. Apart from significant and lasting reduction in patient's distress, economic benefits to them, their families, and the community yielded a worthwhile internal rate of return when benefits from the cohort continued for 3 years, a reasonable assumption based on available evidence

Efficacy of Individual and Group Psychotherapies

Singer et al. (1981) surveys recent issues and findings about clinical interventions, focusing on those aimed at the individual client. Developments in individual psychotherapy practice (including psychoanalysis, behaviour therapies, European imagery methods, and assertiveness and vicarious rehearsal procedures), health psychology and behavioural medicine, and evaluations of psychotherapy effectiveness are reviewed. It is concluded that psychotherapy as a form of clinical intervention is thriving, and its practice is becoming more problem-focused and amenable to evaluation. The move toward cognitive behaviour therapies has integrated psychodynamic components with techniques of behaviour therapies. The most important development is seen as being the increasing overlap between therapy practice and the basic research

areas of psychology; clinical practice may represent the best empirical knowledge in the study of cognition, emotion, personality, and social psychology.

Another review of the research literature concerning the effectiveness of group psychotherapy and the characteristics of client and therapist which promote or hinder a successful outcome was conducted by Grunebaum (1975). Issues considered include therapy casualties, evaluation of outcome, similarity of cognitive style between patient and therapist, positive confrontation, pre-group preparation of patients, duration and frequency of treatment, group cohesiveness and composition, therapist's behavioural characteristics, and patient's sociological characteristics. A therapist's behaviour is considered more important than his belief system in the treatment of patients.

Psychological Treatment Researches Done Locally

Apart from the efficacy of psychological research done in the West a number of important bodies of researches have been done locally that has given significant contribution to psychology and health delivery in Ghana as a whole. A typical example is a study of psychological treatment of hypertension by Baah-Odoom (1999). She sampled 100 patients of essential hypertension from Korle-Bu, Trust Hospital and the general public through media advertisement who were all on medication and assigned them to 2 conditions namely, Treatment Condition and Control Condition. She took participant in the Treatment Condition through intensive 12 Weeks of Psychotherapy which involved Cognitive Behaviour Intervention, Progressive Muscle relaxation and Biofeedback. Three months post treatment follow up revealed that a blood pressure of

patient had come within normal range suggesting that cognitive behaviour therapy and progressive muscle relaxation could be beneficial for short and long term adjunctive treatment of essential hypertension.

Additionally, Amankwa-Poku (2001) studied the effect of stress on diabetic patients and how stress and hyperglycaemic control in Ghana are related. The study sampled 100 type 2 diabetics (50 males and 50 females) from the Diabetics Management and Research Centre at the Korle-Bu Teaching Hospital. In her findings it was discovered that supportive family behaviour and knowledge about diabetes did not necessarily lead to glycaemic control. Also knowledge about diabetes has no effect of compliance. However, non-supportive family behaviour has an effect on glycaemic control. Subjects with high non-supportive family behaviour had poorer glycaemic control. And most importantly, results of the psychological intervention showed a reduction in the blood pressure and pulse rate of subjects after the therapy.

In her studies on some aetiological classifications of different level of parental attitude to mental retardation in Ghana, Ado (1980) sampled 120 rural and urban literate and illiterate parents and their mentally retarded children. A questionnaire was used for investigating the causes of mental retardation. In addition, the case records of the mentally retarded children whose parents were used for the study were examined for more reliable information on the causes of mental retardation. Findings indicate that the major causes of mental retardation included Epilepsy, Brain Injury, Birth Trauma and

Down syndrome. Such a study of the aetiological factors involve in mental retardation is necessary for effective treatment and future preventive measures in health care delivery.

Another important research on infertility in women was conducted by Dickson, (2001). The study was aimed at finding the impact of psychological intervention on Ghanaian women who report at the general hospitals with these problems. Two hundred participants were sampled from two fertility specialist clinics in Tema, Pro-vita specialist hospital and Tema Women Hospital as well as two Government Hospitals, Korle-Bu and 37 Military Hospitals. Out of the participants 20 underwent psychotherapy. Statistical analysis indicated that the cognitive behaviour group therapy resulted in significant improvement in their psychological well being.

A research conducted by Osafo (2002) helps to understand the debilitating effects of schistosomiasis and areas that are prone to the disease in Ghana. In the study the researcher purpose to uncover the psychosocial factors underlying the prevalence and control of schistosomiasis. Emphasis was placed on preventive measures of health delivery (psychoeducation). Three hundred and eighteen subjects were sampled from Domfaase a village in Akwapim South District. The study was instrumental in revealing lack of good transportation, little or no knowledge about the disease and general economic problems and poverty as reflected in poor sanitation, important factors exposing the inhabitants to the danger of the disease.

Bentil (2001) also explored to obtain information regarding the understanding of the schizophrenic patients' beliefs about hearing voices (auditory hallucination) and their adopted coping strategies. Participants were inpatients with clinical diagnosis of schizophrenia. It was found in the study that males and females adopted significantly different coping strategies for hallucination and majority believed that those hallucinations were supernaturally caused, an information which mental health service providers need to know.

An important research intended to unravel why certain heinous crimes negative attitudes were meted out to individuals with mental retardation was carried out by Danquah, (1976). Through interviews and discussions with parents and relatives of retarded children, it became necessary to investigate the belief and attitudes of the public towards severe mentally retarded in Ghana. Results from 306 respondents to a bibliographic questionnaire who were essentially parents of the mentally retarded and 800 individuals interviewed in their homes were interesting. For instance both the educated and uneducated believed that mental retardation is associated with a misfortune which is linked with a curse by a supernatural being. Out of this, about 70% of the formally educated felt it was God's punishment for their evil deeds while about 75% of the uneducated group indicated that where the parents of the severely retarded child have lived exemplary lives the cause could be attributed to evil spirits and malevolent human beings who have powers of witchcraft and sorcery (juju). There were also significant responses among the rural dwellers, both educated and uneducated. The rural group believed that a severely retarded child is an animal in human form for instance snakes

(python), fishes and other amphibians. The human fish is a common belief among the coastal dwellers of the country. This belief explained why infanticides or the child is abandoned on the river bank or near the sea with yam –that is white and red (oto) with eggs and then fired at with guns eventually to death.

STATEMENT OF HYPOTHESES

1. Patients who receive psychotherapy show better improvement in health than their counterparts who had no psychotherapy.

2. More patients with neurotic problems respond better (with no relapses) to psychotherapy than chemotherapy.

OPERATIONAL DEFINITION OF TERMS

Neurosis: Mild conditions of anxiety, depression and stress which lead to maladjustment in daily functioning.

Psychoeducation: A preventive psychological health clinic that focuses on giving educative talks on mental health issues to people.

Traditional Health System: The system of health care in Ghana comprising services provided by physicians, health nurses and traditional healers before clinical psychology was introduced.

Modern Health System: The present health services provided by physicians, nurses, clinical psychologists, social workers and nutritionists as advocated by WHO in the Biopsychosocial model.

Contributions to Health: (1) The provision of practical facts and relevant psychological information which helps for integrative therapeutic approaches; (2) Soothing and healing of victims of the revolution during the National Reconciliation Commission (N.R.C.)

CHAPTER THREE

METHODOLOGY

RATIONALE FOR ADOPTING A QUALITATIVE METHOD IN THIS SECTION

Although the efficacy of psychotherapy research outlined in the literature review section above seems very impressive and advanced, it is only widespread in the West where the practice of clinical psychology is well over a century old. In Ghana, where the practice of clinical psychology and psychologist in general is just a little over three (3) decades old, it will be difficult to immediately follow the trend of efficacy of psychological research that the West can boast about. If anything like that will be done, then it will be for the future, probably such efficacy researches will be generated by this present work.

Secondly, much of the efficacy of psychotherapy research that was conducted in the West used the meta-analytic technique which is a quantitative procedure of data analysis. Over the years, it is becoming clear that increasing number of researchers (e.g. Smith et al. (1980); Prioleau et al. (1983))are beginning to admit the general criticism and limitations associated with the Meta-analytic techniques. A core aspect of the Meta analytic technique is the general problem of quantitative methods which tends to over-look the human factor, and the unique conditions of each case with an attempt to rigidly quantify even the complex and dynamic human behaviour itself.

The change is that human experiences should be experienced, discussed, or debated but not measured or otherwise calculated like materials found in the physical world (Dunn, 2001). Other critics point out that, the quantitative turn of the behavioural sciences is at

odds with its subject matter – the social, political, psychological, and economic lives of people in all their variety and diversity. As a result of the behavioural sciences measurement mania, quantitative research is often criticised for being of limited use (e.g. Flick, 1998).

Statistician Dana Dunn (2001) reports that critics and commentators argue that data collected in behavioural science research are rarely seen as directly applicable or helpful to life in every day world. Experimental vigour, cause and effect relations and concerns about representative population essential to statistical analysis are often deemed to be far removed from the concerns or problems that affect the lives and fortunes of many people (Dunn, 2001). Inevitably, even the most rigorously scientific research and pristine results are coloured by the interests and the social, political and cultural backgrounds of the people conducting it (Flick, 1998). A popular statement which has been attributed to the most influential physicist of the 20th century, Albert Einstein (1879-1955) was of the view that "everything that can be counted does not necessarily count everything that counts cannot necessarily be counted."

Leahey (1997) argues that American psychology, in particular developed a bad case of "physics envy". Because physics was the oldest and most respected of the natural sciences, psychologists naturally sought to emulate its method and techniques. This hope of psychology expecting to gain respectability and prestige – membership really of the club of natural sciences has been called "Newtonian fantasy" by this historian of

psychology (Leahey, 1990), a fantasy that is not likely to ever be realised for reasons of subject matter, methodologies and perception.

However, it should be noted that research and methods should not be monolithic because diverse perspectives not only exist but also flourish. Much as quantitative research techniques are important and useful to getting scientific data, qualitative techniques are also equally useful to understanding certain humanistic studies. It is in this light that the late Statistician and Psychologist, Jacob Cohen (1994), suggested that Psychologists and all Behavioural Scientists must move beyond relying exclusively on statistical methods to make claims about behaviour. Cohen's recommendation about what to do is an obvious one, so obvious that it is routinely over looked – replicate result. The replication of research result is one way to properly emulate work done in the older natural sciences (Cohen, 1994).

Therefore, qualitative and quantitative techniques should be seen as complements and not rivals to one another. As a result of the difficulties frequently encountered in the planning, data gathering, and implementation of results, phases of evaluation projects, recommendations are made for individualised measurement, repeated measure designs and experimental case studies in maximizing the utilisation of research results. (Thomander, 1976).

The literature above has attempted to review the utility of meta-analysis in the context of the evaluation of psychotherapy. Benefits and limitations of meta-analysis have been highlighted to identify essential characteristics of the approach as methodological tools.

And as indicated earlier the employment of meta-analytic techniques in evaluating the impact and role of clinical psychology in Ghana may be premature now and will have to wait until the present preliminary researches are over. As a result a qualitative but critical evaluation of the impact of clinical psychology and its numerous roles played during the span of three (3) decades is being adopted as one of the methods for the present study.

METHODOLOGY FOR THE QUALITATIVE RESEARCH

Sample

This study used samples of verbal content of live or taped communications (e.g., interviews as well as archival material such as diaries, records, books, articles and theses) that are published and unpublished.

Materials

A mini audio cassette recorder (walkman) is used to tape the reports from a number of practicing clinical psychologists. The interview questionnaire contains basic items, asking respondents about the concept, goal and objectives of the profession, its roles, function, and history in Ghana. Other items discussed included some studies conducted, involvement in teaching and training, roles played in assessment, referral, consultancy and management as well as some clinical success they have chalked in the cases they have handled in the past.

The appearance of Clinical Psychologists on talk shows on the electronic media towards psychoeducation and preventive medicine were also discussed. Since this part of the

study is principally that of qualitative research, interviews conducted with sampled individuals and the expressions found in written communication as well as all verbal responses were collated and analyzed. In the same fashion archival or journal publication of research conducted in Ghana, clinical cases treated, referrals, assessments and reports written, were all reviewed. The contribution of clinical psychologists in psychoeducation was analysed through the broad qualitative research technique called content analysis.

Through content analysis, a system or procedure was created to categorize the content, nature and frequency of verbal communication.

The second qualitative research technique adopted for the study was the archival observation technique. By this the researcher monitored records and attempted to interpret the patterns exhibited in unpublished records, books or articles. However for the purpose of convenience, the scope was narrowed the in order to pursue questions deemed to be most essential to the project by the use of focussed observation

Procedure for Qualitative Design

The study began with assembling all the articles, researches, history and inventions relating to Clinical Psychology in Ghana that had been published in various International Journals such as Journal of Psychopathologie Africaine, Journal of Behaviour Therapy and Experimental Psychiatry, Ghana journal of Sociology, Ghana Medical Journal, Report given at the 10th Annual Sociological Society conference etc. (Danquah, 1975).

Furthermore, interviews were conducted with Professor Danquah, Dr. Araba Sefah Dedeh and Dr. Angela Ofori Atta and Sarah Ado on the history of the profession in the country. The presentations were transcribed from the audio recording from the perspectives of each interviewee and juxtaposed to one another and the content analysed.

Also, prominent cases that were successfully treated by these Clinical Psychologists were also presented as excerpts and discussed.

RATIONALE FOR CONDUCTING A QUANTITATIVE RESEARCH

Although it is increasingly being acknowledged by a growing number of researchers that empirical methodologies could be used to collect data and interpret them in nonnumerical forms, it is equally important to note that Psychology's claim to be a credible Science primarily hinges on its ability to numerically measure, quantify and study phenomenon using quantitative research techniques. This is because quantitative approaches seem to be more valid, reliable, and replicable and more exact in its outcome than qualitative methods. Further, the principles of objectivity and dependability which qualitative techniques strive hard to achieve is patterned after automatic features of reliability and validity intrinsic in quantitative techniques.

Based on this important fact and a further great quest to prove that psychotherapy used by Clinical Psychologists in Ghana contributes significantly in relieving patients of their health problems; a quantitative experimental research was conducted to buttress the argument which was started using qualitative approaches such as interviews, archives and content analysis. It is the result of this that an eight week study on the impact of

psychotherapy on neurotic conditions was conducted; so that, the neurotic scores of participants who were exposed to psychotherapy could be numerically and statistically analysed.

METHODOLOGY FOR QUANTITATIVE/EXPERIMENTAL RESEARCH

Sample: Fifty (50) participants were purposively sampled out of the number of the patients who patronised Health services at Pantang Hospital. This purposive and convenient technique was used due to the difficulty of readily obtaining research participants for studies of this kind. There was no special criteria for excluding other potential participants except the non-neurotic symptoms check. That is, participants who did not show neurotic symptoms were excluded from the study. The participants included both in-patients and out-patients and comprised twenty (20) females and thirty (30) males. In the end eight participants including six male and two females dropped out of the study. The principal condition of participants was neurotic in nature ranging from floating anxiety, self esteem problems social avoidance, life stress etc. Patients were within age range of 18 years to 45 years.

Instruments/Materials

The main instrument used for diagnosing patients was the Diagnostic and Statistical Manual (DSM IV) classification mental disorders. Questionnaires that were mainly psychological assessment scales measuring mild conditions of anxiety, depression and stress in daily functioning, were used to obtain data form subjects. Psychometric

Properties of the Depression Anxiety Stress Scale 42 (DASS) developed by Lovibond and Lovibond, (1995) is as follows. The DASS is a 42 item self-inventory that yields 3 factors: Depression, Anxiety and stress. This measure proposes that physical anxiety (fear symptomatology) and mental stress (nervous tension and nervous energy) factor-out as two distinct domains. This screening and outcome measure reflects the past 7 days. Gamma coefficients that represent the loading of each scale on the overall factor (total score) are .71 for depression, .86 for anxiety and .88 for stress. One would expect anxiety and stress to load higher than depression on the common factor as they are more highly correlated and, therefore, dominate the definition of this common factor.

Reliability of the three scales is considered adequate and test-retest reliability is likewise considered adequate with .71 for depression, .79 for anxiety and 81 for stress (Brown et al., 1997). Exploratory and confirmatory factor analyses have sustained the proposition of the three factors ($p<05$: Brown et al, 1997). The DASS anxiety scale correlates .81 with the Beck Anxiety Inventory (BAI), and the DASS Depression scale correlates .74 with the Beck Depression Scale (BDI).

Scoring of the DASS 42

The Depression, Anxiety and Stress Scale (DASS) is likert type scale that rate the responses of subjects from 0-3 a score of 0 indicates "Did not apply to me at all", 1 indicates "Applied to me to some or some of time", 2 indicates "Applied to me a considerable degree or a good part of the time", 3 indicates "Applied to me very much or most of the time". The summary of the test norms are as follows:

A score of 0-20 indicate a range of normal to mild neurotic state while a score of 21-27 represents severe neurosis while 28 and above indicates extremely severe neurotic condition. These norms were modified and adopted for the purposes of convenience in distinguishing severe neurosis from normal to mild neurosis.

Hypothesis Testing

In order to ascertain whether psychotherapy has significant statistical impact on patients with neurotic conditions, the neurotic scores of the experimental (or treatment) group was compared with that of the control group. This is to allow for the observation of possible significant differences between the two situations which would then be indicative of the impact of the psychotherapy introduced.

Design and Procedure for the Experiment

The main variables of the study in this section are psychotherapy and neurotic conditions. The independent variable under observation is whether or not participants' exposure to brief psychotherapy has any significant impact on their level of neurosis as shown by their scores on the DASS 42. The study adopted a simple pre-test post- test experimental design. Anxiety, stress and depression were clinically established amongst subjects as a baseline using the DSM IV and in few instances the DASS 42. Although 25 subjects each were estimated to be in the experimental (or treatment) and control groups, 24 subjects went through the experimental group and 18 subjects were used as comparison group with 8 subjects dropping out. All subjects have gone through chemotherapy or drug treatment already. The experimental group members were taken through a seven (7) week of at least two sessions per week psychotherapy programme, aimed at their

particular neurotic conditions, while the control group was not exposed to any form of psychotherapy apart from their medication. The psychotherapy Programmes package for the experimental group included Progressive Muscular Relaxation, Cognitive Restructuring, Assertiveness Training, Stress Management and Insight Therapy. The experimental or treatment group was given an insight into psychophysiological mechanisms of neurotic conditions. Since each participant neurotic problem significantly differed from the other, although all neurosis is problem of every day living, the client centred psychotherapeutic approach was adopted for each subject. The following are breakdown of activities for the seven (7) weeks:

Week One: Intake Interview and Mental Status Examination

Clients were allowed to narrate the problem from their own perspectives. It was observed that allowing clients enough space to talk about their problems could be cathartic and lead to achieving talking cure. However subjects were also taken through the structured intake interview beginning from case history. It was at this stage that the appropriate diagnosis was established using the DSM IV and occasionally, the DASS 42.

Week Two: Insight Therapy

Clients were given further understanding into their case from a psychophysiological perspective, for instance client with floating anxiety were guided to the possible root cause or genesis of their problem, how it was learnt and reinforced and its corresponding impacts of the sympathetic nervous system. It was also noted here that a good insight into ones problem was the beginning of the therapeutic impact.

Week Three: Cognitive Restructuring

At this time the individuals assumptions (or cognitive errors according to Beck) which are the cause of maladaptive behaviours and dysfunctional attitudes were identified and explained to client. For instance, clients were made to know that their over-generalisation or personalisation of issues was what was responsible for their dysfunctional behaviours such as stress, anxiety and depression.

Week Four: Assertiveness Training

This was done intensively for clients who have self esteem problems in connection with anxiety. They were taught to identify situations, places and people that make them feel uneasy, tensed and inferior in addition, they were thought to set goals, plan their behaviours and consciously express themselves while relaxing. They were given assignment to practice assertiveness in a particular situation that threatened them in the past.

Week Five: Stress Management

Clients were helped to identify and list all their sources of their stress (stresses). Any situation condition or objects that seem to over power or make clients perceive that she or he lacked capability to handle was identified and controlled. The main approach here was that clients were taught to regulate those activities to fall within their copping. For instance client were asked to cut down on their work load when necessary while others were taught to break them into manageable units for a longer period of time.

Week Six: Progressive Muscle Relaxation

Clients were taught this technique which allowed them to relax all the various muscle groups in the body in order to overcome the anxiety and tension of every day hassles in life. They were taught to tense and relax their arms, legs, hand, eyebrow, abdomen, back, neck etc. while imagining total state of relaxation after extreme tension and fatigue. Copies of the relaxation tape were made for client to practice it regularly on their own at home.

Week Seven: General Interaction and Testing

Participants were allowed to share their observations and experiences in the therapy. They were also allowed to ask questions about issues they did not understand and needed clarification.

At the end of the psychotherapy programme both subjects in the experimental (treatment) and control groups were given a post test on the seventh (7^{th}) week. The scale that was used was the Depression, Anxiety and Stress Scale (DASS) (Lovibond and Lovibond, 1995)

The scores of each subject was taken down as a post test measure for the treatment group and control group (whose intervention was to be delayed).

In addition, subjects were monitored for a period up to three (3) months to observe any possible relapses following, subsequent to the experiment. This was done because the study intended to observe the rate of recovery among patients with neurotic conditions

who go through psychotherapy after chemotherapy compared to their counterparts who go through no psychotherapy but only medication.

ETHICAL CONSIDERATIONS DURING THE EXPERIMENTAL RESEARCH

In order to uphold some relevant ethical standards in the conduct of the experiment, a number of ethical measures were attempted:

1) ***Voluntary Participation***: In the study, participants were allowed voluntary participation. Although no informed consent sheets were signed, prospective research participants were made to know that the study would cost their time. However, they individually stand to benefit from the therapy sessions apart from making contributions to knowledge.
2) ***Anonymity***: Respondents of the DASS 42 questionnaire were granted anonymity by way of ensuring that no individual scores on the DASS was linked to a particular name or any other personal demographic data.
3) ***Debriefing***: During the last therapy session on the seventh week, there was a general interaction at which forum the intent of the study was explained to participants and their fears allayed. Participants were told that efficacy of psychotherapy was being evaluated in the study. They responded that the sessions were beneficial.
4) ***Compensation***: Since the author works at Pantang Hospital, the subsequent weeks to the research, visits were made to patients on admission at the wards. For those in town who visit the hospital for reviews, they were attended to at the Clinical

Psychology outfit. Concerning the two nurses recruited and trained to help the researcher; token amounts were given as rewards to them and thanked as well.

5) ***Use of Findings***: Since participants were made to understand that the study was to evaluate whether the practice of psychotherapy was of any efficacy in Ghana, and that results if not favourable, will warrant recommendations to improve the practice; if results was favourable, (that is, psychotherapy was efficacious), then recommendations would be made to the relevant authorities to expand the outfit and train more Psychologists. Participants' fears regarding the mishandling of results were allayed when this explanation was given.

CHAPTER FOUR

RESULTS OF THE EXPERIMENTAL RESEARCH

In order to test the impact of psychotherapy or psychological intervention on neurotic conditions of the research participants (N=42), a simple pretest posttest experiment was conducted. The overall scores of each of the 42 participants on neurosis as well as the respective subtests of depression, anxiety and stress are given in Appendix D. In the interim, the summarized group statistical results are as follows: Table 1 below gives the descriptive statistics of the treatment and control groups for all the neurotic sub-conditions.

Table 1: Summary of Group Statistics of Treatment and Control Neurotic Conditions

Factor		N	Mean	Standard Deviation	Standard Error, Mean
Anxiety	-Treatment	24	6.33	4.21	0.86
	Control	18	18.28	4.17	0.98
Depression	–Treatment	24	6.54	4.28	0.87
	Control	18	20.94	6.44	1.51
Stress	- Treatment	24	6.42	3.87	0.79
	Control	18	17.50	5.02	1.18
Neurosis	- Treatment	24	19.29	10.82	2.21
	Control	18	56.72	12.25	2.89

It is clear from Table 1 above that difference existed among the mean scores of the two groups in each condition. On the DASS high scores indicate high levels of neurotic problems. Apparently participants who went through the psychological intervention had their level of neurosis reduced. In order to test whether the mean differences were statistically significant for the two groups, the independent samples t-test was used for the

purpose. Table 2 below shows the inferential statistics of the treatment and control groups.

Table 2: Summary of Inferential Statistics of Treatment and Control Conditions of Participants' Neurosis

Factor	Mean	Standard Deviation	df	t obs.	t crit.	P
Neurosis: Treatment	19.29	10.82				
Control	56.72	12.25	40	10.48	2.02	<.001

Mean score of participants in the treatment group was 19.29 (SD=10.82) while mean of control participants was 56.72 (SD=12.25), t (40) =10.48 was statistically significant, P<.001. Thus, at the 0.001 level of significance there was a significant difference between patients who were given psychological intervention in addition to their medication and their control counterparts who had no psychological intervention. That is, the rate of improvement (reduction in level of neurosis) of the experimental group was better than their control counterparts.

In effect hypothesis 1 which claimed that participants who go through psychological intervention in addition to chemotherapy will recover (have reduced level of neurosis) quicker than their counterparts who went through only chemotherapy was supported. From hypothesis 1 is a follow up implication, hypothesis 2 which states that neurotic problems respond better to psychological intervention (or psychotherapy) than chemotherapy. Since hypothesis 1 is supported hypothesis 2 is a logical conclusion. The evidence can also be deduced from the archival research explored as well as the interviews conducted with the pioneers in subsequent pages.

QUALITATIVE RESULTS

THE IMPACT OF CLINICAL PSYCHOLOGISTS ON HEALTH PROVISION

By 1957, Ghana had obtained her independence from British rule and by 1960; she had her first republic with Dr. Kwame Nkrumah being her first president. The nation would have to learn to steer her own destiny into development, and no longer depending on her colonial master. The Challenges, of problem and changes of those times bring developmental problems and high degree of psychopathology in society. Some of these changes included the several military interventions that were to bedevil the nation after her independence which began in 1966. As evidenced by research work, a society that is gone through radical changes and disorganization could induce high degree of psychopathology (e.g., Lieghton et al., 1963)

Following these social changes, there was an urgent need for preventive curative measures in the area of mental health. However by the early 1970s Ghana had only eight trained Psychiatrists working in the three government-established Psychiatric Hospitals and there was only one Psychiatrist in private practice (Danquah, 1982). In effect Ghana, who had a population of 12 million then, will have one Psychiatrist to serve 1,333,333 people.

Additionally, the first Pan-African Psychiatric Congress (1968) held in Dakar, indicated that there was not even one clinical psychologist at that time in Sub-Saharan African countries (Foster, 1968) From 1972 to the late 70s Ghana had only two licensed clinical

psychologists. This made the mental health situation in Ghana about three decades ago in a deplorable state. Further more the few trained psychiatrists were pharmacologically oriented and therefore merely coped with behavioural problems which they had not been trained to handle. The only coping mechanism they used was prescription of drugs in attempt to treat those behaviour problems. This created a big vacuum in health delivery in those times since much of the drug therapy created additions and substance dependence in patient yielding futile results.

In this situation a great deal of patients who suffered are those with neurotic conditions such as floating anxiety or generalised anxiety, somatic complaints, phobia and other mild adjustment problems some of which are due to past experience or current stress for example, a floating anxiety or general anxiety are manifested, in somatic complaints (Forster, 1972; Avi, 1964; Danquah, 1979). These neurotic patients seem to follow a peculiar pattern of consultations in the existing treatment facilities. For a client with bodily pains, headaches, burning sensations in the head usually reported to the medical doctor at the general hospital where physical examination reveals no abnormalities, yet medication is given just for temporary relief. After repeated trials of futile results, the patient is suspected of having a mental problem and therefore referred to the Psychiatrist. The Psychiatrists who are also trained with Pharmacological orientation continues the dosage of medication also to no avail. The patient then does not see any significant difference between the classical medical model and psychiatric treatments. In this case both the patients and the relatives lose faith in the "Doctor" and begin to think that the patient's problem could be supernatural. As a result, the next stop in the consultation

process in the traditional healer who basically strengthens and deepens the patient's fears through reinforcement.

By the time the patient leaves the premises of the traditional healer, he or she had been taught some rituals (obsessive compulsive behaviours in order to reduce anxiety and prevent the illness), avoidant behaviours (i.e., certain things he must abstain from) as well as reinforcement of his phobias (the basic fears that all humans can be susceptible to). The patient, thus come with temporary relief and welfare due to the assurance by the traditional healer and his powers of protection which are sometimes given in form of tokens of charms to them. However psychologically, her neurotic condition has aggravated.

It was in the context of this and futile circumlocutions, that the work of a clinically trained psychologist who has had comprehensive training into human behaviour science, behaviour problems, behaviour medicine and behaviour therapy became an indispensable need for the health delivery in Ghana.

Without any doubt, statistics from the various psychiatric hospitals and even general hospital clearly point to the great contribution, trained clinical psychologists are making to health delivery in improving the health of patients. For example, while attendance at the Behaviour Therapy unit in 1972 was 588 patients; eight years later the number increased to 1,751 and during the years 1972 to 1980 the total patient load was 10,256. In effect it was clear that the unit was making impact on health delivery through the

discharge of unique services that was non existent until behaviour therapy in clinical psychotherapy as mode of treatment was introduced.

The following are few of the psychological treatments, valuable studies and contributions from the services provided by clinical psychologists some of which even transcends the health service even to socioeconomic and political development of the nation.

SOME OF THE MAJOR TREATMENTS AND STUDIES

Behaviour Modification among Children Presenting Problems in the Classroom in Ghana. S.A. Danquah (1975)

This was a study that involved research as well as a behaviour modification therapy used in treating three children that were diagnosed to have deviant behaviours (or problem behaviours). The study was a six month pilot experimental investigation into the effects of the principles of behaviour modification on four Primary School children at Legon Primary School. The problem behaviour include disturbing others, out of seat, gazing round, scribbling, ignores teacher, vocalization, rocking, fidgeting and showing aggressive behaviour. The experiment was designed to have three distinct stages. The first stage was the baseline period. At this stage, each pair of observers sat in the classroom with the problem children and their teacher and independently observed the child's behaviour in the categories established. Ten seconds time samples were taken. If one of the problem behaviour occurred during ten seconds, a tick was placed on the check just beside that behaviour. During this time teachers were asked to teach as they normally did. At the 2nd stage following the baseline which happened to be the

experimental period, teachers were given general instructions such as making explicit rules expected to be followed by children, ignoring behaviour which interferes with learning and the use of punishment and positive reinforcement where appropriate) such as giving praise and attention to behaviour which facilitates learning. At the 3rd stage which was the post experimental period, the teacher was requested to stop implementing the previous instructions and to resume normal teaching methods while monitoring of the child's behaviour continued by the two observers who happened to be qualified nurses from a psychiatric hospital. Inter observer reliability was 0.90 in all cases. Findings of the study revealed that reinforcing events such as praise, smiling, ignoring etc were most effective in strengthening and maintaining behaviour of the children. As mentioned above this study became a behaviour modification therapy for the children involved as well as an applied research of behaviour modification therapy to the Ghanaian setting.

Comparative Treatment of Nocturnal Enuresis among Ghanaian Children
S.A. Danquah (1975)

Nocturnal enuresis also referred to as bed wetting is the involuntary voiding of urine during sleep after the ages of four and five without demonstrable organic pathology (Coleman, 1964). This syndrome which is associated with immaturity, emotional disturbance, inadequate bladder capacity, indirect expression of anxiety, expression of anxiety, expression of hostility against parents confirms existing literature that no single factor account for the condition. Treatment of enuresis varies in kind and effect and can be categorised under four general types: (1) Surgery, (2) Medication, (3) Psychotherapy, and (4) Training Procedures. Bed wetting which is of grave concern to Ghanaian families

has even led to the use of live frog to frighten the child and other shaming techniques. The main motive of these various techniques among various ethnic groups is to make the patient feel ashamed. The aim of the research was to evaluate the effectiveness of three forms of treatment in Ghana: (1) Traditional method of 'shaming the child, (2) Medication and (3) Behaviour Therapy.

Traditional Method of 'shaming' the child among the Ga ethnic group around the Korle Lagoon

A patient who wets his bed is smeared with red, white and blue powder and sent to the Korle-lagon with all the children and adults in the community in a procession singing "Oyaa Korle Mli? Obaaya" ('meaning won't you go to the Korle Lagoon? You will go'). At the lagoon, the patient is pushed into the water and has to chase the crowd home. The problem is repeated every morning until the patient recovers.

Medical Treatment, Psychiatry

Different types of drugs such as Tryptizol Amitriptyline Hydrochloride and Imipramine are used. Triptizol has been found to be effective in reducing the incidence of enuresis in cases with no organic pathology. The drugs only help improve patient's underlying depressive mood which is sometimes associated with enuresis.

Behaviour Therapy

A conditioning apparatus is used. The apparatus consists of urine sensitive pad placed under the child at night. When the child urinates, the urine wets the pad and triggers a

relay circuit with an electric bell. The noise inhibits urination and wakes the child. The theory is that, repeated such experiences lead to avoidance learning. The unconditioned stimulus, the noise of the bell, causing sphincler contraction and relaxation of the destrusor becomes associated with the child's mind with the increase bladder tension.

Method

Subjects: The subjects were 30 male enuresis (whose enuresis was not due to organic cause) population of 40 enuresis in Accra who were undergoing the traditional methods of treatment not more than a week. However, the remaining 30 had neurotic behaviour such as anxiety and developmental disorders. They had an average IQ of 85.4 with S.D. 20.12. The 30 children were then randomly allocated to three forms of treatment.

- Traditional method of shaming
- The drug treatment
- Behaviour therapy

A response to treatment was defined as twenty-one (21) consecutive nights in 6 weeks (42 days). A relapse was defined as a return to a wetting frequency of once or more per week after initial response to treatment. Analysis of covariance revealed a significant F ratio 12.02, $P< 0.001$ for both drugs and behaviour therapy. But the traditional form of treatment showed no significant improvement among the subjects assigned to it. Again the group in the behaviour therapy treatment improved significantly by a tremendous decrease in the frequency of bed wetting more than the drug treatment group (Danquah et al., 1975).

The Therapeutic Significance of Widowhood Rites in Ghana (Schroeder, Danquah & Mate-Kole. 2003)

A very important study that was carried out in Ghana relates to some local cultural practices. There has always been the temptation of Christianizing Western cultural practices while idolising or considering every local cultural practice as fetish and evil that needs to be debunked. In this light, culture specific studies of this kind go a long way in helping to overcome these difficulties. The study focussed on the concept of widowhood, with much consideration to the procedure, rationale, and the therapeutic significance of the practice of widowhood rites among the Ashanti. The Ashanti and perhaps all cultures perceive death like inevitable which everyone has to experience. Every death, especially the death of a spouse results in grief to relatives, and more especially the surviving spouse. The women in this culture are perceived to the more vulnerable sufferers of grief. As a result, a number of widowhood rites are performed for the surviving wife of a dead husband. The study found intriguing practices in the widowhood rites that have good correspondence with therapeutic techniques in Psychology. Firstly, the widowhood rites help the widow to recognise, acknowledge and accept the reality and finality of the husband's death, which is an important step in the resolution of grief. For example, the throwing away of the stones which signify the end of the love relationship helps the widow to untie the emotional ties that bind her to the deceased husband. This is a form of reality therapy. More so, the rites help the widow to mourn the death of her husband and thus heal her of the pain and prevent her from experiencing delayed grief. Additionally, the rites offer the widow an opportunity to freely express her emotions and fears both verbally and symbolically. For example, through the adowa dance and music the widow communicates her pain and sorrow along the economic hardships that she may be

experiencing and ask for help. This gives her a sort of cathartic relief. The music is therapeutic in that it soothes the widow. The Adowa dance also serves as psychomotor expression of the widow's emotion that could help break the psychomotor retardation associated with depression, thus protecting the widow from getting depressed. Finally, the widow is also given a guide. The presence of the guide and the extended family are also very important in protecting her from depression and loneliness and giving her overall social support. Unlike the traditional cultures, the bereaved in the western society with lack of communal support would experience long periods of emotional instability resulting in psychiatric and psychological intervention. In many instances, the bereaved may be prescribed anti-depressants and /or neuroleptics with profound side effects. Further the financial and emotional burdens are significant.

A Study of Convulsion and Mental Retardation among Ghanaian Children (Danquah, 1976)

Another important contribution of clinical psychologists in Ghana has been pioneering researches conducted on the mentally retarded that were left as derelicts that are deserted and abandoned. In this research a group of Ghanaian children with convulsive disorders were studied with a view to determine their mental states; to inquire into the possible relation of mental retardation to different types of convulsive attacks and to investigate the relation of electroencephalographic findings to mental retardation and clinical diagnosis.

Of the case histories of 296 patients actually examined with convulsive disorders who were treated at the children's department of Korle-Bu Teaching Hospital between 1973 and 1975, the research yielded an important conclusion that the percentages of the retardation was greater in cases diagnosed as definitely symptomatic or organic (pathology affecting physiology or the body's organs) than in those classified as idiopathic (arising from unknown cause). The percentage in the case of the former was 73% and in the case of the latter 22.2%. It was also found that the incidence of retardation was greater among the patients who had more frequent convulsive attacks than among those who had less frequent attacks.

A very important implication of this research for the outcome for patients and parents is that convulsion is a symptom due to one or more causes and may result in mental retardation particularly if the causes are symptomatic or organic rather than idiopathic. Most importantly, it is worth noting that convulsion can be treated early in order to reduce damage leading to mental retardation. The researcher consequently recommends the necessity of sending convulsive children to hospitals for thorough investigations and treatment.

Another important contribution of the nation's Clinical Psychologists has been in the area of language development with retarded children in Ghana. A study (Danquah et al., 1976) found that in the institution for mentally retarded children in Ghana, 69% of the severely retarded children with the age range of 5-9 years had never spoken more than the odd few words. It was assumed that language like other behaviours is learned and

that factors known to influence learning would be operating and could be used to enhance learning. A basic language training scheme was drawn by the researcher for nine children using behaviour modification and manipulation of rotary solenoid, on which was mounted a mirror which reflected a picture from a projector on the screen. This acted as reinforcer.

Each child had seven trials and the performance of each trial was assessed on a six-point scale. The analysis of variance for each training session indicated a treatment effect and subject effect.

It was found that language improvement in retarded children is a possibility and that producing a therapeutic environment will have a significant effect on their development of functional speech. The provision of a child operation manipulation with visual feed-back was clearly reinforcing for the child.

THE TREATMENT OF NEUROTIC CONDITIONS AMONG GHANAIANS

A very important area where Clinical Psychologists dispose of unmatched competence and skill is the treatment of neurotic problems. Neither chemotherapy nor traditional heading methods has achieved any significant gain in this area. Two of the prominent cases of phobia successfully treated using behaviour therapy (of clinical psychology) were frog phobia and sneeze phobia.

The Case of Frog Phobia (Danquah, 1982)

An eight years old schoolboy was referred by the psychiatric hospital to the behaviour therapy unit for diagnosis and possible treatment. According to the history taken, the boy stepped on a frog a year before the phobic symptoms appeared and then about 4 months later he suddenly became terrified of them. Following from this situation, the boy was reported to become petrified, shivers, cries and could not move upon seeing a frog. At times he woke up at night complaining of frogs in his bed and clothes.

Following a thorough behaviour analysis it was revealed that the condition started when the boy was 7 years old, he was working on a corn farm and it started raining and his body came in contact with wet corn leaves which roused him to itch all over. Simultaneously he stepped on a frog and associated it with his body itching. His younger brother who was with him reinforced his fear by saying that if a person steps on a frog that urinates on his leg, he would itch all over his body and eventually die. Thus, the boy's fear was conditioned to frogs. The boy, before coming to the hospital had been seen by a traditional healer. The healer described his condition as witchcraft practice, saying the boy had been bewitched by his friend's mother who envied him for his excellent school performance. The healer's treatment obviously was not effective and therefore the boy's parents decided to see a physician who in turn referred him to the psychiatric hospital. From the psychiatric hospital the boy was referred to the behaviour therapy unit to be assessed and treated.

The mode of treatment used in this case was systematic desensitisation and gradual exposure. In addition the boy was gradually exposed to pictures of frogs, plastic toys,

dead frogs in containers, live frogs viewed from decreasing distances and finally live frogs caught by the boy himself. A follow up at the end of 6 months and 1 year showed no signs of the phobic reactions.

It is unquestionable that cases of this nature can best be handled using psychological interventions. Medication will lead to substance dependence. On the other hand, traditional healing techniques usually reinforce patients' fears and further tend to teach many avoidant behaviours.

The Case of Sneeze Phobia (Danquah, 1982)

Mrs. C, a 30 years old Ghanaian housewife, reported a history of severe and constant anxiety symptoms. She had a belief that if anybody sneezed on her right side it is a bad omen and she immediately will have to rush out and hit her toe against a stone in order to reverse the bad omen. Because of this the only time she felt relatively calm was when she was in a position which she was certain that nobody would sneeze on her right side. This belief was reinforced by the traditional healer who taught their patients avoidance behaviour and obsessive compulsive practices (rituals). In most cases her anxiety was constantly high at the anticipation of sneezing on her right side. Mrs. C's reaction of this happening was to become upset, anxious, hyper, and begin uncontrolled running in unpredictable directions looking for a stone on the ground to hit with her right toe in order to counteract the effect of the sneezing. Mrs. C's sneeze phobia caused her to fail her Common Entrance Examination (equivalent to British 11+ and American Pre S.A.T.) because somebody sneezed on her right side but she could not do the stone ritual there.

Thus, she associated her failure in the exam with the sneezing, a situation termed classical conditioning. She started having headaches and during sensations in her head any time she made an attempt to learn or read a book. She found it difficult to sleep, followed by body pains, palpitations and loss of appetite. She grew lean and lost weight drastically. The second incident was at the time she travelled on a public bus to the market and some body accidentally sneezed on her right side. She could not jump from the bus to perform the ritual with the stone. On arriving home she received the news that her mother had died. The third and final incident occurred while on her way to visit her son in the general hospital. Somebody sneezed on her right hand. Upon arrival, she was told that her child had died. Her sneeze phobia became more aggravated and she had to remain indoors all the time. This scenario explains a typical classical conditioning and respondent learning. Mrs. C went to see a traditional healer and she was diagnosed to be suffering from mysterious illness caused by witchcraft. Following her failure with the healer's therapy of hitting her leg against a stone, she was admitted to the behaviour therapy unit as an out patient. Her treatment started with cognitive restructuring assisted by husband and children. The attribution theory was explained to them that Mrs. C is not mentally sick. Her anxiety and symptoms were originally acquired as a superstitious behaviour and mystical beliefs through accidental pairing of events. Mrs. C's irrational behaviours were consistently interrupted without being associated with bad consequences. Her husband and two children were given a mild smelling tobacco to make them sneeze. Every morning each member after sniffing was asked to make sure that they would sneeze on Mrs. C's right side. Mrs. C. was asked to remain at home and record all events that happened to her each day and during the day. She was definitely

instructed not to follow the 'stone rituals'. This was the use of Exposure techniques as a therapy to extinguish the anxiety and stone rituals without the undesirable outcome but rather reinforcement. Following the self monitoring for 7 weeks, she showed various changes. During the first 7 weeks she received gifts from four different people despite the massive doses of sneezing on her right hand side. In the second week nothing eventful occurred. During the third week, Mrs. C received a gift from an old friend who visited her and bought some good news about her son's success. In the forth week, her husband came home from work to announce that they had won Fifteen Million Cedi (¢15,000,000.00) on the weekly national lottery. During the fifth week, in spite of the fact that somebody sneezed on her right hand while on the bus to the market, nothing eventful occurred. On Sunday of the sixth week, the family went to church service and she sat with her right hand facing the congregation. There were about six people who sneezed on her right side during the church service but nothing significant occurred. In the seventh week, while visiting her friends house and being sneezed on her right side she came home to hear that her husband has been promoted to head a department in another city. Her family moved away and follow up of Mrs. C. continued. One year later she reported a significant change in her life. She even started to dispute the existence and influence of witches and other evil forces as the causes of her illness. People were allowed to sneeze on her right hand side without any reaction. She remained calm and returned to normal life. Thus, Mrs C. totally recovered from this disturbing obsessive compulsive anxiety disorder through psychological intervention after the futile attempts of classical medicine and traditional healers.

The Invention of the DanCS (Danquah, Mate-Kole & Zehr, 1996).

Apart from the several important cases that have been successfully treated by clinical psychologists, few of which has been mentioned in this paper, and the numerous researches having been conducted by them regarding the area of mental retardation in Ghana, Drug Abuse in Ghanaian schools, beliefs about mental retardation in Ghana etc, another important contribution of clinical psychology has been the invention of Danquah Communication System (DanCS). The Danquah Communication System (DanCS) consists of specially defined boards with a computerized voice interface to help residents to communicate to care givers by means of audio and visual signs (Danquah et al 1996). The DanCS was born out of a commitment to increase the independence and self esteem of the mentally challenged by offering them an effective means of communicating to care givers and others. The equipment chose home automation technology since it is based on one centralized controller interfaced with a computer, located at the care givers' station, which can communicate and manage a number of remote transit and receive 'talking' boards that each resident is given. The use of a centralised controller allows the individual DanCS board to cost less than computerized talking board currently on the market. The system uses radio frequency (RF) transmission for the boards (thus making them portable) and powerlene carrier (PLC) digital information transfer (to extend the range) to the systems controller, and hand-wired connections interfacing the systems controller to a computer to complete the task. (Danquah, Mate-Kole. & Zehr 1996). The board has large buttons with picture symbol on it for a resident to easily identify and activate. The symbols on each board are customised for the individual resident based on

his or her needs and ability. When a button is pressed on the board, a series of events take place before the resident receives the voice transmission confirming the call for his/her needs and assistance. The equipment which was tested on subjects of 30 residents which represents 75% of the total of intellectual impaired residents of the Halifax Country Regional Rehabilitation Centre in Nova Scotia, Canada proved effective. Even a follow-up data collected after 6 months of the intervention showed that residents continued to express their needs significantly using the DanCS boards. They also maintained significantly positive social interaction with staff and care givers and continued to control their aggressive behaviour significantly (Danquah et al., 1996). In a nutshell, the follow-up data proved DanCS boards to be an efficacious medium through which intellectually impaired and non-verbal communicative residents could express their needs to staff and care givers and thereby reduce their aggressive behaviour in both the short and long term. Not only has the equipment been used in the Halifax Country Regional Rehabilitation Centre in Nora Scotia, Canada, but it has also been widely used in Ghana especially the Dwowulu Special School of the mentally retarded.

CONTRIBUTION OF CLINICAL PSYCHOLOGISTS TO NATIONAL DEVELOPMENT

The usefulness of services dispensed by clinical psychologists has not been confined to health delivery or networking within other health service providers in the health system of Ghana. More than that, clinical psychology and clinical psychologists has been contributing to the political and socioeconomic development of the country especially in the immediate past. The social, economic and political history of Ghana at least since

independence is common knowledge to the average citizen. After about forty-eight years of independence interspersed with five different military interventions, the last of which was the Armed Forces Revolutionary Council (AFRC)/ Provisional National Defence Council (PNDC) regimes, the nation was fragmented and left with emotionally damaged citizens or individuals with past hurts which could predispose them to psychosomatic illnesses as a result of the military heritage. In order to heal these emotional wounds and scars resulting from the atrocities meted out to individuals or their loved ones, the present government instituted the National Reconciliation Commission (NRC) in 2003. From a psychological point of view the commission served as a platform for individuals to pour out their unresolved emotional distress and pain (which they have carried for years) experiencing a cathartic relief or talking cure to use Freudian nomenclature. It is worth noting that, behind the scenes, one of the major contributors to achieving this national goal and objective were a team of clinical psychologists and counsellors who were led by Dr. Araba Sefah Dedeh and her team of staff. Among the thousands of individuals who testified at the commission and perceived to have been emotionally harmed, a good proportion of them were taken through intensive counselling sessions and subsequent sessions of psychotherapy as needed. Without doubt the role played by these clinical psychologists and counsellors in the National Reconciliation Commission has been so significant that there is an upsurge of attendants and patrons of clinical psychologists at the various psychology clinics as well as a demand of clinical psychologists to give talks on health issues, habits and lifestyles as well and how to adapt to new environments and situations (*Personal Communication, 2005*).

The psychologists and counsellors delivered talks, seminars and discussions in schools, vocational centres, industrial organisations, churches television and radio. One important psychologist who has featured on a good number of television and radio talk shows in recent times has been Nortey Duah. He is one of the early trainees of the Clinical Psychology Programme at the Department of Psychology, University of Ghana. Through these presentations on both TV and Radio programmes such as Counselling Hour on GTV hosted by Rev. Tetteh Djangmah, Youth Time hosted by Dzifa Gbeho etc, millions of Ghanaians have been educated on mental health issues as well as having their particular and peculiar problems and questions addressed (*Personal Communication, 2005*).

Other Senior Practitioners like Samuel Danquah, Araba Sefah Dedeh, and Angela Ofori Atta have all made significant number of appearances on both private TV and Radio networks as well as the national radio and TV networks of the Ghana Broadcasting Corporation (GBC). The central and essential issue in all of the appearances of each of these clinical psychologists was psychoeducation commonly referred to as mental health education which is aimed at educating people about psychological health, issues on lifestyles and habits and self defeating practices, (such as cognitive distorted thinking, wrong interpretations, lack of stress management behaviours, wrong dieting, lack of exercises etc.) all of which are aimed to achieve total health as prescribed by the Biopsychosocial approach to health care (*Personal Communication, 2005*).

OTHER AREAS OF CONTRIBUTION IN THE COUNTRY

Clinical psychologists in the country practice in a number of areas and institutions where they discharge their services to the individuals, in that jurisdiction. Some of the common areas include schools, the Prison service, the Police service (WAJU), Sports, Churches to mention a few.

Clinical Psychologists in Schools

Due to the rich and comprehensive nature of their training, many clinical psychologists are able to function as full fledged School Psychologists without problems, since they are trained in developmental psychology and psychopathology from childhood to adulthood and their treatment methods. School psychologists assess pupils and students with emotional, learning or concentration problems and attempt to counsel, train and evolve teaching methods that will solve those problems. Many clinical psychologists have been contracted by private elementary schools that help the children to learn psychologically healthy attitudes and habits in order to adjust better in the school situation as well as home. Childhood and developmental disorders includes: Attention deficit and hyperactively disorder (ADHD), learning disorders such as reading disorder, mathematics disorder, disorder of written expression, stuttering, expressive language disorder, selective mutism, tic disorder autistic disorder etc. These disorders are problems that fall outside the competence of a lay teacher and this is why Clinical Psychologists are engaged with giving services to some schools. For instance, Nortey Duah is the Psychologist in charge for Merton International School. Sarah Ado is a Clinical Psychologist who is attached to the Counselling and Placement Centre of the University

of Ghana Legon (*Personal Communication, 2005*). In 1993-1994, Araba Sefah-Dedeh and Ofori-Atta organised and ran parenting classes for interested parents on how to raise their school going children. Due to the impact that the classes made, several schools consulted these psychologists with children having various learning and behavioural disorders. *(Personal Communication with Dr. Araba Sefah-Dedeh, 2005, University of Ghana Medical School)*

Clinical Psychologists in the Prison Service

The prison system intends to house, take custody, rehabilitate and reform individuals, many of whom, as a result of deviant behaviours or criminal activity, have been incarcerated. Due to the behaviour problems and possibly emotional distress of prison inmates, professionals trained in behaviour science – psychologists are the most appropriate for such individuals. Over the years, the prison system in the country have benefited from Clinical Psychologist intern who had to do their one year practicum with them in order to fulfil their requirement for Master of Philosophy degree. As a result of the impact the Intern Clinicians have made on the prison system in the past, the prison system has began engaging substantive clinical psychologist with the rank of DSP example of recent enlistments are Victoria Aquaye and Erica Dickson. *(Personal Communication, 2005)*

Clinical Psychologists with the Police

Clinical psychologists who are in the police service are specifically attached with the Women and Juvenile Unit (WAJU) where cases involving child abuse as well as violence against women are reported, investigated and pursued. For example in order to strengthen

WAJU in the late 1990s, Araba Sefah Dedeh and Angela Ofori-Atta trained several police officers and NGOs in psychological issues related to domestic violence and child sexual and physical abuse. Here Clinical Psychologists conduct comprehensive assessments on individuals (who could be victims of rape or sexual abuse, emotional abuse, physical abuse etc) to determine the diagnosis and take them through appropriate treatment procedures to restore them. Clinicians at the police service may also refer cases to physicians or other health service providers. They may also write reports which can be used as forensic or expert testimony during court room proceedings. They may also be required to be physically present to give forensic testimony at court during legal proceedings. Haleema Boakye, who graduated recently, is an example of the new Clinical Psychologist appointed to serve in the Police Service. Various Psychologists have interned with WAJU such as Adolf B. Awuku and Angela Adu-Nyarko. *(Personal Communication, 2005)*

Clinical Psychologists in Sports

Due to their increasing momentous upsurge and growth, Clinical Psychologists are beginning to appear in active sports as professionals who offer effective advice and counsel to both technical bench and the play-body or entire team that engage in competitive sporting activities. As a result of periodic poor performance of a team which had nothing to do with skill or competence of the team, but rather their morale and emotional status, calls for a professional who can assess the eligibility of players at each time they are to engage in active contest became vehement. Not only do Clinical Psychologists assess players or team members on their emotional status but they also are professional motivators who "psyche" them up, increase their morale and instruct them to

be goal oriented, never being discouraged but maintaining a constant high morale throughout the competition. This is because they know winning a contest begins with a mental attitude of winner. For the first time in Ghana, a football team, Kumasi Asante Kotoko is said to have a Clinical Psychologist on their team management board. *(Personal Communication, 2005).*

Clinical Psychologists in Churches

Many Clinical Psychologists are affiliated to one church or the other especially where they are substantive members of those churches. Since many of those churches have counselling departments and marriage committees, they naturally engage or allow Clinical Psychologists who are considered to be professional in those areas to lead or head such departments. Apart from functioning as heads on members of those departments, Clinical Psychologists are generally invited to give several talks on dating and relationships marital life, career choice and vocational development. In such meetings, many questions misconceptions and beliefs of individuals are answered and clarified. Araba Sefah-Dedeh, Ama Edwin and Joseph Osafo are few examples of Clinical Psychologists who have engaged in educating church folks on psychological issues. *(Personal Communication, 2005)*

It is worth mentioning that these are not the only areas of function of clinical psychologists in the country. This is because one area where it is common to find Clinical Psychologists is in colleges and universities where a whole range of undergraduate and post graduate training programmes are being ran and taught by them. The current situation of ever-increasing and momentous development of the discipline is a predictor

of how it will in the near future become a major health institution whose involvement in national development can not be dispensed with. It is therefore important for the government to show interest in the discipline and provide funding for the training of more professionals at least at the masters level.

In effect, the health system is just one area of the numerous sectors where Clinical Psychologists dispose of their services. Because the subject matter of Clinical Psychology as a discipline is the total man (i.e., the cognitive or mind, affective or emotions, feelings and connative (i.e., behaviour or physical or physiological function), it is important to every institution or organization ranging form family to community to business and any social grouping where human beings are found.

THE PIONEERS OF THE PROFESSION IN GHANA

The followings are brief biographical accounts of Clinical Psychologists who have been pioneers as far as the profession of clinical psychology and its practice in Ghana is concerned. In addition there is a cursory review of some major researches and programmes they undertook which contributed to the development of the profession.

DR. ARABA SEFAH DEDEH. A PIONEER AND THE MAIN CLINICAL PSYCHOLOGIST OF THE NATIONAL RECONCILIATION COMMISSION

After her first degree at the department of psychology, University of Ghana Legon, Araba Safah Dedeh left to pursue her doctoral training in Washington University in the United State of America at St. Louis Missouri as a Fulbright scholar. She returned to Ghana in 1980 after obtaining her Ph.D degree in Clinical Psychology. Upon returning she immediately had an appointment with the University of Ghana Medical School as a

Lecturer as well as a practitioner at the Behaviour Therapy Unit within the Department of Psychiatry.

At the same time she also took her part time lectureship position in the Department of Psychology in the University of Ghana, Legon where she met with the third batch of the Clinical Psychology Students. Subsequently, these students were handed over to her by Professor Danquah who was embarking on an African mission to introduce the practice of behaviour therapy in some West African Universities such as University of Calabar in Nigeria.

Dr. Araba Sefah Dedeh was also one of the pioneers in establishing the Advise Centre currently called Counselling and Placement of the University of Ghana. Having been practicing the past twenty-five years, she has had to handle various, diverse and countless amount of cases and therefore has much experience. She also has taught many undergraduate and graduate students for these long years and she is now a Senior Lecturer at University of Ghana Medical School. She has conducted numerous assessments for children with intellectual handicap whose cognitive level of competence must be assessed to determine their eligibility for admission into the Dworwulu Special School or the New Horizon School. The various, diverse and countless number of cases she has handled over the years range from mild anxiety conditions to severe psychotic suicidal depression. As a result of her work in the medical school, she has had to liase and network with medical doctors, psychiatrists and even clinical social workers in determining diagnosis and appropriate treatments and prognosis for cases. According to

her, she uses a wide range of therapies from all the theoretical perspectives in her conceptualization of psychopathology and eventual treatment in order to get results. For instance she mentioned using Freudian Defence Mechanism as a concept in understanding why certain individuals evade reality with their behaviours. She also uses Cognitive Behaviour Therapy, Reality Therapy, Insight Therapy and what she also refers to as Pastoral Counselling which involves using the person's religious belief to help them.

Dr. Araba Sefah Dedeh has engaged in a number of studies including Learning Disabilities among the children of the Ga rural communities, such as Ashalaja near Weija, University Staff Village Primary Schools and some Adabraka Schools. She has also done a research on Schistosomasis (Bilhazia) and Cognitive Development. This was a World Health Organization Partnership for Child Development research meant to find how the worm infestation affects the cognitive development in children. At the moment she is undertaking research in Suicidology (Suicide studies) among women in Ghana.

As part of community mental health function of clinical psychologist, which aims at educating the general public about mental health and mental hygiene so as to avoid psychological disorders resulting from life style and bad habits, Araba Sefah Dedeh has been at the forefront presenting seminars and being guests to various talk shows on radio and TV since the 1980s. Some of these talk show programmes in those days included Pepsodent Heath Guide family life, parenting, adolescent and relationships were some of

the important topics discussed more often. *(Personal Communication with Dr. Araba Sefah-Dedeh, 2005, University of Ghana Medical School)*

National Reconciliation Commission (NRC)

Apart from all the other functions and services Araba Sefah Dedeh has been involved in, her role in the National Reconciliation Commission was most crucial to clinical psychology and the nation as a whole. She functioned as the head of counselling unit of the commission. The commission was set up to help people over come their pain and their past in order to forge forward for a better future. To this end, the counselling unit which were constituted by Clinical Psychologists had a strategic role to play. There were to help people face their past and overcome it and secondly to help them overcome their hurts, wounds and problems in order to adjust better.

These Clinicians, who were distributed in the five offices of the NRC nationwide, used counselling as their main tool of intervention in helping victims of various atrocities and torturing to overcome their past and forge ahead with their lives. In all five hundred people went through the counselling sections under the Clinical Psychologists. Some of these Clinical Psychologists include Daniel Bieu, Adolf Bekoe, Bright and Margaret Amankwa Poku. All evidences point to the fact that their work at the NRC, was successful. It was successful in the sense that all those who went through the counselling therapy admitted that they felt better after meeting with the counsellors although it was not without some challenges. Some challenges included time constraint, logistical constraints; follow up difficulties since some times there was the need to see the whole

family. *(Personal Communication with Dr. Araba Sefah-Dedeh, 2005, University of Ghana Medical School)*

DR. ANGELA OFORI-ATTA, THE CLINICAL PSYCHOLOGIST WHO ALSO SERVED IN POLITICAL AND PUBLIC OFFICE

Angela Ofori-Atta completed her first degree in Psychology major and Zoology minor at the University of Ghana between 1980 and 1984 where she had a solid foundation in psychology under competent instructors.

After the first degree training she proceeded with her graduate education at the University of British Columbia in Canada as a commonwealth scholar where she obtained her Master and PhD degrees in Clinical Psychology from 1986 to 1992. She later returned to Ghana and received an appointment as a Lecturer at the University of Ghana Medical School. She also rendered teaching services at the Department of Psychology at the main campus where she taught M-Phil Students. Some of the students who passed through her instruction and supervision included Dr Ama Edwin who is currently at the Korle Bu Teaching Hospital, Dr. Dickson at 37 Military Hospital and Dr Margaret Agamah who is with the Military. Others who in one way or the other benefited from her supervision included the first batch of the renewed clinical psychology programme in 1997: Nortey Duah, Adote Anum and Kwame Asante, Subsequent students like Dinah Odoom and Samuel Atindabila also took mentorship from her. During this time, she collaborated with Araba Sefah Dedeh in developing the ethics of professionalism for Clinical Psychologists who pushed it through the Academic Board of the University of Ghana.

As a Clinical Psychologist as well as a Lecturer, Angela Ofori-Atta undertook a number of studies. One of the major studies was the work on alcohol intake and attitudes towards it, in Upper West region of Ghana undertaken in collaboration with Dr Sefah-Dedeh and Dr Ohene from 1994 to 1998. In this research they explored the various attitudes that inhabitant of that area had toward alcohol the level of consumption and the psychosocial and economic consequences of such widespread and heavy use. Another important study was the exploration of the cultural beliefs and practices of the people of the Upper West with respect to mental health. The research findings were used to design mental health training in the Upper West Region funded by DANIDA *(Personal Communication with Dr. Angela Ofori-Ata, 2005, American Peace Corps).*

A prominent and novel research which she independently undertook even before she started the graduate education training was the Traditional Healers conceptualisation of Psychopathology and Psychotherapy at Aprede a town at the Akwapim Ridge in 1986. According to her, she had been conferring with one Dr. Oku Ampofo who had set up a herbal medical centre in the town at the Akwapim Ridge. It was this man who recommended the traditional herbalist at Aprede as a study she could explore. Angela Ofori-Atta therefore sponsored herself and travelled to the centre of this herbalist and stayed there for one week where she engaged in Naturalistic Observation of the man's concept of Psychopathology and the various systematic treatment approaches he adopted in solving the problems of his client or patients. She also interviewed the healer on what she was doing. She reported that when the very violent cases of psychotic patient were brought to the healer, he first chained and detained them after which he gave them herbal

concoctions which is made up of Anxiolitics and Antipsychotic herbs, a caffeine type components, colanuts, rawofia and other psychotropic medicines. These concoctions were brewed and given to the violent patients who drink and thereafter became calm. After they had calmed down, he would integrate them into his family where they helped his three (3) wives with farm work, fufu pounding and other household chores. Additionally the healer interacted with the almost healed client about their ambitions, desires and work they intended to do when they were discharged. Afterwards he would call for relatives of the patients and take them through counselling about how to deal with the patients at home and provide the work opportunity which they desire to do.

It is amazing the interesting integrative model which the traditional healer used in treating his patients. There was a medical approach, the family therapy approach, a cognitive restructuring approach which all helped in total recovery for the patients. The researcher reported that the patients she observed looked better than those treated in mental hospitals except for the few observations of glassiness in the eyes of the patients as a result of the strong antipsychotic concoctions which was used to counteract the side effect of Parkinsonism.

Another interesting observation was the training programme the traditional healer took his own two sons through knowing that he also was mentored by his father in the model he inculcated and supervised his two sons on the practice of treating patients who come to the centre with the intent of educating and training more healers or therapists to propagate the good work.

Being a practice Clinician for so many years Angela Ofori-Atta had handled so many cases ranging from conditions among children such as conduct disorders, developmental delays, autism and attention problems some of which consisted only of assessment and referral. Others with problems in anxiety, stress, depression, marital problems, job problems, alcoholism she not only assessed but took them through 12 to 14 sessions of intensive psychotherapy which is essentially of the cognitive behavioural model. She took them through these sections and gradually phased them out with discharge counselling to its logical conclusion of the case.

Like Dr Araba Sefah-Dedeh, Dr Angela Ofori-Atta was asked to serve in various capacities from 1996 to 2000. For example Dr Ofori-Atta served as the main consultant of the American Peace Corps until her political appointment. According to her, the Clinical Training Programme at the University of Ghana has a number of challenges. These include limited number of teachers, limited facilities for training and overall logistical constraints. Due to this students may not get the highest quality of training. Secondly, a large intake of students for the Clinical Programme will mean inadequate supervision during the clinical practicum which has negative consequences for quality professionalism *(Personal Communication with Dr. Angela Ofori-Ata, 2005, American Peace Corps).*

SARAH ADO – THE FIRST STUDENT OF THE CLINICAL PSYCHOLOGY PROGRAMME AT DEPARTMENT OF PSYCHOLOGY, UNIVERSITY OF GHANA

Sarah Ado was the pioneer student who was first admitted into the post graduate Clinical Psychology training programme at the Department of Psychology, University of Ghana, Legon in 1974. After completion of her first degree, she was taken on as a Research Assistant to help the lecturers of the Department. Some of the important courses for the programme included Child and Adult Psychopathology, Advance Behaviour Modification, Advance Psychometrics and Statistics and so on. In those days, some of the courses were done at the Department of Psychology while she had to attend the course in Psychopharmacology with the Medical Students at the University of Ghana Medical School, Korlebu. The practicum took place both in the wards when she had to see patients or clients, take them through the interview process, conduct possible assessment and design the behaviour therapy programme as an intervention. At other times she took her practical at the Accra Psychiatric Hospital with the medical students under the supervision of Professor Danquah.

She reports that clinical psychology contributed a distinct and significant impact to the diagnostic and recovery process of all clients that came her way. Eventually, she submitted a final Masters Thesis in partial fulfilment for her graduation requirement. Sarah Ado conducted her thesis research on Mentally Handicap Children. And this became the basis of her employment at the Special Education Unit of the Ghana Education Service in 1979. She worked with the Special Education Unit until 1984, when she took a lectureship position at the University College of Wineba in 1987. She

taught at the University College of Wineba from 1987 to 2000. In 2001, she occupied a lectureship position in the Department of Psychology at the University of Ghana, Legon. At the same time due to her clinical training background, she works as a Counsellor at the Counselling and Placement Centre, University of Ghana. In her training as a Clinical Psychologist and practicing as a Counsellor at the Placement Centre, she has been involved in giving guidance seminars to coordinators in some of the District Assemblies *(Personal Communication with Sarah Ado, 2005, Dept of Psychology, University of Ghana, Legon).*

Some of the programmes she and the Centre conducted include Re-entering Academic Life for Mature Students, Relationships and Academics on Campus, Preparing effectively for examinations and dealing with examination anxieties. Others include the Annual Ten Week Career Development Programmes which is meant to prepare final year students for the world of work and the Career Fair which involves bringing business organisations, the representative of Ghana Employers Association to interact with final year students on preparing for the job market, preparing for interviews, entrepreneurship and so on.

In her practice as a Counsellor, she attends to an average of six students a day at the Counselling and Placement Centre who need guidance from a variety of areas involving career, marriage and relationship, examination problems and family problems *(Personal Communication with Sarah Ado, 2005, Dept of Psychology, University of Ghana, Legon).*

THE INPUTS OF PROFESSOR SAMUEL A. DANQUAH

Before the introduction of Clinical Psychology into the health system, the main stream health delivery was classical medicine and psychiatry. While Medical doctors concentrated on the general somatic and physical conditions of patients, the psychiatrist focussed on the mental problems of patients. However, both categories of doctors were trained in chemo-therapeutic approach of treatment. As a result all categories of patients including those with somatic problems, mental or psychiatric problems and even mild neurotic conditions were treated solely to pharmacological drugs, a situation which poses risk more especially to patients with neurotic conditions.

It is unquestionable that drugs play important role in therapy for all cases. However, neurotic conditions are essentially problems in living such as phobias, chronic self doubts and repetitive interpersonal problems. Freud who probably first introduced the word, related it as over indulgence in defence mechanism and therefore it is mild adjustment problems that all boil down to anxiety and stress.

The Behaviour Therapy Centre in U.G.M.S

As a result of their mildness and adjustment in nature, the prescription of anti anxiety drugs which existed before clinical psychology was introduced did not help the problem. In fact in some cases, it worsened the plight of patients since it created substance abuse and substance dependence in them with all the general side effects of drugs. In this context the Behaviour Therapy Centre which was introduced with behaviour treatment programmes such as systematic desensitisation, Behaviour modification, Social Skills

Training, Stress Management to mention a few, came to salvage the situation (*Personal Communication, 2005*)

The Behaviour Medicine Programme at K.N.U.S.T.

Apart from the introduction of the Behaviour Therapy Centre at the Department of Psychiatry in the University of Ghana Medical School (UGMS), Professor Danquah took the same idea to the then University of Science and Technology (UST) now Kwame Nkurmah University of Science and Technology (KNUST) in Kumasi. With the assistance of Professor Laing and others from the medical school at Legon, Sarah Doddoo and Professor Twumasi, the Behaviour Medicine Programme was introduced at the Medical School of the KNUST in 1976. The Behaviour Medicine Programme which also broadened to be a social science course at the University is patterned after the Edinburgh model consisting of Psychology, Sociology and Anthropology. This was very crucial because there was a need to train a new breed of medical doctors who understood human behaviour from anthropological and sociological dimensions as well as psychological perspective *(Personal Communication with Professor Samuel Danquah, 2005, Dept. of Psychology, Legon).*

The Counselling and Placement Centre on Legon Campus

As Clinical Psychology continued to gain momentum in terms of the distinct role it was playing in order to achieve total health and wellbeing, a growing need developed in the University of Ghana for a unit like that which could cater for the needs of students. What endeared people to clinical psychology were that although it was effective in helping

people solve their problems, it used no mystical or mysterious approaches, but simply scientific. The presence of clinical psychology prompted individuals like Professor Fichian, Mr. Bulley, Professor Danquah, Dr. Adomako and Mrs. Banaman to join efforts in establishing the Centre in the early1970s *(Personal Communication with Professor Samuel Danquah, 2005, Dept. of Psychology, Legon).*

The Guidance And Counselling Programme at the Methodist University

Professor Danquah also served as the consultant at the Methodist University in Ghana to develop the Bachelor of Arts Degree and Master of Philosophy Degree Programmes for the University. In the year 2004, the two programmes were accredited by the National Accreditation Board (N.A.B.) and the training was commenced in the 2005/2006 academic year *(Personal Communication with Professor Samuel Danquah, 2005, Dept. of Psychology, Legon).*

CHAPTER FIVE

DISCUSSIONS

The present study investigated the role and impact of clinical psychology on the health delivery system in Ghana since its introduction in 1972. Archival research of the impact of clinical psychology on the total health delivery, interviews with the pioneers of the profession in Ghana and the authors own research findings from one year of clinical experience were conducted. An important and essential aspect of all the researches was to find out whether, the treatment model or approach which is mostly adopted by psychologist (i.e. psychotherapy or psychological intervention) is valid or effective in boosting the health of patrons. Secondly, the study's theme sought to find out whether clinical psychologists contribute some distinct service and play a role in the whole health delivery process or it merely duplicates another health service provider's responsibility.

In agreement with results of other related published studies (e.g., Thase et al., 2005) a significant difference in improvement of neurotic condition was observed in clients who were given a combination of psychotherapy and pharmacotherapy than their counterparts with only pharmacotherapy. That is, the neurotic condition of clients in the combined treatment approach yielded a significant improvement than the pharmacotherapy alone group. In connection with this, it was evident that neurotic conditions are better treated using psychological intervention than pharmacological or chemotherapeutic intervention.

Moreover, evidence from the comprehensive review of archives of clinical psychology practice in Ghana since the early 1970s, the individual and group cases that psychologists

got involved in treating, and interviews and interactions with the pioneers of the profession seem to suggest that there has been a significant impact of clinical psychology on health delivery as well as a contribution of a distinct and unique role in the overall health provision in the country.

Finally, cursory observations of the behaviour of patrons or clients in recent times indicate a drastic change in their health seeking detour. This also seem to suggest that psychoeducation, a preventive mental health campaign used by clinical psychologists to educate the public on health issues has eventually contributed to the popularisation of the profession among the Ghanaian people than it was some three decades ago, when the profession was introduced here. The finding that psychotherapy combined with pharmacotherapy is effective in yielding perfect treatment was consistent with the findings of existing literature. Secondly, that psychotherapy alone is the best treatment method for neurotic cases and stress related psychological disorders was also found to conform to earlier studies. And this is also in support of the work of Baah-Odoom (1999) who used Cognitive Behaviour Psychological Intervention in treating 100 essential hypertensive patients by reducing their blood pressure to fall within normal range. Additionally, the study conducted by Amankwaa-Poku (2001) on the effect of stress on diabetic patients also found cognitive behaviour psychological intervention to be effective in the control of hyperglycaemia among her patients. A post treatment physiological measurement taken revealed a drastic reduction in the blood pressure and pulse rate of the patients after the therapy. However there were slight distinctions in the internal design among the various studies. For example, although the work of Tarrier and

Borrowclough (1995) showed that adjunctive psychological intervention yielded effective treatment of variety of health problems, it distinctly identified that whereas PTSD responded better to cognitive behavioural psychotherapies, exposure procedures are the treatment of choice of panic attacks.

Furthermore, Smith et al. (1980) worked on the benefits of psychotherapy for treatment of neurosis, true phobias and emotional somatic complaints, findings indicated that behaviour and psychodynamic therapies were more superior to other therapies. The distinction and relative effectiveness of several psychotherapeutic techniques was not the main focus of the present study. The author's current study merely combined various types of psychotherapies in a practical manner in treating neurotic conditions and there was no further analysis on the relative contributions of each therapeutic technique. In fact while in many of the efficacy and impact of psychotherapy researches (e.g., Singer et al., 1981 and Smith et al., 1981), where psychoanalytic techniques incorporated into cognitive behavioural therapies seem to yield significant or even better contribution to treatment, an earlier notion in Ghana seemed to suggest that the use of psychoanalytic therapy does not work for the Ghanaians situation. This notion was found to be erroneous and misleading. The notion was rather that Freudian Psychosexual development was what did not apply well to the Ghanaian situation but his therapy did. Senior Clinical psychologists like Samuel Danquah and Araba Sefah-Dedeh admitted to the usefulness of psychoanalytic techniques in the clinical therapeutic sessions. As to whether the belief that Freudian psychosexual stages of development being inapplicable to the Ghanaian situation is a truism or fallacious, that is yet to be determined by very many future

researches in Ghana. However it is worth mentioning that the present study used aspects of Psychoanalytic techniques (i.e., insight therapy) to help clients unravel the sources and root causes underlying their anxieties and neurotic conditions. And the cumulative effective of this complemented the treatment outcome.

With regard to the increasing popularity of clinical psychology it will even be a logical result if there was no statistical evidence to substantiate that. Just about a decade or two ago, a health seeker would first go to a local pharmacy shop for a drug to cure their health problems. If symptoms persist, they proceed to the general hospital to see a medical doctor. And if the situation or condition is not responding to the medical doctor's intervention, the doctor may refer the patient to the psychiatrist. And if all proves futile they may lose faith in medical science and seek spiritual help from either a traditional native healer or spiritual prayer centres. With the advent of psychology in Ghana in 1972, and a steady growth till date, there are a number of clients who report at the psychology units of general hospitals and even centres of private practitioners without any case history of the detouring journey mentioned above. Others are also readily referred to us by both medical doctors and psychiatrists for psychological evaluation and intervention.

The author, who is doing his clinical internship, sees an average of five clients in a week. In the year that Clinical Psychology was introduced (i.e., 1972), clients attendance amounted to 588 individuals, eight years later the number increased to 1751 (an increase of 198%) and a total patient load of 10,256 by 1980 (Danquah, 1982). The rate of growth

is suggestive of how popular the profession was becoming. Moreover, the frequent demand of psychologists to give a talk on one health issue or another, the increasing demand of students for psychology courses on university campuses, the demand of psychologists by NGOs and the increasing demand of the MPhil clinical psychology programme at department of psychology, University of Ghana, all point to a current trend of a popularisation and ever-developing discipline in Ghana. For instance in the year 2005, about 200 qualified graduates applied for the MPhil clinical psychology programme while in the year 2004, the number of applicants was 80.

OTHER RELATED ISSUES

Another important issue which the present study explored was to evaluate the content of the clinical psychology programme at the department of psychology, university of Ghana, Legon, and find out whether it is comparable with high placed clinical psychology training programmes (CPTP) in the United States and Canada. Many of these CPTP in the West have been in existence for a very long period of time ranging from fifty years to a full century. As a result of their longevity, they have matured since they might have had to do a periodic review of the programme content as well as trained thousands of the world's clinical psychologists who are practising in various countries across the globe today.

Upon close analysis of the programme, it is observed that the CPTP of University of Ghana was comparable to their Western counterparts in a considerable number of ways. For instance, in terms of programme content, courses like Child and Adult

Psychopathology, Personality Theory, Psychological Assessment and Research Methods are commonalities among all.

More so, the practical experience that the programme takes its students through by attaching or affiliating them with general hospitals was also common to all. The distinction however is, while the other CPTP quote the requirement in years, it is quoted in number of hours at University of Ghana. For example, while the Centre for Cognitive Therapy at the University of Pennsylvania quotes a 150 supervision hours for 1 year under an assigned Mentor, the CPTP at Legon quotes the requirement as 500 practicum hours of actual engagement with clients under supervision in a health facility. The second issue of the CPTP in Legon of comparable value to its counterpart CPTP in the West is the Model upon which the programme is based. It can be observed that the CPTP at University of Ghana, Legon uses the same Boulder model characteristic of virtually all the Western CPTP. The boulder Model also known as the scientist practitioner model allows clinical psychologist to be trained as research scientists who can conduct research into certain human behaviour or individual cases as and at the same time being a practising clinician who attend to his clients by assessing, diagnosing and treating them.

However, although the programme content and model used were found to be virtually the same with each other, there was an observed significant area of diversity among the CPTP in Legon and its Western counterparts. And this has to do with the length of training and the degree awarded. The length of training for most of the Western CPTP seemed to range from 3 to 5years. And because of this, the degree awarded to students

upon graduation is the doctor of philosophy (PhD) degree. At the moment, the CPTP at University of Ghana on the other hand has an average duration of 2 to 3 years and therefore the degree awarded upon graduation is Master of Philosophy (MPhil) degree. It is however worth mentioning that this is for the interim, since plans are being advanced in upgrading the programme to a Doctorate degree in the proposed School of Psychology.

In effect the duration of the programme is what perhaps leads to the different awards of degrees, otherwise it is unquestionable that the final thesis work or dissertation based on the research students conduct, at CPTP in Legon are standard and comparable to the doctoral dissertations submitted for graduation in their Western counterparts. As indicated earlier, it is believed that, the architects and founders of the CPTP in Legon would expedite action on this very important issue for future programme review and upgrade.

THE PHYSICIANS CRAVE FOR CLINICAL PSYCHOLOGY

An important trend being observed at the CPTP in Legon is the increasing desire of medical officers and pharmacists expressing their interest to take clinical psychology as a post graduate training. So far about five medical officers have gone through the CPTP at Legon and more are still applying. In the 2004/2005 academic year, one applicant who was admitted into the programme was a Pharmacist. Although they may not have any direct training in the Principles of Psychology and Human Behaviour, they are being given concession and quota since at least they have a good training in the biological basis of human behaviour, an important aspect of Clinical Psychology. These students are

therefore required to attend the relevant undergraduate courses to make up for the lack of a first degree in Psychology. Furthermore, the nature of the CPTP is tasking and demanding and it is believed that medical officers and other medical science students, due to the nature of their training, have the discipline and commitments to complete the programme. In other words, the CPTP at University of Ghana, Legon is doing quite well.

CHALLENGES FACING THE TRAINING OF PSYCHOLOGISTS IN GHANA

Although the CPTP at Legon is doing well and many qualified applicants continue to desire to be trained, it is not without problems. Some of these problems include the limited human resources for the training. As at now, there are three PhD Clinical Psychologists one of which is a professor. For some time now it has been the professor of clinical psychology programme who has had to co-ordinate and gives overall supervision to all the students since the other two PhD Clinical Psychologists were engaged with other assignments. Fortunately, the clinical practicum is being supervised and assisted by the other practising clinicians in the various hospitals and health centres some of whom are M.D senior lecturers. It is worth mentioning that other professors not necessarily of clinical psychology background but of backgrounds such as Cognitive Psychology, Developmental Psychology, Research Methods, Statistics and Psychometrics also teach and supervise theses in the programme. Clinical practitioners who are practising at the various health centres send reports about practicum students to the co-ordinator of the programme.

Secondly, there are also limited facilities and general logistical constraints making the admission of more students difficult. Access to a number of instruments is either limited or entirely unavailable. For instance there are so many assessment tools and psychological tests that need to be developed in Ghana to suit the African condition in order to get the highest level of quality training for students. This will help bring a faster development of the profession in the sub-region instead depending on psychological tests from the West.

Finally as a stated above, it is unfair that a large amount of students who apply for the programme will have to be turned away yearly even though they are adequately qualified to pursue the training. All this, is as a result of the general logistical constraint and understaffing. It is the logical result of this that only few applicants are taken at a time in order to prevent inadequate supervision and lower level of training which cannot be compromised for the sake of professionalism. A typical and more current example is even though about 200 people applied for the 2005/2006 academic year intake, only 15 which is about (7.5%) of them could be taken. Again, in the 2006/2007 academic year only 5 out of 12 applicants who were successful at the interview were taken. This is an unfortunate reduction of the number of trained health professionals as Clinical Psychologists that should have been added to the national grid of qualified health professionals. This seems to suggest that the rate of the national build-up of this health profession is on a regression as well as having a negative toll on professional development.

RECOMMENDATIONS

From the above research findings and discussions, it is mandatory to make the following recommendations to the appropriate authority bodies and stake holders.

1) As a medium term project both the DPUG and the University itself should consider upgrading psychology to the status of a school as stated in the University's Strategic Plan for 2004 and beyond. This will help to cater for the ever increasing applicants who seek all manner of specific and specialised courses from undergraduate level to the Masters Level in Psychology.
2) In connection with this, the University should show extra commitment to the CPTP at Legon, by recruiting more qualified instructors, expanding the current facilities for the programme and general logistical provision. For example, the development of assessment tools and psychological tests, in order to improve the training of clinical psychologists is very critical for professional development.
3) If the government claims to be committed to total quality health service as advised by W.H.O to be the biopsychosocial model, then it must invest funds for the training of more clinical psychologists by building offices, seminar and lecture rooms, modern teaching tools and all the necessary audio-visual aids that modern information technology makes possible. In this case, the current intake of an average of 5 to10 students a year, which is woefully inadequate for health delivery, can be increased to 50 per year.
4) The government should show extra commitment by ensuring that the proposed clinical psychology Act which will be the constitutive document to regulate the

activities of practitioners is passed promptly, in order to prevent the infiltration of unlicensed and unqualified practitioners from posing a danger to health seekers.

5) Government should commit funds for a special project of developing Ghanaian/African Psychometric measurements and Assessment tools as the governments of the West did and are now reaping the results.

6) The Department of Psychology should step up the campaign of encouraging research into African traditional cultural practices in order to reveal the negative and positive impacts on health and development. This will help to better focus the attempt and efforts to discourage negative cultural practices such female genital mutilation, that cause severe psychopathology as well as strengthening and improving the positive cultural practices.

SUMMARY AND CONCLUSIONS

For the past three decades, clinical psychology have increasingly made impact on the health delivery process by contributing a distinct and essential aspect of general and mental health, using psychoeducation and other psychological techniques.

In the last 10years, the programme has generated very many and important research works conducted and submitted by final year students as part of their academic graduating requirements. Some of these researches include the dimensions and impact of child abuse, effects of music therapy on depression, some psychological correlates of adolescent sexual behaviour in Ghana, relationship of stress and hyperglycaemic control in Ghana, self esteem and assertiveness as psychological factors influencing marital distress, and pain perception and coping strategies among people living with sickle cell disease in Ghana. Others include cognitive therapy and self concept among Ghanaian adolescents, the mental health status of convicts on death role, substance abuse among prisoners in Ghana, personality characteristics of sexual offenders, impact of stress management intervention on the level of stress of pastoral care-givers and personality profile among substance abusers and nonsubstance abusers. Some of the studies have been reviewed earlier on in this work.

An important contribution and implications from these numerous studies is that it informs health providers with practical facts and information on the ground about various health issues and helps them to adopt more effective and integrative therapeutic approaches in order to achieve maximum results. For example, were it not for the research on

Preliminary survey of beliefs of mentally retarded conducted by Danquah (1976), that afforded us with actual beliefs about the mentally retarded for which many were being killed, remedial actions would not have been taken to curb the infanticide situation that was prevalent in some cultures then.. Parents were therefore educated on medical, biological and psychosocial factors that can cause mental retardation in children.

In addition to these researches being carried out in the programme, another important thing is the intervention that is conducted for the patients who were used in the study in order to help with their condition. In most cases these psychological interventions have either been of immense benefit alone to patients or in combination with patients' own chemotherapeutic programme yielded tremendous recovery results. Further, the study by Schroeder et al. (2003) on the therapeutic significance of widowhood rites in Ghana has helped Ghanaians appreciate certain of our own cultural practices that have been proven to be good by scientific research and must therefore be strengthened while at the same time pruning them of practices that prevents good health and development.

Over these years, more clinical psychologists have been trained amounting to about sixty-five as at present. Many of these are affiliated to one hospital or another with others having formed their own private practice networks. Their activities in the hospitals, clinics, appearances on media talk shows, church seminars and so on have all contributed in improving the health of people in Ghana. This may appear to be a claim by the researcher who may be perceived to be having interest in the research. However, everyday survey and informal interactions with the various Medical Officers and

Psychiatrists at the various health centres confirms this "claim". For example, all the Psychiatrists and Medical officers at Pantang Hospital (where the researcher is currently interning at), have come to develop much confidence in the work of Clinical Psychology and ceaselessly refer patients to the psychology clinic for all manner of help ranging from psychological testing and assessment to intervention. The other colleagues in the other health institutions confirm this same experience. This explains why Medical Officers are increasingly opting for Clinical Psychology as a post graduate training. Dr. Wozuame, a Senior Medical officer who recently completed the MPhil programme in Clinical Psychology has developed a habit of encouraging his medical colleagues (who seek his help on postgraduate training carrier) to consider the option of Clinical Psychology for the reason, as he puts it "your own health" *(Personal Communication with Dr Benedictus Wozuame, Pantang Hospital).*

One thing is clear in all of this. The potency and validity of Psychological interventions in Ghana has been proven to be effective in Ghana as it does elsewhere in the world. In all the interventions done in this research as well as in the studies and treatments done which was earlier on reviewed in the work there is no doubt about on the efficacy of Clinical Psychology as a Health Profession and Clinical Psychologists as Health Professionals. The interviews conducted with pioneer Clinical Psychologists as well as other paramedical professionals (though not all were recorded in this work) revealed a common trend. And that is the work of Clinical Psychologists does have significant positive impact on health provision and would have to be engaged for total health delivery as being advocated in the current Biopsychosocial Model to health care. In the

U.S and other Western countries Like Canada, Germany, Britain and so on, the discipline is solidly established as an autonomous institution recognised by government. Although the Ghanaian Situation is faced with a number of challenges as outlined earlier on, it seems to be on this path and trend of development as the West.

It is therefore in this context that the government and the Ministry of health are being called upon to show commitment in the training of more clinical psychologists as well as passing the necessary legislative instruments to give the profession the requisite backing.

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APPENDICES

APPENDIX A

The DASS 42

Please read each statement and circle a number 0, 1, 2, or 3 which indicates how much the statement applied to you over the past week.

The rating scale is as follows

0 Did not apply to me at all.
1 Applied to me to some degree, or some of the time.
2 Applied to me a considerable degree, or a good part of the time.
3 Applied to me very much, or most of the time.

1.	I found myself Getting upset by quite Trivial things	0	1	2	3
2.	I was aware of dryness of my mouth	0	1	2	3
3.	I couldn't seem to experience any positive feeling at all	0	1	2	3
4.	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5.	I just couldn't seem to get going	0	1	2	3
6.	I tended to over-react to situations	0	1	2	3
7.	I had a feeling of shakiness (eg, legs going to way)	0	1	2	3
8.	I found it difficult to relax	0	1	2	3
9.	I found myself in situations that made me so anxious I was most relieved when they ended	0	1	2	3
10.	I felt that I had nothing to look forward to	0	1	2	3

11.	I found myself getting upset rather easily	0	1	2	3
12.	I felt that I was using a lot nervous energy	0	1	2	3
13.	I felt sad and depressed	0	1	2	3
14.	I found myself getting impatient when I was delayed in any way (eg. lifts, traffic light, being kept waiting)	0	1	2	3
15.	I had a feeling of faintness	0	1	2	3
16.	I felt that I had lost interest in just about everything	0	1	2	3
17.	I felt that I wasn't worth much as a person	0	1	2	3
18.	I felt that I was rather touchy	0	1	2	3
19.	I perspired noticeably (eg, hands sweaty) in the absence of high temperatures or physical exertion	0	1	2	3
20.	I felt scared without any good reason	0	1	2	3
21.	I felt that life wasn't worthwhile	0	1	2	3
23.	I had difficulty in swallowing	0	1	2	3
24.	I couldn't seem to get any enjoyment out of the things I did	0	1	2	3
25.	I was aware of the action of my heart in the absence of physical exertion (eg. sense of heart rate increase, heart	0	1	2	3
26.	I felt down-hearted and blue	0	1	2	3
27.	I found that I was very irritable	0	1	2	3
28.	I felt I was close to panic	0	1	2	3
29.	I found it hard t calm down after something upset me	0	1	2	3
30.	I feared that I would be "thrown" by some				

	trivial but unfamiliar task	0	1	2	3
31.	I was unable to become enthusiastic about anything	0	1	2	3
32.	I found it difficult to tolerate interruptions to what I was doing	0	1	2	3
33.	I was in a state of nervous tension	0	1	2	3
34.	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
35.	I felt terrified	0	1	2	3
36.	I could nothing in the future to be hopeful about	0	1	2	3
37.	I felt that life was meaningless	0	1	2	3
38.	I found myself getting agitated	0	1	2	3
39.	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
40.	I experienced trembling (eg. in the hands)	0	1	2	3
41.	I found it difficult to work up the initiative to do things				

APPENDIX B

Demographic Group Statistics of Sample

Educational Level of Respondents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	basic	15	34.9	35.7	35.7
	secondary	14	32.6	33.3	69.0
	tertiary	13	30.2	31.0	100.0
	Total	42	97.7	100.0	
Missing	System	1	2.3		
Total		43	100.0		

Frequencies

Age of Respondent

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	18.00	1	2.3	2.4	2.4
	19.00	3	7.0	7.1	9.5
	20.00	1	2.3	2.4	11.9
	21.00	1	2.3	2.4	14.3
	22.00	4	9.3	9.5	23.8
	24.00	2	4.7	4.8	28.6
	25.00	4	9.3	9.5	38.1
	26.00	6	14.0	14.3	52.4
	27.00	4	9.3	9.5	61.9
	28.00	1	2.3	2.4	64.3
	29.00	2	4.7	4.8	69.0
	31.00	3	7.0	7.1	76.2
	32.00	4	9.3	9.5	85.7
	35.00	2	4.7	4.8	90.5
	36.00	1	2.3	2.4	92.9
	41.00	1	2.3	2.4	95.2
	43.00	1	2.3	2.4	97.6
	45.00	1	2.3	2.4	100.0
	Total	42	97.7	100.0	
Missing	System	1	2.3		
Total		43	100.0		

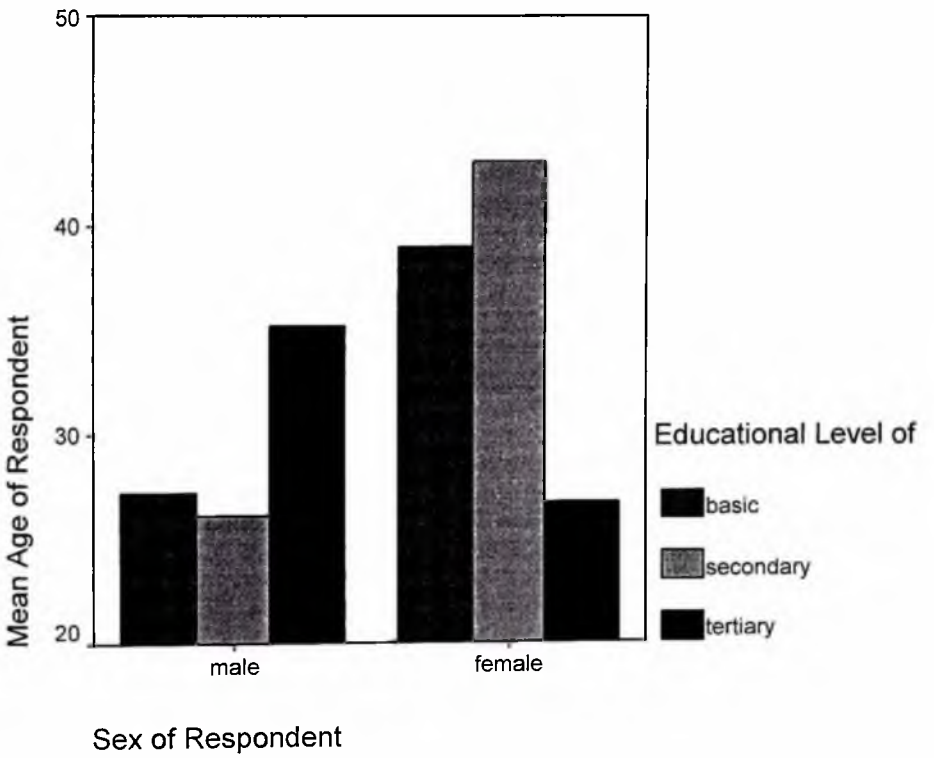
Frequencies

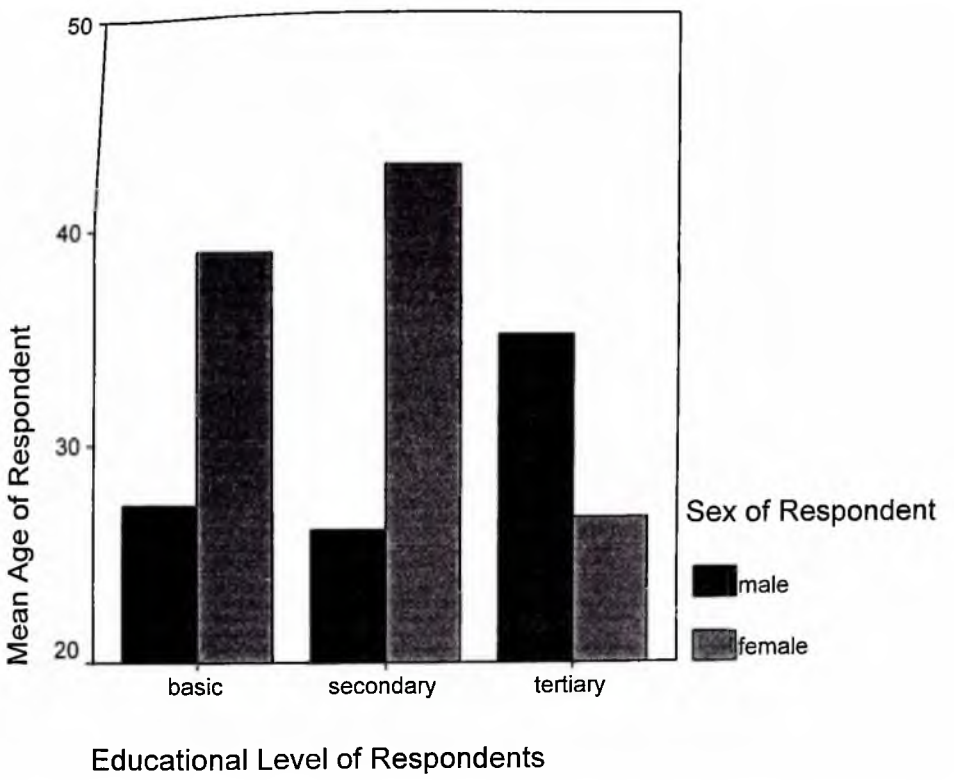
Sex of Respondent

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	male	24	55.8	57.1	57.1
	female	18	41.9	42.9	100.0
	Total	42	97.7	100.0	
Missing	System	1	2.3		
Total		43	100.0		

APPENDIX C

DEMOGRAPHIC DATA GRAPHS





APPENDIX D

NEUROSIS SCORES FOR CONTROL AND EXPERIMENTAL GROUPS

Subject No.	Condition	Anxiety	Depression	Stress	Neurosis
1	Control	23	26	18	67
2	Control	20	19	14	53
3	Control	16	4	6	26
4	Control	12	16	21	49
5	Control	12	11	9	32
6	Experimental/Treatment	2	10	2	14
7	Experimental/Treatment	8	9	3	20
8	Control	23	25	16	64
9	Experimental/Treatment	3	5	9	17
10	Experimental/Treatment	3	7	4	14
11	Control	12	18	21	51
12	Experimental/Treatment	4	2	4	10
13	Experimental/Treatment	4	2	1	7
14	Control	21	23	19	63
15	Experimental/Treatment	4	7	4	15
16	Control	5	2	2	10
17	Control	18	29	19	66
18	Experimental/Treatment	1	6	3	10
19	Experimental/Treatment	16	18	10	44
20	Control	25	22	20	67
21	Experimental/Treatment	0	0	3	3
22	Experimental/Treatment	3	4	4	11
23	Control	19	28	17	64
24	Experimental/Treatment	13	6	9	28
25	Experimental/Treatment	9	4	8	21
26	Control	20	27	14	61
27	Experimental/Treatment	14	17	14	45
28	Experimental/Treatment	13	11	11	35
29	Control	15	23	22	60
30	Experimental/Treatment	6	7	8	21
31	Experimental/Treatment	6	4	8	18
32	Control	22	26	14	62
33	Experimental/Treatment	6	9	9	24
34	Experimental/Treatment	10	9	8	27
35	Control	17	18	23	58
36	Experimental/Treatment	12	12	12	36
37	Experimental/Treatment	4	8	9	21
38	Control	17	19	25	61
39	Experimental/Treatment	3	2	1	6
40	Experimental/Treatment	10	12	16	38
41	Control	23	26	23	72
42	Experimental/Treatment	9	16	13	38
43	Experimental/Treatment	7	1	5	13