

**The Effectiveness of NTU Africentric System of
Psychotherapy in the Management of Trauma Among
Refugees in Ghana**

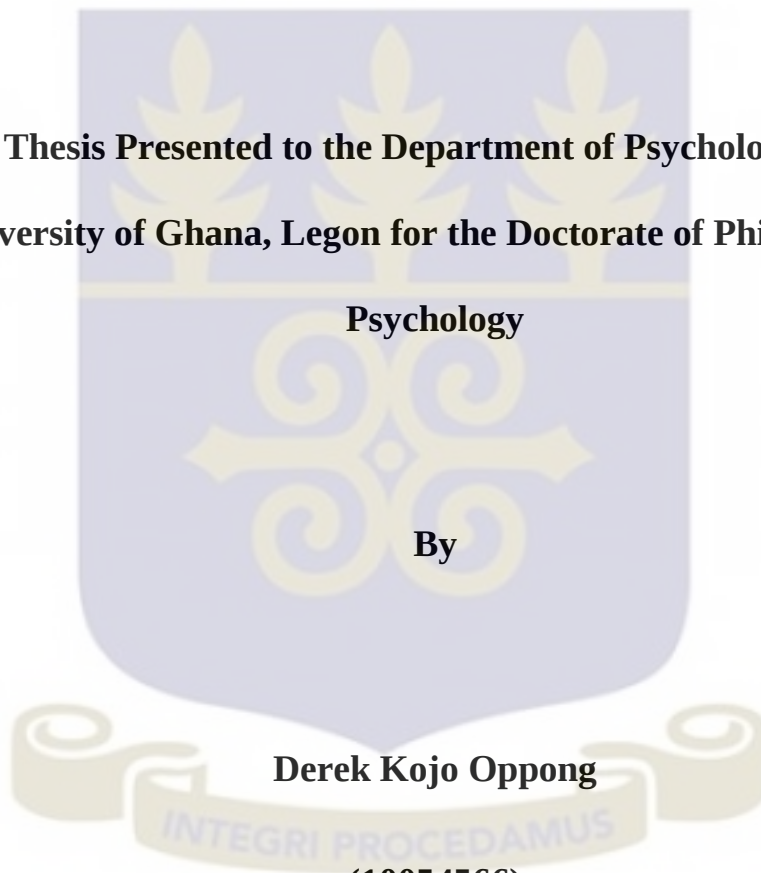
**A Thesis Presented to the Department of Psychology of the
University of Ghana, Legon for the Doctorate of Philosophy in**

Psychology

By

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DECLARATION

I, Derek Kojo Oppong, the author of this dissertation do hereby declare that except for the reference to the work of other people who have been duly acknowledged, the work presented here was undertaken under supervision by me as a graduate student of the University of Ghana, Legon.

This work has never been submitted either in part or in whole for any other degree in this university or anywhere.

.....

Derek Kojo Oppong

Certification

We hereby certify that this work has been submitted for examination with our approval

.....

Prof. Joseph Osafo

.....

Dr. Samuel Atindanbila

Acknowledgements

There are so many people to whom I owe a debt of gratitude for this work that it would be impossible to mention all of them by name. My first thanks go to The Almighty God who has blessed me with life, grace, wisdom as well as everything and everyone whom I have needed to get me to this point. I will be eternally grateful to my two supervisors, Dr. Samuel Atindanbila for proving to be such a Godsend in my undertaking this thesis and also to Prof. Joseph Osafo for being an inspiration and a guide to me. During the course of this work I lost two supervisors and great mentors; Prof. S.A. Danquah who has been a mentor a father and a guide to me in more ways than I can mention and the late Prof. J.Y. Opoku of blessed memory whose meticulousness and attention to detail is inimitable

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Abstract

Ntu psychotherapy is an African centred system of psychotherapy specifically developed to deal with a wide variety of psychological and social problems. The present study sought to investigate how effective Ntu psychotherapy is in the management of trauma among refugees. The objective of the study was to investigate if Ntu psychotherapy could lead to an alleviation of signs and symptoms of psychotrauma. The study was also aimed at helping to establish a baseline or reference for which an African culturally competent intervention can be further developed or adopted. The study employed a mixed method approach. Qualitative data was collected and analysed to identify the major psychological challenges of refugees who are living in the refugee camps. Quantitatively the study employed a within-subject multiple baseline approach. Thus, each participant served as their own control. There was an initial baseline (pre-test) established and then there were two other post-test measurements taken; one in the middle of the study and another at the end of the study.

The results showed that participants who undertook Ntu psychotherapy reported a continuous steady improvement in trauma, thus confirming the effectiveness of Ntu psychotherapy. Participants who underwent Ntu Psychotherapy also reported a significant improvement in symptoms of trauma such as somatization, depression, anxiety, hostility and obsessive-compulsive behaviour. The study further revealed that Ntu psychotherapy brought about an increase of the individuals Africentrism (Awareness and consciousness of being African). The study further showed that Ntu psychotherapy can be applied as a suitable system of therapy for persons of African origin. The study recommends further evidence-based research into Ntu psychotherapy and its potential for use across a wider spectrum of psychological disorders among more diverse cultures. It also recommended that Ntu psychotherapy could be used to provide

psychological services in Ghana because its philosophy and techniques are well-grounded in African belief systems

LIST OF ABBREVIATIONS

BAWS- Belgrave Africentrism Worldview Scale

BDHI- Buss-Durkee Hostility Inventory

BPSs-Biopsychosocial Spiritual Model

BSI- Brief Symptom Inventory

HTT- Historical Trauma Transmission

PCL-C – PTSD Checklist-Civilian Version

PTSD- Post-Traumatic Stress Disorder

UNHCR- United Nations High Commission for Refugees

WHO- World Health Organization

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Chapter One

Introduction

Background

This chapter introduces the reader to dimensions of global conflicts and how these have led to a dramatic rise in the number of refugees. It also highlights the nature of problems faced by refugees and identifies the problem of this research, which is mainly to investigate how an African culturally competent system of psychotherapy may help refugees. The chapter further outlines the scope and objectives of this study.

Global Conflicts and Its Impact on Civilians

During the four decades between the 1960s and the 1990s, there were about 80 violent changes of governments in the 48 sub-Saharan African countries (Adedeji, 1999). During the same period, many of these countries also experienced different types of civil strife, conflicts, and wars. At the beginning of the new millennium, there were eighteen African countries facing armed rebellion, eleven facing severe political crises (Adedeji, 1999), and nineteen enjoying less desirable states of stable political conditions. And some of the countries in the last two categories have only recently moved from the first category (Bujra, 2002). With each of these conflicts has come a staggering loss, in terms of finance, property and yes, human lives.

The situation has not improved as of 2016. The UNHCR (2015) asserts that 1 in every 122 persons alive is either a refugee, an internally displaced person or an asylum seeker. The number of refugees worldwide has increased from 37.5 million in 2005 to 59.5 in 2014; an increase of over fifty percent in the past decade. In the words of the UNHCR, 'If this were the population of a country, it would be the world's 24th biggest'.

This clearly posits that the world refugee situation should not be regarded as an isolationist concern for just one or two countries, but rather it should be seen as a humanitarian problem, affecting a huge number of people across the globe and so more and more people must be concerned with helping to manage it.

These conflicts have been largely caused by several factors. The DFID (2001) identifies that the conflicts occurring especially in the West African sub-region are known as factional wars. According to the DFID (2001):

“Factional wars are fluid by nature. There is rarely a defined front line and fighting is frequently opportunistic rather than strategic. Warfare is low tech and small arms are the main weapons. Such wars are not costly and can easily be sustained without external support. Frequently these conflicts move rapidly from the original cause to revolve around the exploitation of commercial, mineral and natural resources” (DFID, 2001. p.8).

Because of the generally fluid and mobile nature of these conflicts, civilian populations are compelled to flee from their native areas of abode and this gives rise to refugee populations and internally displaced persons. More often than not, these refugees lose valuable property and even loved ones by the time they get to places of safety. By the time they get to a safer country, refugees would often find that they are badly in need of psychological help to recover from the traumas that they have experienced. In the absence of such help, their situation would be seriously exacerbated and they get progressively worse in all aspects of their lives.

WHO (2002) also argues that mortality rates during conflict can be attributable to several factors including psychological distress. In providing yet still more damaging statistics on the impact of war and conflict, the WHO (2002) still gives some scary information.

- The 20th century was one of the most violent periods in human history. An estimated 191 million people lost their lives directly or indirectly as a result of conflict, and well over half of them were civilians.
- In 2000, over 300, 000 people died as a direct result of violent conflicts. Rates varied from less than 1 per 100, 000 population in high-income countries to 6.2 per 100, 000 in low and middle income countries.
- Worldwide, the highest rates of conflict-related deaths are found in Africa (32.0 per 100, 000).

Impact of Conflict and How Refugee Situations are Created

The impact of civil conflicts can broadly be divided into economic, psychological and social.

Conflicts and war not only cause poverty and pain, but it also destroys the future of the nation.

We see this in the loss of manpower that the country would often endure. Sadly, the refugees may not also be able to put their employable skills to use either because the law in the host country does not allow them to or because they may not be able to fit into the local economy.

Refugees are a blunt manifestation of the impact that violent conflict has on human beings. Everything that they experience during the period of the conflict as well as after (both immediate and in the long term) can be attributable to the impact of these violent conflicts. Further to this, the impact of conflict can be measured in real monetary terms. Persons have suffered from exposure to conflict in so many ways. For instance, according to the UN Millennium Development project (2005), ‘During the 1990s, half

of the countries where life expectancy, income and education went backwards had experienced violent conflict. Of the 34 countries farthest from reaching the millennium development goals, 22 are in the midst of - or emerging from- violent conflicts.’

In the year 2000, alone, almost 14 million people were uprooted from their homes by conflict (Obidegwu, 2004). The World Health Organization (2002) asserts that ‘The impact of violent conflicts on health can be very great in terms of mortality, morbidity and disability.’

Skaperdas, Soares, Willman and Miller (2009), further point out that the costs of violent conflict can be measured in terms of both direct and indirect costs. Whilst direct cost can be measured in terms of monetary and physical loss and destruction of property, indirect cost is equally as powerful and can be seen in such aspects as:

- population displacement
- reduced production due to violence or its threat
- reduction in educational opportunities
- brain drain (that is, emigration of educated work force)
- reduced tourism from abroad

.

Whenever violent conflicts such as civil war, war between states, ethnic conflict, and so forth arise, the impact has the potential to be far-reaching if not nipped in the bud. According to the ICRC (2009), ‘the armed conflict in Liberia has had a number of long-lasting and wide-reaching negative effects on civilians.

Indeed, the impact of violent conflicts can be felt even for decades or generations after the conflicts have ended particularly, be they refugees, internally displaced persons (IDPs) or residents, even if it was a protracted conflict. Justino (2010) undertook a study

on ‘How Violent Conflicts Impact on an Individual’. Indeed, in her study, many respondents stated that their experiences have shaped the person that they have become and affected how they respond in certain situations and relate to others (Justino, 2010, p.38).’

What this statement appears to suggest then is that experiences of persons affected by war shapes their personality; this apparently goes beyond just leaving them with psychological scars, but it affects their view of the world and how they interact, that is their very personality. This is how psychotrauma develops. She established that, ‘Relatively minor shocks to educational access can lead to significant and long-lasting detrimental effects on individual human capital formation in terms of educational attainment, health outcomes and labour market opportunities.’

In other words, a civil conflict can lead to deficits in education for the population and by extension render them unemployable and unproductive if care is not taken. This is indeed the case in several of the refugee camps - there are plenty of young and able-bodied men who do not have the education and skills to hold down a job and support their families. Clearly, this can only have the effect of exacerbating their plight, sometimes even for life. This study shall however focus on the psychological impact (trauma) among refugees and how they can be helped to heal so they can function properly irrespective of circumstance or location.

Conflict and Migration

Whenever conflict arises, persons are forced to run away from their places of residence, with all the attendant inconveniences and challenges.

As these conflicts lead the affected civilian populations to flee the conflict zone, they either become refugees or internally displaced persons (IDPs). Internally displaced persons are those who have not crossed a border to find safety, rather they are on the run in their own country. This means that they are still under the protection of their own government even if their government is the cause of their danger (UNHCR, 2017).

A refugee on the other hand is defined as ‘someone who has been forced to flee his or her country because of persecution, war or violence. Most likely they cannot return home or afraid to do so (UNHCR, 2017). Refugees are provided with refugee status in the host country and they are then either hosted in a refugee camp or in other accommodation as the law of the host nation may allow.

Currently in Ghana there are over five refugee camps scattered across the country namely Fetentaa in the Brong Ahafo region; Egyeikrom and Budumburam in the Central Region; Ampain and Krisan in the Western region. The present study however focuses on three camps namely Budumburam, Krisan and Ampain. These camps are quite different in several ways. There are differences in their geographical location, proximity to large urban areas, differences in ethnic grouping, languages spoken and even in terms of population size (Kpatinde, 2006). These differences have also affected the ability of the refugees to recover and integrate.

The Psychological Impact of Conflict on Refugees

Vamik Volkan (2006), a leading authority figure in trauma research explains it in more vivid terms thus; ‘When a society becomes the deliberate target of other people’s aggression, the victimized group has to deal with five interrelated psychological phenomena, namely:

- (1) a shared sense of shame, humiliation and guilt,
- (2) a shared inability to be assertive,
- (3) a shared identification with the oppressor,
- (4) a shared difficulty or even inability to mourn losses, and
- (5) a shared trans-generational transmission of trauma.

Other phenomena experienced are related to these five main ones. Even when political systems change and traumatizing elements are removed, individual and societal responses to the previously devastating system do not disappear quickly. Depending on the severity of the traumatizing events and how long they lasted, the trauma shared by the victimized group and their descendants may continue for decades.’

In the light of this, then. it should come as no surprise that despite the relative political stability and tranquility that a country of asylum like Ghana would offer refugees from several different countries, they still continue to wallow in relative poverty and stagnation, even in spite of the meagre help that might have come their way.

The implications of this are far-reaching for the nation, the community and the family structures. Violent conflicts have led to a breakdown of the family structure and by extension, the fabric of nations. For nations to heal, it is essential that the healing must take place first at the individual level, then the family level and finally, the communal level. It is against this background that nations that have undergone some amount of trauma at a certain national level attempt to heal themselves. The National Reconciliation Commission of Ghana, and the South African National Reconciliation Commission were attempts to reach out to heal the nations.

In Sierra Leone, Verhey (2001) identifies that in the process of healing for former child soldiers, among the most important factors were ‘family reunification, psychosocial support, and education/economic opportunities’ (Verhey, 2009, p.24). This underscores the value of the family and the community as the structure that suffers the most from conflict, but at the same time, is the unit that heals the fastest. NTU Psychotherapy as a system of psychological intervention works well with individuals but is also quite excellent with families because it views the individual as a part of a unit (the family and the society). Thus, it sees both the individual and the family as a larger unit of change that can be used to heal the society. What the study seeks to do is to investigate the extent to which NTU psychotherapy can be used to help refugees manage psychotrauma.

The challenges of life as a refugee have the potential to be quite debilitating. It can be argued that some of the biggest challenges that refugees are faced with is the certain loss of identity, roots and even separation from family. There is a need to investigate how refugees respond to this loss. Being uprooted from your place of origin to a strange new world can be a daunting experience and there are those refugees who never fully adjust to their new environment and its own cultural, social and geographical challenges. In a nutshell, all these challenges and experiences that refugees go through can be expressed in one single word. Trauma.

Trauma

The concept of trauma can be somewhat tricky to explain. It is such a complex phenomenon, yet so simply defined, that it is almost as if something gets lost qualitatively along the way. The *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, Text Revision (DSM-IV-TR; American Psychiatric Association [APA],

2000) specifically defines a trauma as a “direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one’s physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (Criterion A1). The person’s response to the event must involve intense fear, helplessness, or horror (or in children, the response must involve disorganized or agitated behaviour) (Criterion A2) (p. 463).”

More recently, the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-V) provides a more inclusive and comprehensive description of trauma.

“Trauma and Stressor-Related disorders include disorders in which exposure to a traumatic or stressful event is listed explicitly as a diagnostic criterion. These include reactive attachment disorder, disinhibited social engagement disorder, posttraumatic stress disorder (PTSD), acute stress disorder, and adjustment disorders (APA, 2013, p.265).”

The DSM-V further attempts to distinguish between the more ‘traditional’ symptoms of trauma, such as depression and more recently recognized symptoms, such as hostility. In its own words,

“Psychological distress following exposure to a traumatic or stressful event is quite variable. In some cases, symptoms can be well understood within an anxiety- or fear-based context. It is clear, however, that many individuals who have been exposed to a traumatic or stressful event exhibit a phenotype in which, rather than anxiety- or fear-based symptoms, the most prominent clinical characteristics are anhedonic and

dysphoric symptoms, externalizing angry and aggressive symptoms, or dissociative symptoms. Because of these variable expressions of clinical distress following exposure to catastrophic or aversive events, the aforementioned disorders have been grouped under a separate category: *trauma- and stressor-related disorders*. Furthermore, it is not uncommon for the clinical picture to include some combination of the above symptoms (with or without anxiety- or fear-based symptoms).” (p.265).

The DSM-V therefore firstly acknowledges a wider spectrum of responses or behaviours to a stressful event are more likely to occur. Thus, anger, anhedonia, dissociative symptoms and depression are all recognized as potential challenges that an individual dealing with some form of trauma may suffer. Earlier versions did not recognize some of these as responses.

Trauma is one of the most common, and yet still, one of the most dramatic psychological challenges that an individual can endure. There are several ways an individual can experience trauma; this can be through vehicular accidents, personal tragedy, by exposure to intense and horrifying abuse or even natural disasters. The circumstances are infinite, but the expected result will be quite similar and so also will be the symptoms. This study is particularly interested in trauma that civilians experience as a result of war or civil conflict.

Trauma also tends to manifest in several ways and through a wide range of symptoms. For instance, the DSM-V (APA 2013) identifies some of the symptoms of trauma as including fear, anxiety, hostility, guilt, depression, hypervigilance, somatization and anhedonia among others. Each of these symptoms may manifest with varying levels of intensity among different persons with different responses to experiences. Again, not

everyone who has experienced trauma will manifest all these symptoms in response to a traumatic experience.

War involves a very wide range of violent and traumatic experiences, including immediate threat of death and/or disfigurement, physical injury, witnessing injury and/or death of others, and involvement in injuring or killing others (both combatants and civilians) (Kulka et al.,1990; Weathers, Litz, & Keane, 1995) as well as a wide variety of other forms of loss. For some victims, war experiences include witnessing or participating in atrocities, as well as undergoing rape, capture, and prisoner-of war experiences such as confinement, torture, and extreme physical deprivation. These traumas, in turn, can produce a variety of symptoms and disorders.

One of the most powerful sources of trauma emanates from exposure to intense and horrifying conflicts. This is experienced by both security and support personnel, as well as victims who are exposed to these intense levels of violence. People who may have experienced trauma in any way are more likely to be experiencing certain symptoms. Signs and symptoms of post-traumatic stress typically begin within three months of a traumatic event. In a small number of cases, though, PTSD symptoms may not occur until years after the event (Andrews, Brewin, Philpott and Stuart, 2007; Tull, 2011).

Tragically, there is no nation-wide program in place in Ghana to deal with trauma. It is against this background that this study proposes the need to have a system of intervention in place that can deal with the elements of psychological trauma and its implications for national development. Although a variety of options exist for the treatment of trauma, research has consistently shown that trauma is best treated using psychotherapy

Systems of Therapy for Management of Psychotrauma

Vitzthum, Mache, Joachim, Quarcoo and Groneberg (2009), identified some of the more common traditional systems of therapy for managing trauma. These include the following

- Debriefing. This is a short term psychological intervention that consists of meeting affected persons and going through the experience with them so as to refute any wrong notions they may hold of the traumatic event. There is some disagreement over the effectiveness of debriefing in trauma management (Vitzthum et al, 2009).
- Pharmacotherapy refers to the use of drugs and medication to help relieve the pain of psychotrauma. Often times this is used in conjunction with other systems of intervention like CBT. Pharmacotherapy appears to focus on the salient symptoms that the person suffering with PTSD may be experiencing hence a variety of medications may be used such as Serotonin Selective Reuptake Inhibitors (SSRIs), tricyclic antidepressants or Benzodiazepines, just to mention a few. There is still a lot of divided opinion on the efficacy of pharmacotherapy (Sullivan and Neria, 2013).

It can be seen from the above that all these different traditional systems of treatment have their limitations. One thing that is largely agreed upon however is that psychotherapy is one of the best ways of managing psychotrauma.

Cultural Competence in Psychotherapy

In recent times there has been a renewed interest in cultural competence among systems of psychological intervention.

There are several reasons why there is such a strong advocacy for culturally competent systems of therapy in contemporary times. The complex nature of human personality can be accounted for by differences in interaction between influences of nature and nature. In other words, differences among individual personalities can be accounted for by differences in genetic and hereditary factors as well as environmental factors. This is a point echoed by Millon (1996).

Alarcon, Foulks & Vakkur, (1998) point out that, ‘A cultural component exists in every clinical event, intervention or interaction between the treating agent and the identified patient. This applies not only to ethnic minorities or distant societies outside the Western World.’ Thus, it can be realized that the role of cultural competence in the delivery of proper and efficient psychological services cannot be overestimated. In helping traumatized refugees, it is essential that health care providers understand what they’ve been through and how it has affected such core aspects of their socialization and cognitions such as spirituality, sense of self and sense of belonging. Interestingly, it is these same belief systems that cultural competence uses to heal the traumatized individual and community.

Refugees have suffered not only from exposure to conflict but typically experienced loss of family, friends and of It is against this background then that there is the need for a study to confirm or disprove the relevance of culturally competent systems of therapy for use in Ghana today.

Cultural competence in psychotherapy can be regarded as a system of therapy in which the therapist is guided by a consciousness of the ethnicity and socio-cultural background of the client and how this can be used to help the client to heal better.

“The delivery of quality services is especially difficult because of cultural and institutional influences that determine the nature of services. For example, Bernal & Scharroón-Del-Río (2001) maintain that ethnic and cultural factors should be considered in psychosocial treatments for many reasons. They propose that psychotherapy itself is a cultural phenomenon that plays a key role in the treatment process. In addition, ethnic and cultural concepts may clash with mainstream values inherent to traditional psychotherapies” (Sue, Zane, Hall and Berger, 2009).

Thus, we need culturally-competent systems of psychotherapy to manage psychological problems in an environment that is culturally aware and with therapists who are culturally sensitive. NTU Psychotherapy is one of such culturally competent interventions.

NTU Psychotherapy

“The term *NTU* (pronounced "in-too") is a BaNTU (central African) concept that describes a universal, unifying force that touches upon all aspects of existence (Jahn, 1961). NTU psychotherapy is based on the core principles of ancient African and Afrocentric world view, nurtured through African American culture, and augmented by concepts and techniques of western psychology. NTU psychotherapy is spiritually based and aims to assist people and systems to become authentic and balanced within a shared energy and essence that is in alignment with natural order.” (Philips 1990)

For this matter, the goals of NTU are two-fold; to help an individual function authentically within themselves and in their relationships within the natural order. Secondly it aims to help the individual function within the seven principles of kwanzaa

(healthy living) (Philips, 1990). Thus, it may be said that NTU psychotherapy is both restorative and reformatory in orientation.

NTU Psychotherapy therefore offers a system of intervention and management for trauma that is:

- Culturally competent in the sense that it is guided by the cultural background of the client and the client system. It is this very cultural background that shapes the belief systems and by extension, the worldview and outlook of the individual. Thus, it is this same cultural outlook that shapes and influences the nature of the disorders and psychosocial challenges that the individual may be facing.
- Restorative in the sense that it seeks to restore the balance between the client system and their environment. According to Philips (1990), “From a NTU therapeutic perspective, the overriding focus of life and, indeed the goal of the mentally healthy person, is to be in harmony with the forces of life.” Once an individual suffers a debilitating or psychologically crippling experience (such as a traumatic experience) it throws them out of harmony with these forces of life. NTU psychotherapy therefore helps the individual or client-system to reestablish or restore that balance.
- Reformatory in that where an individual or client system may have developed unhealthy behavioural or cognitive patterns which may be creating an imbalance with their environment, NTU helps to reform these unhealthy behaviours. This is done by taking the person or client system through the five stages of NTU psychotherapy. This will be discussed in the next chapter.

The present study seeks to investigate the effectiveness of NTU psychotherapy, firstly as a system of intervention in general, but more precisely in the management of psychotrauma and in helping people to recover their equilibrium with the environment. It is hoped that this study shall help create an awareness of the need for cultural competence in psychological interventions in the Ghanaian psychological space.

Statement of The Problem

Traditional systems of psychotherapy are heavily westernized in design and orientation. And more often than not, directly importing them into other cultures may actually hamper rather than help the intervention process. In the words of Lo and Fung (2003), “psychotherapy as developed in the West may not be directly applicable in other cultural settings” (p.161).

For an African country like Ghana, psychotherapy should be seen, not just as a tool for healing and therapy, but also as an instrument of empowerment and upliftment. People who have suffered trauma as a result of conflict and have thus become refugees or internally displaced persons (IDPs) would most likely experience some of the problems previously mentioned and it is essential that psychological interventions be capable of offering them healing and empowerment. This healing must not just be aimed at responding to the physiological symptoms or presenting complaints, but it must also be able to help them to reintegrate within whichever society they may find themselves and also experience growth within the same environment.

NTU psychotherapy offers itself as a system of therapy that is culturally competent and thus it is holistic, family-focused and values-driven (Gregory and Harper, 2001). Unfortunately, there are only a handful of published studies investigating the effectiveness of NTU psychotherapy. These have focused on other psychosocial

challenges (Winn and West-Olatunji, 2008; Woods-Giscombe and Black, 2010; Jackson, Gregory and Davis, 2004).

There is the need therefore to add to the growing body of knowledge on the effectiveness of NTU psychotherapy and particularly how it can be used to manage trauma among refugee populations. This study aims at contributing to this body of knowledge and shedding light on the application of NTU in trauma management among refugee communities.

Objectives of the Study

The main objective of this study is to investigate the effectiveness of NTU psychotherapy in helping refugees to manage trauma and the sense of loss they may have to deal with in the refugee camps. Specifically, this study intends to:

1. Identify the main psychological challenges of concern among refugees in the refugee camps
2. Investigate if NTU psychotherapy can lead to a decline in signs and symptoms of trauma
3. Investigate if differences will exist in the recovery levels among participants in different refugee camps

Significance of the Study

This study shall shed light on NTU psychotherapy as a culturally competent system of intervention. It also intends to add to the growing body of knowledge on culturally competent psychotherapy. Although there has been an increase in the research on culturally competent psychotherapy, not a lot has been done specifically on NTU psychotherapy. The study shall also seek to provide a culturally competent

psychological intervention and then measure its effectiveness in dealing with those symptoms and challenges reported by the refugees.

Although a plethora of studies exist on trauma among refugees, very few studies have been done that focus on psychological challenges of refugees in Africa. Yet still fewer studies exist on psychological challenges of refugees in Ghana. It is expected that this study shall identify the major symptoms of refugees struggling with trauma. Thus, the study hopes to serve as a reference point for the design and implementation of further studies, firstly into culturally competent interventions and secondly into the psychological challenges of refugees in different types of camps especially in Western Africa.

Definition of Key Terms

Refugee: A person who has been forced to flee from his/her country of origin due to conflict. They may or not be living in a refugee camp

Psychotrauma: Psychological trauma that has been created by being exposed to violence or loss during civil war or conflict. This may be either directly or indirectly

Ntu Psychotherapy: A system of psychotherapy developed for persons of African origin taking into consideration African belief systems and culture.

Chapter Two

Literature Review

This chapter presents a review of the literature surrounding culturally competent psychotherapy and the management of psychotrauma among refugees. It shall also examine the literature on refugees and the history of the refugee situation in Ghana. This chapter shall also explore other studies and interventions that have been used in other jurisdictions to help manage refugees' psychotrauma.

Theoretical Framework

This study is guided by two main theories. The first model is Lo and Fung's (2003) model on cultural competence. The second is the model of Historical Trauma Transmission (HTT) which was advocated by Wesley-Esquimaux and Smolewski (2004).

Lo and Fung's Model on Cultural Competence

Lo and Fung (2003) opine that culturally competent psychotherapy is of two dimensions; there is generic competence and specific competence. Generic cultural competence includes the knowledge and skill set necessary to work effectively in any cross-cultural therapeutic encounter. Specific competence enables therapists to work effectively with a specific ethno-cultural community and also affects each phase of psychotherapy. In order to assess the impact of culture on a patient or a client-system, a comprehensive assessment should be undertaken. They refer to this assessment as cultural assessment (CA).

According to Lo and Fung (2003), Cultural Assessment is a clinical tool developed to help therapists systematically review and generate hypotheses regarding cultural

influences on the patient's psychological world. Cultural Assessment examines issues under 3 domains: self, relations, and treatment. Successful therapy requires therapists to employ culturally appropriate treatment goals, process, and content. Specific cultural competence empowers therapists to use specific cultural knowledge effectively.

The term cultural competence (in Cross, Bazron and Denals, 1989) denotes the capacity to perform and obtain positive clinical outcomes in cross-cultural encounters (p.162). In other words, what is the level of sensitivity or awareness of the therapist to the cultural background of the client and how does this sensitivity affect the therapeutic experience? From this, then it may be deduced that the less culturally-conscious a therapist may be, this could most likely influence their ability to work with a variety of persons.

Generic Cultural Competence

Generic Cultural Competence refers to competence in working with issues that emerge at different phases of psychotherapy, regardless of the cultural group to which a patient belong. In this regard, generic competence concerns itself with the aspects of the problem that may (for want of a better word) be more universal in nature. For instance, what has been the role of the family in the issue being managed? Are they enablers? Have they made previous attempts to manage the problem? What has been the consequence?

Lo and Fung (2003) further divided the phases of psychotherapy into five stages, namely pre-engagement, engagement, assessment and feedback, treatment and termination. At each of these stages there is the need for some degree of responsiveness, especially on the part of the therapist.

This is not true of just the therapist, but the patient and the family or support group to which they may belong.

Preengagement	cultural sensitivity	explanatory model	attitude of group	positive referral
Engagement	Therapists role Ethnic match	patient role	group agenda	cultural naivete psycho-education
Assessment	Therapists worldview Ethnic match	patient's worldview cultural identity	Family dynamics community dynamics	BPSS Feedback cultural analysis cultural consultant gift pre-therapy preparation
Treatment goal	Therapists goal	Individual goal	Group goal	Negotiation
Treatment content	Content defined By therapist	Content defined By patient	Content defined By group	Negotiation response to concrete content
Treatment process	Therapist's language and communication Counter transference	patient's language and communication style Transference	involvement of family community healing practices	language independence
Termination	Tolerance of dependency	Need for ongoing support	View of treatment	'Door ajar' Institutional Transference

BPSS = BIOPSYCHOSOCIAL SPIRITUAL

Stages of Culturally Competent Therapy

Lo and Fung (2003) present a table (as seen in figure 2.1) to show some of the techniques as well as the kinds of competencies required of all concerned parties (the therapist, the client, and the significant others) in the therapeutic process. This figure is presented on the next page:

Stages, Competencies and Techniques of Culturally Competent Therapy

Figure 2. 1: Stages, Competencies and Techniques of Culturally Competent Therapy Generic Cultural Competence Axis in Psychotherapy (Lo and Fung, 2003 p. 162).

This table from Lo and Fung (2003) identifies the major stages and the core components of culturally competent systems of therapy. This is particularly relevant because the main stages and techniques identified by the authors appear to cut across several systems of culturally competent therapy. Indeed, for the purposes of this research we can see a similarity between the stages of NTU psychotherapy and the stages outlined above.

From the table above, one can identify five main stages:

Pre-engagement phase

The pre-engagement phase is the initial stage and this could typically occur, even before first contact with the therapist and the client. In the words of Lo and Fung (2003), ‘Factors at work prior to clinical contact may influence the eventual clinical outcome. Working with a culturally different patient places certain demands on the therapist’s skills, some of which may be intuitive, some of which can be learned, and all of which should be considered as essential components of psychotherapeutic training.’

Being culturally sensitive is a key requirement at this stage and with cultural sensitivity comes objectivity, openness to new experiences and a willingness to learn. Another important factor here is the patient’s perception and understanding of the nature of their challenge.

Engagement phase

Engagement phase is where the therapist and the client actually do meet each other for the first time. Engagement begins with actual clinical contact. In this initial phase, the therapeutic alliance starts to develop and solidify. In practice, this phase unfolds concurrently with the assessment phase and even in a few cases it might also occur with the treatment phase. During this phase, the therapist and the client would typically be expected to form a relationship which would influence the therapeutic process. There are often several factors that may influence this relationship. For instance similarity of culture, or educational or social background are all factors. Interestingly, there may be variations depending on the nature of the chemistry between therapist and client. Hence some clients may prefer a therapist from the same ethnic background and others may be more comfortable with another of a different ethnicity or even gender. Even within the client-clinician conceptualization, there may be cultural differences. Within one relationship the client may see the therapist as a kind of elder or authority figure, all-knowing who does not have to ask too many questions to properly assess a situation (Dyche & Zayas, 1995).

‘Therefore, to avoid making erroneous assumptions and indulging in unjustified stereotypes, therapists must learn to recognize and operate within the contrasting frameworks of therapeutic omniscience and naiveté.’ If one were to examine this concept from a Freudian perspective, then it would be at this stage that transference and counter-transference would occur.

Transference refers to the situation in which a client or patient brings in past relations, emotions, feelings, conflicts, and attitudes into present relationships, situations, and circumstances. In the therapeutic relationship this may often reflect in how the patient

treats the therapists or what expectations they may have of how the therapist should treat them. Transference may often occur as a result of unresolved conflicts or issues from a patient's past. Issues to do with family, care-givers or significant others may all play a role in the development of transference issues (Wilson and Kneisl, 1996). For instance, a patient who may have lost her father at an early age may respond to an elderly therapist by 'treating him like a father' thus evoking daughterly or even child-like behaviours.

Countertransference is the reverse, that is, how the therapist treats the patient or client. Or better yet, it refers to how the therapist responds to the patient. Again this may occur when the therapist projects their personal experiences into the client-clinician relationship. For instance, a therapist whose wife divorced him, may get irritated with a woman who is not sure whether she wants to marry her partner or not.

The cultural competence issues related to transference and counter-transference are aptly represented by Spiegel (1965) in Comas-Diaz and Jacobsen (1991) when he asserts that 'working with patients from different cultural backgrounds engenders a very complicated strain within the therapist. Psychotherapy with the ethno-culturally different patient frequently provides more opportunity for empathic and dynamic stumbling blocks in what might be termed ethnocultural stumbling blocks (p.392).' Prasko et al (2010) provide a few guidelines on how to manage issues of transference and countertransference in the therapeutic process. With regard to transference they argue thus:

- Firstly, the therapist should always pay attention to how the client responds to them, whether negatively or positively. The therapist must be on the lookout for signs of strong emotions from the client such as anger, disappointment or even frustration.

- The therapist must also be aware of exaggerated positive emotions such as love, excessive idealization, praise or any other such efforts that might shift the focus of the therapeutic relationship from the patient onto the therapist. These are essential because they provide opportunity for a better understanding of the clients relationships and how they may have contributed to the problem.

With regards to challenges of transference they also further propose the following

- The therapist must also be conscious of countertransference schemas as may occur to him/her. They must be aware of how they tend to exhibit countertransference with their clients. The therapist must also pay attention to his/her own cues that may suggest countertransference. One thing that may be quite helpful would be for the therapist to also visit his/her supervisor regularly or even have sessions themselves with other more experienced therapists who may help to keep them on an even keel.

Assessment and Feedback Phase

Assessment and Feedback is another critical stage. It is important at this stage that the therapeutic relationship be maintained. A comprehensive approach to assessment includes examining the problems from biological, psychological, and social perspectives. The spiritual perspective is another significant component in many cultures (Larson, Milano and Lu,1998).

Later in this chapter the biopsychosocial spiritual model of healing shall be discussed.

Treatment Phase

Lo and Fung (2003) discuss the treatment process as being made up of three components namely; goal, content and process. They argue that goals of therapy should be negotiated between the therapist, the client and, (if they are involved) the family or

support group. All parties should be in agreement as to what goals should be achieved by the end of the intervention. Without this the concerned parties could be working at odds with each other, and the client and their families could be left unfulfilled by the end of the intervention.

The content of the intervention is again also negotiated by all the concerned persons. According to Lo and Fung (2003), ‘the patient’s culture often influences the choice of content in psychotherapy. For example, some patients may want to work on practical issues, such as somatic symptoms or relationships with neighbours that may appear to be too concrete to therapists.’

Then thirdly, there is the issue of process and at this point Lo and Fung (2003) stressed the essence of communication. ‘

Therapists may need to accommodate their communication style, both verbal and nonverbal, to that of a culturally different patient because, for example, apparently linguistically equivalent words may evoke different psychological associations. Some patients report different comfort levels when using different languages to discuss certain topics like sex. For example, bilingual Chinese patients may choose to speak about sexual matters in English rather than in Chinese’ (Cheng and Lo, 1991).

Termination Phase

Termination is the stage where the intervention is supposed to have been concluded. However for culturally competent interventions, this may not be the case. The client-therapist relationship may continue long after. According to Lo and Fung (2003), ‘Ethnic patients and their families may particularly need to maintain contact after termination, owing to limited support in the community and to their cultural understanding of relationships, which are rarely terminated artificially. Therapists may

choose to leave the “door ajar” and maintain a link with patients and family members by defining appropriate circumstances in which they should reconsult (p.164).’

Culturally competent psychotherapy must be able to encompass these five stages and within the framework of NTU psychotherapy one can also identify these five stages of the NTU intervention.

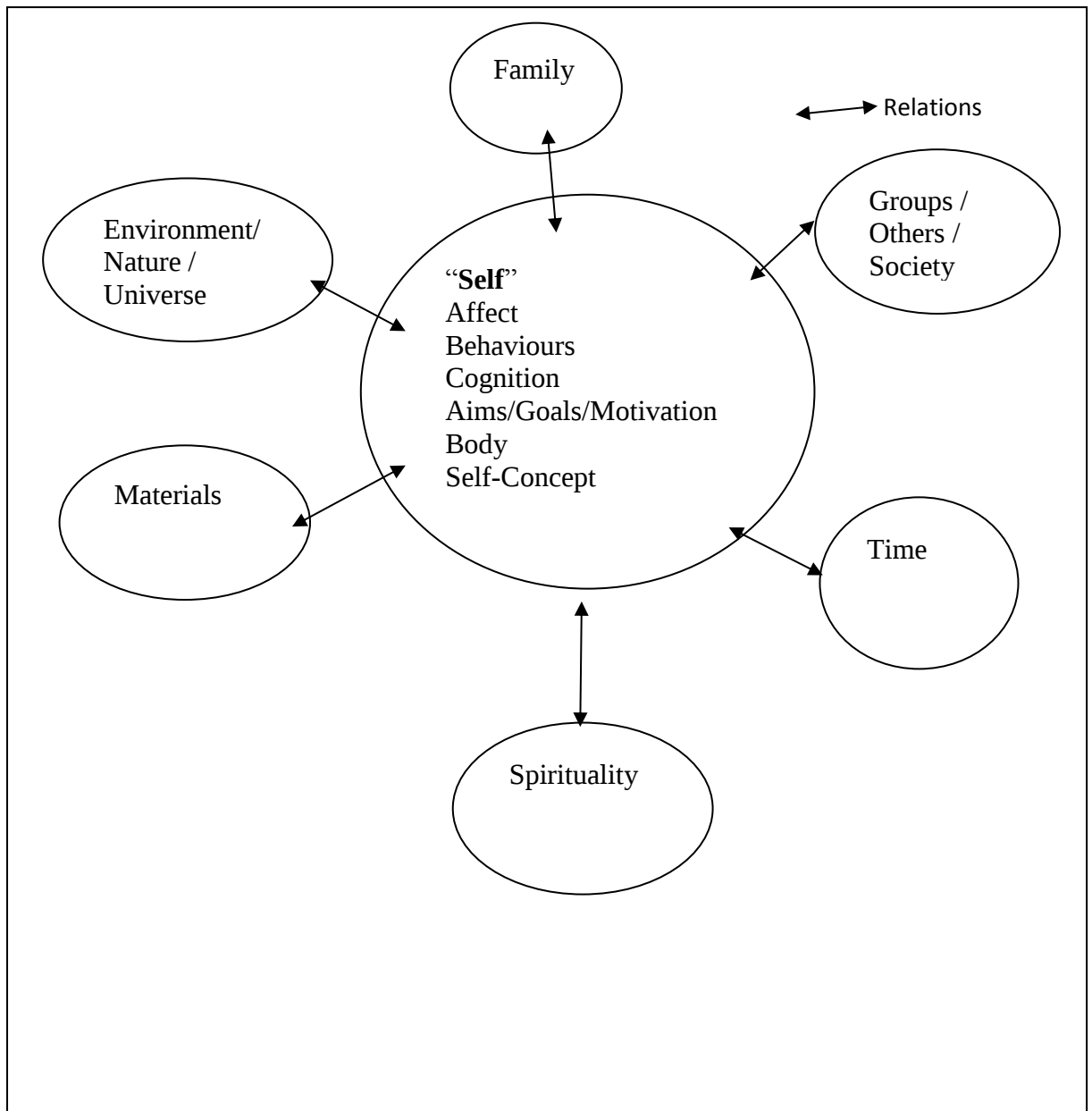
The DSM-IV TR proposes the use of cultural formulation to systematically assess cultural influences on diagnosis and treatment (Mezzich, 2005). This process consists of examining 1) an individual’s cultural identity, 2) cultural explanations for individual illnesses, 3) cultural factors related to the psychosocial environment and levels of functioning, 4) cultural elements of the therapist–patient relationship, and 5) overall cultural assessment for diagnosis and care.

Indeed, according to Lo and Fung (2003). cultural-specific knowledge, ‘should inform biological, psychological, social, and spiritual components of the clinical assessment (p.5).’

Culture powerfully influences patient relationships with immediate family members, friends, and the community at large. These relationships are guided by socio-culturally defined roles, expected deportment, value systems, and the power hierarchy. Apart from human relationships, culture may influence patient relations with “others”: culture influences patients’ conceptions of nature and their attitude toward it. They may regard nature and the environment as something to be subservient to, live in harmony with, or dominate (Sue, 1999).

Lo and Fung (2003) explained the influence of the internal representations of one’s self and one’s relation with others using a diagram as shown in figure 2.2 on the next page:

Figure 2. 2: Conceptual diagram of the internal representations of self and relations in cultural analysis



From the diagram, it can be seen that an individual's internal representation of themselves essentially comprises their cognition, affect and behaviour, as well as their aims, self-concept and body. These processes that emanate from one's self in turn influence the individual's relations with the external environment which Lo and Fung identify broadly as comprising one's family, the environment around the person in a broad sense, material assets (e.g. property or the lack of it), one's spirituality, their concept of time, and the society at large or groups to which they may belong.

It must be noted that Lo and Fung (2003) assert that a reciprocal relationship exists between the individual and each of these external processes, but more importantly each of these relations may vary among cultures. For instance, Sue and Sue (1990) in discussing the value of material property discuss the concept of time and even gift-giving among Chinese cultures. In some Chinese cultures for example, it is a cultural faux pas and an insult to give clocks as gifts, because the phrase "giving a clock" in Chinese sounds like "seeing you off to your final end or death."

Cultural competence therefore demands that the therapist must possess a certain acute knowledge of how different phenomena are perceived and interpreted in different cultures. African cultures for instance commonly emphasize spirituality in the healing process (Conservative Africa, 2002). NTU psychotherapy would typically tap into the spirituality of the client or client system and use it in the healing process. Such techniques as prayer and libation can be very powerful in the healing process. This is known as specific cultural competence.

Specific Cultural Competence

Specific cultural competence empowers therapists to use specific cultural knowledge effectively (p.165). In practice, culturally specific knowledge begins to be useful in the engagement phase and is often most fully used from the assessment phase onward (McGoldrick, Giordano and Pearce, 1996).

Culturally-competent therapy can be used in the management of a wide variety of problems. Trauma management is just one of them and that is the focus of the study.

In summation, therefore Lo and Fung (2003) argue that in culturally competent psychotherapy, the therapist must be able to fuse both specific and generic cultural competence to achieve optimum results with their clients.

This theory helps explain the role of environment factors such as family, spirituality and groups in the management of trauma among refugees in Ghana. One can be sure that living together in the same camp with people with whom one shares common culture can help boost resilience and this may be seen in Ampain refugee camp. But what happens in Krisan which is more isolated and hosts refugees from over 13 different countries spanning east west and central Africa?

Although the model identifies the various connections with self, it does not identify how many connections are needed to ensure that a person is functioning authentically within the various relations between the self and the other parts. The study shall seek to identify those aspects of identity that have helped refugees to continue to function authentically within their environment.

Biopsychosocial Spiritual Model of Health Care

The biopsychosocial spiritual model of health care is a holistic model of health care that advocates that in caring for the individual one must be guided by four main thematic areas; Biological factors, psychological factors, social or cultural factors and spiritual factors. It is actually an advancement of the biopsychosocial model of health propounded by Engels (1997).

On this understanding, the biological component of the biopsychosocial model seeks to understand how the cause of the illness stems from the functioning of the individual's body. For individuals struggling with trauma, they are typically likely to present with a variety of psychosomatic illnesses. Somasundaram (2002), in a study of child soldiers in Sri Lanka reported that a sizeable number of them had such biological problems as depression and somatization. There are also likely to be other biological factors that may be contribute to this trauma.

The psychological component of the biopsychosocial model looks for potential psychological causes for a health problem such as lack of self-control, emotional turmoil, and negative thinking.

The social part of the biopsychosocial model investigates how different social factors such as socioeconomic status, culture, poverty, technology, and religion can influence health (Santrock, 2007).

The spiritual component focuses on the role of spirituality in the individual's life. How has the individual's spiritual belief systems served as an effect defence against personal stressors? Do they belong to any spiritual community or have any spiritual affiliations? Indeed, in modern times studies appear to be making a strong case for the role of spirituality in healing and therapy (Freeman 2004 p. 546 and Micozzi 2006 p. 305).

Spirituality also plays a key role in the development of resilience (Khosravi and Nikmanesh, 2014).

There is however a lack of clarity about what comprises ‘spirituality’ (Saad, de Medeiros and Mosini, 2017). Saad, de Medeiros and Mosini (2017) argue that ‘spiritual’ in the biopsychosocial-spiritual is a rather fluid and open concept which can refer to many things. Indeed, within the healing or therapeutic experience, there are many dimensions to spirituality. This would typically include the spirituality and health relationship of the client, the spiritual-religious coping of the client, the spirituality of the therapist and how it affects his/her practice, just to name a few dimensions.

Spirituality and health relationship

In populations that have experienced civil war or intense and extended violent conflict inter-generational trauma is most definitely a threat that one needs to look out for and try to forestall.

For the refugee community, what this implies then is that even within the safety and security of the refugee camp, there are still those for whom the impact of the war will still have a distant effect. In a place like Budumburam refugee camp, for instance, it is very difficult to see intact families where a man lives his wife and children under the same roof (Romig, 2007).

During an interview with the camp manager, Mr. Gavivina Tamakloe, he intimated that most of the families in the camp are single-parent families who still struggle with even trying to provide the most basic needs for their families, but still they refuse to go back to Liberia, because they still feel it is unsafe.

It is also for this same reason that any system of intervention for those who have been protracted refugees for a relatively long period must be guided by the possibility that

most of them would have become family persons and they might actually transfer some of these challenges onto their children. Thus, psychological support and interventions must be guided by the culture and belief systems of the clients. It must also be family-oriented or communally-oriented if the next generation is to avoid the bonds of the said historical or inter-generational trauma.

Several studies exist to suggest that Africans are mostly a spiritual people and that spirituality plays a key role in the African psyche (Masango, 2006; Cilliers, 2008). There is a need to explore the role that spirituality also helps in the psychological healing process. Although NTU psychotherapy works with the spirituality and belief systems of the client, what the study must seek to do is to identify the common points of spirituality and belief systems among the clients and how NTU psychotherapy works with all these different persons.

Review of Related Theories

The Historical Trauma Transmission Model

The Historical Trauma Transmission model was propounded by Wesley-Esquimaux and Smolewski (2004). It is also sometimes referred to as the inter-generational trauma transmission model.

“Intergenerational or multi -generational trauma happens when the effects of trauma are not resolved in one generation. When trauma is ignored and there is no support for dealing with it, the trauma will be passed on from one generation to the next. What we learn to see as “normal”, when we are children, we pass on to our own children. Children who learn that physical and sexual abuse is “normal”, and who have never dealt with the feelings that come from this, may inflict physical abuse and sexual abuse

on their own children. The unhealthy ways of behaving that people use to protect themselves can be passed on to children, without them even knowing they are doing so” (Aborigines Healing Foundation, 1995).

Implicit in this definition or explanation is the fact that trauma may sometimes be manifested by an individual who has not necessarily experienced trauma directly, but nonetheless they continue to suffer as a result of it. Brokenleg (2011), in a presentation entitled “A Dialogue on Cultural Competency for Health Advocates and Health Educators,” identified some of the signs of historical trauma. These include the following:

- i. Shame
- ii. Loss of concentration
- iii. Addiction
- iv. Violence and suicide
- v. Fear and distrust
- vi. Anger
- vii. Loss of sleep
- viii. Isolation
- ix. Anxiety
- x. Depression
- xi. Discomfort around people

Essentially what can then be realized is that it is not just the victims who endure the tragedy of the trauma, but those living with and around them including those yet unborn

can also become victims of the circumstances. This could provide a partial explanation as to why from an economic perspective, countries that have been ravaged by war and conflicts continue to wallow in poverty sometimes even decades after the conflict is over. Can it be said that trauma on a large scale as experienced by war-torn countries can be one of the main reasons why they are unable to recover within a relatively short time?

Date-Bah (2008) attempts to answer this question by asserting that “without reconciliation and rebuilding of social capital, economic recovery can be undermined as the lack of social capital could prevent cooperation between community members and the formation of other social and business networks (p. 42).”

Typically, one would also find a lot of residents of refugee camps struggling with at least one or more of the symptoms listed by Brokenleg (2011). Bombay, Matheson and Anisman (2009) provide us with a model explaining how historical or inter-generational trauma can trickle down to even future generations. Their model is replicated in figure 2.3 on the next page.

Figure 2. 3: The Transmission of Inter-Generational Trauma

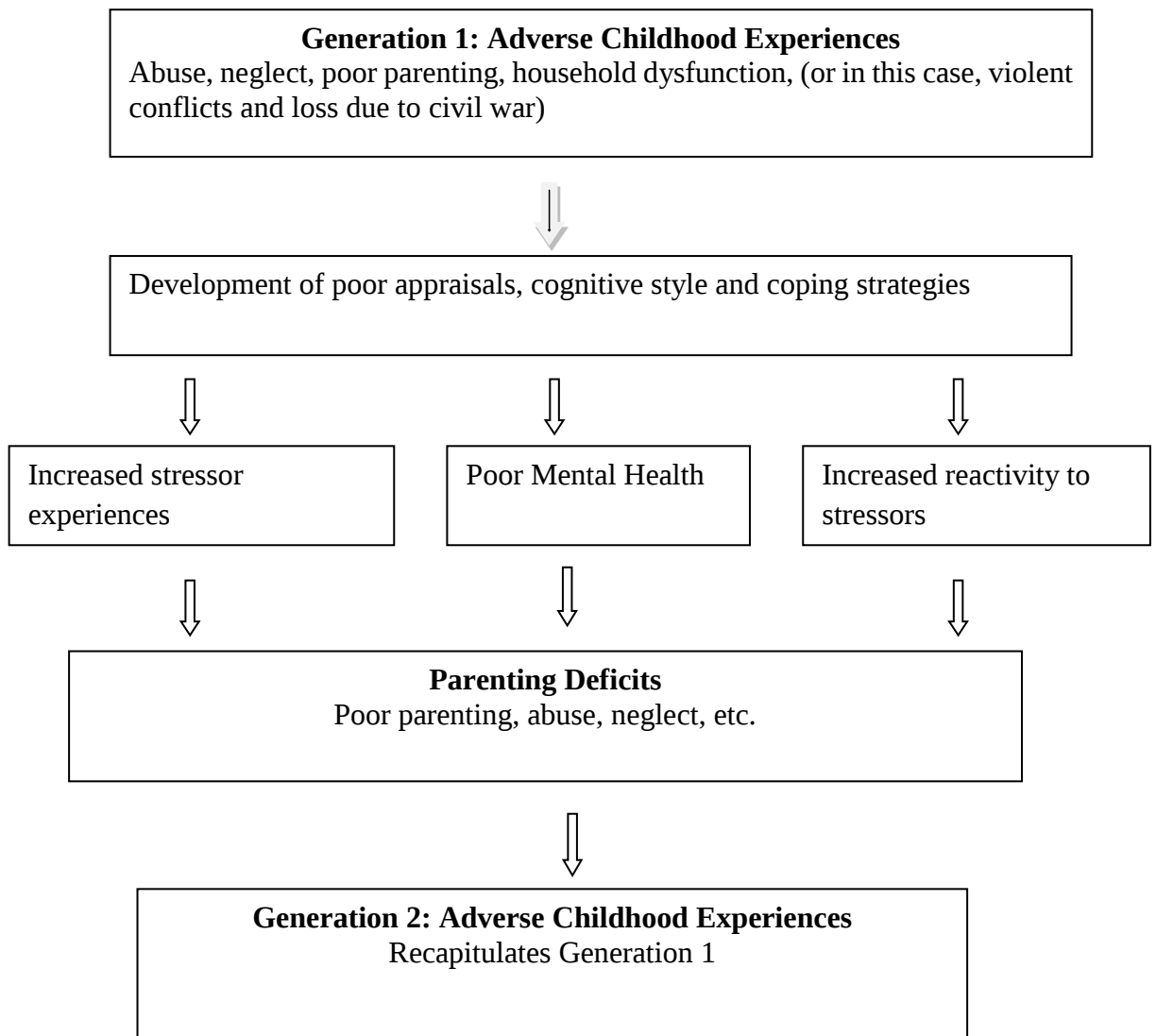


Figure 2.3

Figure 2.3 seeks to explain how inter-generational or historical trauma can be passed down from one generation to the next. The first generation would typically be the generation that experienced the adverse childhood experiences such as abuse, neglect or other challenges.

In the case of this study, it could refer to those individuals who were directly exposed to violent conflict and were forced to flee from their home countries as a result of this.

This generation then ‘infects’ or ‘transmits’ their traumatic experiences and behaviours onto the next generation, typically their children or dependants who in turn continue the ‘tradition’. According to Bombay et al (2009), some of these negative practices would include a development of poor appraisals, coping strategies, and cognitive style. This has the potential to negatively influence the individual in several ways for instance, inculcating in them a negative value system, stereotypical or prejudicial behaviour and even outright hatred for a particular group of persons.

Other researchers like Lederach (2005) may however interpret this diagram slightly differently. Lederach argues that peace-building and the role of history and culture may be looked at through four levels. These are the levels of recent event, lived history, remembered history and narrative. Lederach (2005) argues that it is at the level of remembered history that chosen trauma would most likely occur. By implication, the things that people hold on to, be it selective or holistic that they transfer to the next generation is what fuels the trauma. Hence for him, the first generation of trauma would include such persons as care-givers, teachers who transmit their values, cognitions and belief systems to the next generations. These persons for instance may transfer ethnic, racial or cultural stereotypes to the next generation and they in turn begin to function with these negative cognitions.

The relevance of this is seen in the fact that refugees still continue to struggle with taking care of themselves and their families sometimes even for years after they have lived in the host country. This suggests that not only is their economic well-being affected as a result of this, but their psychological wellbeing as well. There is therefore the need for a system of psychotherapy not only to lead to psychological healing, but also economic and social empowerment. The biopsychosocial model of healthcare delivery for instance appears to offer this alternative since it examines illness as being

caused by an interplay of biological, psychological and social factors (Enriques, 2015). Apart from this there are other theories that explore the various dimensions of trauma and its management.

One of such new dimensions is contemporary research into epigenetics (Weaver, et al, 2004). Epigenetics is the study of heritable changes in gene activity that are not caused by DNA. It is particularly relevant because it asserts that persons may manifest behaviour (genetically) as a result of environmental factors. Szyf and his associates discovered that rats' ability to withstand stress was actually influenced by the amount and type of care they received during their infancy. This is relevant because for purposes of this study it would suggest then that parents who were struggling with mental challenges may inadvertently 'pass' these problems down to the children. Research into this field of psychology has demonstrated how epigenetics have influenced such psychological behaviors and traits like resistance to stress, predisposition to substance abuse, psychopathy and other mood disorders (Hwang, 2006; Jiang et al, 2008; Carver, 2010). It should however be noted that so far a lot of research in epigenetics has been conducted on animals due to lack of access to human tissues and other ethical concerns. Epigenetics however holds a lot of promise into understanding how human behaviour and mental health problems can be brought about genetically by environmental factors.

The Concept of Trauma

As a word, 'trauma' has been used in several ways by several disciplines that are so inter-connected that it is difficult to give it a simple straightforward definition.

The DSM-V (APA, 2013) identifies PTSD as occurring to persons aged 6 and above (p.265). It also broadly identifies some major criteria by which PTSD may be diagnosed as follows:

Criteria A: Exposure to PTSD either directly or indirectly

Criteria B: Presence of one or more intrusive symptoms as following exposure

Criteria C: Avoidance of stimuli associated with the traumatic experience

Criterion D: Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred

Criterion E: Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred

Criterion F: Duration of the disturbances (Criteria B, C, D and E) is more than 1 month

Criterion G: The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning

Criterion H: the disturbance is not attributable to the physiological effects of a substance

From criteria B, C, D and E, it can be seen that PTSD has an element of subjectivity. That is to say, an experience may be regarded as traumatic by one person and yet to another it may not be considered a cause for concern. Again, the DSM-V notes that the onset of trauma may not always be immediate.

“PTSD can occur at any age, beginning after the first year of life. Symptoms usually begin within the first 3 months after the trauma, although there may be a delay of months, or even years, before criteria for the diagnosis are met. There is abundant evidence for what DSM-IV called "delayed onset" but is now called "delayed

expression," with the recognition that some symptoms typically appear immediately and that the delay is in meeting full criteria (APA, 2013, p.276).

The DSM-IV-TR (APA, 2003). introduces PTSD as ‘characterized by the re-experiencing of an extremely traumatic event accompanied by symptoms of increased arousal and by avoidance of stimuli associated with the trauma (p. 429).’ Giller (1999), points out that, “it is an individual's *subjective experience* that determines whether an event is or is not traumatic.” Thus, Trauma is a very subjective experience.

Psychological trauma is the unique individual experience of an event or enduring conditions, in which:

1. The individual's ability to integrate his/her emotional experience is overwhelmed, or
2. The individual experiences (subjectively) a threat to life, bodily integrity, or sanity”.

Giller (1999) further quotes Allen (1995). “There are two components to a traumatic experience: the objective and the subjective:

"It is the subjective experience of the objective events that constitutes the trauma...The more you believe you are endangered, the more traumatized you will be...Psychologically, the bottom line of trauma is overwhelming emotion and a feeling of utter helplessness. There may or may not be bodily injury, but psychological trauma is coupled with physiological upheaval that plays a leading role in the long-range effects" (p.14).

“In other words, trauma is defined by the *experience of the survivor*. Two people could undergo the same noxious event and one person might be traumatized while the other person remained relatively unscathed. It is therefore not possible to make blanket generalizations such that "X is traumatic for all who go through it" or "event Y was not traumatic because no one was physically injured." In addition, the specific aspects of an event that are traumatic will be different from one individual to the next. You cannot assume that the details or meaning of an event, such as a violent assault or rape, that are most distressing for one person will be the same for another person.”

This is a particularly interesting statement because then the implications are that trauma is more or less, the fruit of an individual’s subjective interpretation of a situation. This subjectivity, it can be assumed, is also influenced by other external factors such as an individual’s own mental toughness, socialization (or lack of it), previous exposure to similarly related experiences and the cultural interpretation associated with the (traumatic) experience.

What causes trauma?

The causes of trauma are several and varied. Bombay, Matheson and Anisman (2009), assert that,

“These traumas can occur at a personal level (e.g., car accident, or rape) or at a collective level (war, natural disasters, or genocide), and the responses to such events are not identical. In the latter instance, there is now considerable evidence that the effects of trauma experiences are often transmitted across generations, affecting the children and grandchildren of those that were initially victimized.”

Collective trauma may have profound intergenerational effects. These effects may go beyond easily observed or measured factors that come from the survivors' narratives of the trauma (or in contrast, by the deep silence, that is common among some survivors).

According to Vitzthum, Quarcoo and others (2009),

“Psychotrauma occurs as a result of a traumatic event, which may involve witnessing someone's actual death or personally experiencing serious physical injury, assault, rape and sexual abuse, being held as a hostage, or a threat to physical or psychological integrity. Post-traumatic stress disorder (PTSD) is an anxiety disorder and was defined in the past as railway spine, traumatic war neurosis, stress syndrome, shell shock, battle fatigue, combat fatigue, or post-traumatic stress syndrome (PTSS). If untreated, post-traumatic stress disorder can impair relationships of those affected and strain their families and society.”

It appears that for some of the refugee communities in Ghana it has already reached that level where it has now come with a breakdown in family structures (Boamah-Gyau, 2008).

Trauma and the Family

According to Verhey (2001), the family plays a very critical role in helping child soldiers and other subjects who have been through the doldrums of trauma. Studies also exist that indicate that where children who experienced war-related trauma either as active combatants or war-affected youth, were reintegrated into families (whether biological or adopted) they tended to recover better. For instance, according to Williamson (2006), 98% of Sierra Leonean children demobilized by the War Foundation were reunited with either one or both parents. A considerable number

however were not able to do this for several reasons. Some had been branded with tattoos of the factions to which they had been forcibly conscripted to; others were simply afraid of the repercussions if they were to return home. In the absence of a communal-based system of psychotherapy that is both restorative and responsive it is easy to see these individuals who are themselves victims also struggling to deal with their own experiences from the war. A system of intervention like NTU psychotherapy has been used in other situations to deal with groups that are struggling with trauma.

Kimball (2002) also asserts that, “Traumas of all types tend to be found festering within family systems that are coping with daily roadblocks associated with medical/psychological problems, addictions, physical/emotional abuse, and hardships like poverty. Trauma, when constantly applied to an already weakened family system, can literally reshape not only the personal workings of a family but also the delicate mechanisms of each family member.”

Kimball (2002) is of the opinion that trauma creates three key obstacles that most families have to go through; the first is constriction. Constriction involves the strangling of all emotions and dissension within the family unit. The reason why constriction will be used as a defence mechanism is in order to ensure that disagreements and past traumas do not resurface. In other words, everyone silently ‘agrees’ not to raise the past. She does however concede that it is only useful as a short-term defence mechanism. In her own words, ‘Maintaining complete compliance and being able to successfully bury emotions within the family will not help it at all in the long run. However, it will definitely allow for a superficial sense of peace and safety for all involved.’

Avoidance is the second obstacle she identifies. When using avoidance tactics, family members start to correlate their continuing fear of trauma with a specific person(s)

within the family unit. This trauma will be so psychologically disagreeable that the family member(s) will try to avoid as much contact or physical proximity to that person(s).

Impulsivity is the third obstacle identified. Kimball identifies this as the most powerful and most volatile obstacle. Here family members are battling with emotions that are highly volatile and very difficult to repress. Some family members are too fragile and/or immature to handle the intense blame, anger, abuses, and yelling that family members may be constantly dishing out to others. This can cause permanent psychological damage to family members and the effects may take years to overcome.

From the above it can be realized that whilst the family can be the principal bastion in the fight against trauma and PTSD, it can also be an instrument that can be inadvertently used to accelerate the worsening of symptoms and the eventual breakdown of the individual. Hence, for interventions for persons who have suffered trauma and displacement emanating from war or civil conflict, it would be worth looking at the role of the family as a solid support unit and not as an instrument for further relapse. Indeed, it would be better still if they enjoyed the support of a psychological intervention that is not only culturally competent, but family-oriented.

Trauma among Women

During civil conflicts and strife, women are easily one of the most common victims. The UN secretary-general in his 2002 report on Security Council Resolution 325 pointed out that, “The reality on the ground is that humanitarian and human rights laws are blatantly disregarded by parties to conflicts...women and girls continue to be subject to sexual and gender-based violence and other human rights violations.” The

impact of such violence can be far-reaching in its impact. It may affect them in several aspects of their lives. Indeed, it is well known that women who may have suffered such trauma will indulge in substance abuse and physical abuse. Others may choose to remain in abusive relationships. The result of this in the long-term, is that children raised in such abusive conditions may adopt such negative patterns in later life. Portes et al (2009) also argue that high incidence of mental health challenges among refugee women can have a debilitating effect on their families, especially the children. Edberg Cleary and Vyas (2011) as well as Godziak (2004) assert further that refugee women are among some of the most vulnerable groups in the US. They are most likely to be at risk of stress and other mental health problems and yet be among those least likely to seek the proper health care. This could take a toll especially on the children and may even be likely to lead to inter-generational trauma thereby constricting the healthy development of the next generation. Any effective system of psychotherapy must therefore be responsive to the needs of women because of the special role they play in managing the home and by extension the society.

Trauma and Hostility

Traditionally, persons suffering with PTSD are stereotypically perceived as struggling more with guilt and fear than with hostility (Brewin and Holmes, 2003). In recent times, however since the DSM IV-TR (APA, 2003) and other recent versions have identified hostility as a major symptom of PTSD, it has received more attention. A steady body of knowledge is being developed as to how PTSD may manifest through hostility (eg. (e.g., Chemtob, Hamada, Roitblat, and Muraoka, 1994; Frueh, Henning, Pellegrin, and Chobot, 1997; Riggs, Dancu, Gershuny, Greenberg, and Foa, 1992; Schutzwohl and Maercker, 2000; Novaco and Chemtob, 2002).

Novaco, Chemtob and others (1997), for instance propose that individuals with PTSD will develop a much lower threshold for perceiving situations as threatening and so they will have higher scores of aggression. They refer to this as the survival mode theory.

Again, Foa and others propose that “individuals with PTSD are motivated to avoid trauma-related feelings of fear, which are activated by posttraumatic intrusions, and that trauma-related anger serves as a welcome focus of attention because anger is an emotion with a more positive emotional valence than fear” (Feeny, Zoellner, & Foa, 2000; Foa, Riggs, Masie, & Yarczower, 1995; Riggs et al., 1992 in Orth and Weiland, 2006).

All these point to the fact that hostility is a major challenge that persons with PTSD may be struggling with. The question that this raises is, ‘To what extent can NTU psychotherapy help to bring down the levels of hostility and aggression that such persons may be suffering?’

Trauma among Refugee Communities

Rustad (2006) asserts that the lack of focus on family hampers “Western” medicine’s ability to care for the refugee population. For example, Bosnian refugees feel disconnected from traditional clinic based mental health services due to the lack of emphasis upon family.

Even more interesting, Nicholl and Thompson (2004) assert that, ‘Western psychological health care agencies are increasingly finding themselves concerned with assisting traumatized individuals originating from non-Western cultures. This increased demand has been associated with considerable political, practical and resource issues (p.3).’ They also point to some studies that question the concept of PTSD and trauma in refugee communities:

“The PTSD concept has been applied effectively in the diagnosis and treatment of individuals exposed to a number of different trauma situations including war, torture, rape, natural disasters and industrial accidents (Friedman & Jaranson, 1994). However, the majority of research studies have been based on populations of Western countries (Roth & Fonagy, 1996).”

The symptoms of the constructs that make up trauma or PTSD are one of the big issues in the study of PTSD. What may be traumatic in one culture may be proper or even desirable in another. Zur (1996) for instance describes PTSD among Quiché Mayan widows in Guatemala; among that culture, expressions of grief, sadness or anger are seen as harmful. Indeed expressions of grief are only permitted for a nine-day ritual. One would thus quickly realize then that the five stages of the grieving process may not necessarily apply within this culture.

Beyond this, it can also be realized that the concept of trauma and PTSD is not the only psychological problem that has been questioned in recent times by authorities in psychological research. This notwithstanding however it is still important that trauma be explored within as many different cultures as it may manifest itself; Friedman and Jaranson (1994) advocate that wider cultural practices and beliefs be explored within the purview of what makes up psycho-trauma.

The same point is perhaps more aptly presented by Nicholl and Thompson (2004) in the closing paragraph of their publication when they write:

“...a key conclusion appears to be a reminder that it is particularly important for the therapist to appreciate and explore individual clients’ cultural beliefs (this would

include religious, spiritual and ritualistic practices) as well as the individual personal beliefs/appraisals (usually assessed for in Western therapies). Stemming from this is a need for greater therapist awareness and ability to work with issues of diversity and a willingness to facilitate access to appropriate practical support (p.1).” Here we find a sharp reminder of the essence of cultural competence in the management and treatment of trauma among refugee populations.

From the above we can realize that although psychotrauma can be managed in a variety of ways, the therapist must always be mindful of the cultural background of the client and they must approach the therapeutic process with the appropriate cultural competence. What remains to be seen is how cultural competence and in particular how NTU psychotherapy can enhance the therapeutic outcomes.

Cultural Competence: What is it?

In recent times, there has been an increasing support for cultural competence in systems of psychotherapy. This is reflected by Barreto (1992), when he asserts that, ‘It is by belonging to a group, to a set of cultural values that the individual nurtures himself and creates an identity. Culture for the individual is like the web for the spider.’

There are several reasons why there is such a strong advocacy for cultural competence in contemporary times. The complex nature of human personality can be accounted for by differences in interaction between influences of nature and nature. In other words, differences among individual personalities can be accounted for by differences in genetic and hereditary factors as well as environmental factors. This is a point echoed by Millon (1996), Watson, Maslow and even Bandura just to name a few.

Alarcon, Foulks & Vakkur, (1998) point out that, ‘A cultural component exists in every clinical event, intervention or interaction between the treating agent and the identified

patient. This applies not only to ethnic minorities or distant societies outside the Western World.’ Thus, it can be realized that the role of cultural competence in the delivery of proper and efficient psychological services cannot be overestimated. As Africans however, it is debatable whether we can assert that we’ve developed a system of psychology that is relevant to us and addresses our needs and aspirations. It is against this background then that there is the need for a study to confirm or disprove the relevance of culturally competent systems of therapy for use in Ghana today.

From the assertion of Alarcon, Foulks and Vakkur it must also be noted that no particular system of psychotherapy can be described as a ‘culturally competent system of psychotherapy’ because cultural competence exists in every system of psychotherapy. It is seen in the competence of the therapist as well as in the principles and techniques of the system of therapy.

Cultural Competence among African Cultures

Africans have always had a distinct cultural pattern that has set that apart from other world cultures. We may share a few similarities with other cultures, but by and large, the African traditional culture and belief system, even at its most adaptive and corruptible has always managed to retain an identity of its own.

A few distinct characteristics run through at the core of African personalities

- i. Africans are primarily a very spiritual people. Some of the ways in which this manifests itself is the focus on the human struggle with issues of purpose and meaning, which are cornerstones of existentialist thought (Gregory & Harper, 2001).
- ii. Africans are a community-oriented people. (Dana,1993; Grills & Longshore, 1996; Karenga, 1988). According to Philips (1995), among the Akans of Ghana

for instance, illness is regarded as a state of disharmony in the body. The Akans therefore traditionally recognised the role of multiple factors such as somatic, psychic, genetic as well social and cultural factors in the treatment and avoidance of illness and disease. We also see this reflected in the need for families to investigate the background of potential suitors before agreeing to marriage proposals.

From the above, at least two essential characteristics are readily identified that distinguish Africans. These differences highlight why there is a need for a cultural competence in any system of therapy that is designed or used in helping persons of African origin and other diverse communities . Currently, NTU psychotherapy offers that Africentric system of healing and this is why it is essential that this be researched into right here in Africa.

Piper-Mandy and Rowe (2010) also provide insight into what should lie at the heart of African centred psychology. They argue that it must be founded on four foundational assumptions

- i. African centred psychology must advance the re-ascension of African cultural patterns and styles for understanding human behaviour
- ii. It must reflect the ways that African persons have sought to understand, articulate and project themselves
- iii. It utilizes the scientific and moral criteria that emerge out of the study of African cultural patterns
- iv. It verifies the reality of African human processes through an examination of historical moments and movements. That is to say it relies on African

sources to authenticate the African experience. This includes oral literature, spiritual systems (such as prayers, praise songs and moral teachings), the dynamic interdependence of community nature and spirit and ‘sankofa’ (Asante and Abarry 1996; Rowe and Webb-Msemaji).

It would be worthwhile to investigate the features and techniques employed by Ntu psychotherapy by which it fits into this criteria. Philips (1990) asserts that Ntu psychotherapy has two main functions; firstly to assist the client systems to function harmoniously and authentically within themselves (Philips 1990, p.5). In so doing, it helps the African to rediscover themselves and realign themselves with the natural order. Nwoye (2010) provides an interesting definition of African psychology which is also quite relevant to this study. He defines it as ‘The study and application of the best practices in Western and Indigenous psychological therapies to the amelioration of the psycho-social wounds and damages, and stresses and challenges of the post-colonial African and their world. Characterized in this way, it encompasses the study of the major theories and perspectives and the techniques and approaches of individual psychotherapy, family therapy and systemic practice (Papadoupalous, 2008) in both indigenous Africa and the modern West (p.28)’

This definition is relevant for a number of reasons. Firstly, it accepts that African based psychology is somewhat eclectic. Thus, it incorporates both western and indigenous psychological theories and practices with the aim of helping persons of African origin. Secondly it is restorative. Not only is it curative in that it helps deal with specific psychological challenges, it also aims at helping clients navigate life’s major challenges and also achieve personal growth. Thirdly, African psychology can be applied across at least three levels: the level of the individual, the level of the family and the level of

the community. This is particularly relevant because it positions African psychology to be able to respond to a larger spectrum of problems.

Thus, African centred psychology is not just a tool of healing but also of growth and development. Thus, it has proven to be quite useful in addressing psychosocial and cultural challenges facing people of African origin. Ntu psychotherapy appears to fit in quite well with Nwoye's examination of African psychotherapy in that it is both curative and restorative.

Ntu psychotherapy uses several techniques that are African based and rooted in African belief systems. This includes genograms, Afro drama and rites of passage just to name a few.

Cultural Competence and Communality as a Tool of Healing

Psychology Beyond Borders has done a lot of work in the area of working with refugees, child soldiers and societies that have been exposed to trauma. Having had a presence in all major continents of the work they have chalked up an impressive resume of experience, some of which might be worth reviewing in this study. Their mission statement declares that, "Psychology Beyond Borders (PBB) is committed to international leadership in evidence-informed psychosocial preparedness, prevention and response to disasters, armed conflict, and terrorism."

Interestingly, one of the very first observations that they make is that exposure to trauma may not always necessarily lead to PTSD. Bleich, Gelkopf & Solomon (2003) in one study discovered that Israelis who had been exposed to terrorism showed higher levels of distress and lower perceptions of safety (they were more cautious, alert and vigilant) but they did not necessarily display higher levels of PTSD. This might appear to create a paradox: if persons exposed to terrorism do not necessarily display higher levels of

PTSD then what is all the hue and cry about? It is the opinion of this researcher that where a community is constantly exposed to traumatic events, they develop more resilience. For want of a better description, one could view this as a form of ‘in vivo exposure’ whereby the persons exposed may stop manifesting signs of PTSD. Again, this is also a trend worthy of further scientific investigation. However, in the case of members of this particular study, violence was not a part of their everyday lives and so they were unprepared for the backlash of civil conflict that disrupted their lives.

Secondly, in a state like Israel (which was the focus of Bleich, Gelkopf & Solomon’s (2003) study) the ability to restore a certain semblance of normalcy would also most likely have contributed to the resilience that the citizenry would be manifesting. The Society for Community Research and Action (2010) identifies five main elements of communal healing namely, a sense of safety, calming, a sense of self and collective efficacy, connectedness and hope (SCRA, 2010, p.15-16). Typically refugees in the camps would be coming from several different locations and even ethnic groupings all brought together by unpleasant necessity into a refugee camp. Thus, the desired sense of safety may not always be there. In the same vein, the sense of self and collective efficacy may take a while to develop along with connectedness and hope. This would be where group-based interventions such as NTU psychotherapy may be of help.

Even more instructive is what SCRA (2010) has to say about resilience and its role in community healing. “Resilience is an ongoing process that is achieved over time. Resilience is not something that a person or community has or doesn’t have forever. Given that resources associated with resilience can be cultivated; skills associated with resilience can be learned and practiced.” (SCRA, 2010, p. 16). By implication then

whether a society is more resilient or not in dealing with traumatic events would depend to large extent on measures that are put in place to help them deal with them.

For instance, the Israeli concept of a Kibbutz was originally designed to operate under the principles of communality (it still largely does). According to The Jewish Agency for Israel on its website, ‘The Kibbutz operates under the premise that all income generated by the Kibbutz and its members goes into a common pool. This income is used to run the Kibbutz, make investments, and guarantee mutual and reciprocal aid and responsibility between members (pp. 2).’

Further to this, Rubenstein (2007) asserts that ‘Based on the voluntary participation of its members, the kibbutz is a communal society which assumes responsibility for its members' needs throughout their lives. It is a society that strives to allow individuals to develop to their fullest potential, while demanding responsibility and commitment from each person to contribute to the welfare of the community. For some, the feelings of security and satisfaction engendered by belonging to a small, closed community are among the advantages of kibbutz living, while others might find communal life very confining.’

Apparently, then the communality of the Kibbutzim has not only helped to engender resilience among the residents but has also helped to bring healing in several ways to the people. This is no different from the external family system that used to exist in traditional African societies.

NTU psychotherapy aims at healing the individual but also restoring balance and authenticity between the person and his environment. The reciprocal relationship between the individual and his community is thus adequately typified by the Kibbutzim and within the African milieu any such imbalances can be restored by NTU psychotherapy.

This becomes more relevant in modern times where due to industrialization, urbanization and the rise of the digital age, communal interdependence within the extended family network has become more and more impracticable. The concept of the community and the society must evolve if the individual survivor of trauma shall be able to benefit from it. In the absence of a solid extended family support network then society must evolve a support network of its own. For instance, in the severed environment of refugee camps individuals must learn to draw strength from each other and even nurture and 'create new families' for themselves. Indeed, Miller et al (2002) discovered that Bosnian refugees who had fled with their nuclear families intact were less likely to suffer social isolation, helplessness and other challenges of adjustment that other refugees who had been separated from their families would experience.

Wessells (2008), identifies with a similar position when he asserts that of the two main types of approaches to trauma management in Africa, the first being a traditional trauma approach that emphasizes PTSD and the latter being a more holistic, community-based and psychosocial approach, the latter has proven to be the more efficacious (p.10).

Wessells (2008), also further identifies other challenges with the traditional, PTSD based approach to trauma. He identifies that trauma victims are often victims of

structural violence and even on occasion, state-sponsored violence. There is a damage to social cohesion within the society.

‘Furthermore, problems such as distrust and low social cohesion often stem from a host of political, economic and social factors (Collier et al., 2003; Wessells & Monteiro, 2001), none of which are addressed by the trauma approach.’ (p.11).

Boyden, (2004); Bracken, (1998); Gibbs, (1994) and Wessells, (2006) all also argue further that for war-affected Africans, the greatest challenge is often times not the PTSD, but rather the stress of daily basic challenges of their shattered lives and the destruction of social (including family) support systems. The argument being pushed forth here, then, is that there is the need for a departure from traditional conceptualizations of PTSD and the need for a greater focus on social reconstruction as a tool for healing especially in war-affected communities.

Another interesting dimension that Wessells points out is the failure of traditional approaches to recognize and utilize the strengths of the communities. Within the African milieu some of the most important assets include our traditional practices (such as rites of cleansing and rites of initiation), social structures, elders, healers, religious practices and beliefs, women’s groups and youth groups are all instances. Of course, the traditional PTSD approach to healing does not make use of these assets. Even within the restricted environs of the refugee camps, one still sees an evolution of some of these structures taking shape within sub-communities of the camps.

Dudley (1999), Baily (1999) and Harris (1999) have established that even within refugee camps, the experience of violence does not lead to a total erasure of culture and

cultural knowledge. In studies among Burundian refugees being hosted in Tanzania, Fouere discovered that informal ways of keeping and passing down cultural knowledge still existed. Refugees still communicated in their local language and in fact spoke these languages to their children. Indeed, among Burundian refugees Kirundi was the official language of instruction even in school. Add to that social upbringing and the fact that young women were instructed in how to dress and conduct themselves, and the fact that they were taught preparation of traditional meals and one begins to see how a sense of national identity can still be held in the refugee camp. Effective psychotherapy must aim at ensuring that people recover and learn to deal with trauma within their cultural setting and develop socio-culturally within the same.

NTU Psychotherapy offers itself as a system of psychotherapy that works quite well at both the individual and communal level. The question however is, ‘what makes NTU psychotherapy so unique and how does it depart from other traditional systems of psychological intervention?’

Criticisms of Cultural Competence

From the above, one may be tempted to believe that cultural competence is a universally accepted phenomenon in the literature, but that is not so. According to Sue, Zane, Hall and Berger (2009), the argument that cultural competence or, as they put it, multiculturalism should be available to ethnic minorities is at least four decades old and during this period there are those who have challenged its necessity, empirical support and even political correctness.

One of such concerns is to do with whether cultural competency can be distinguished from the general competency of the therapist. The general consensus is that although

both have certain overlapping characteristics, a distinction can still be made between the two and therapists who display higher levels of cultural competence are ranked higher (Fuertes et al, 2006; Constantine, 2002).

Another major concern is with stereotyping of ethnic minorities (Weinrach and Thomas, 2002, 2004; Herman et al, 2007; Hwang, 2006). Cultural competence 'boxes' members of the same ethnic grouping into the same category and presumes that they all share the same psychosocial cultural and other attributes without sufficiently taking into account such moderating factors as education, residential situation and even place of upbringing.

A third concern is to do with the fact that there are no commonly accepted or universal viewpoints of what cultural competence is. It therefore becomes difficult to establish a common viewpoint or framework over what should be the content or composition of cultural competence in care.

In spite of this criticisms of cultural competence there are several variations to cultural competence and how it can be viewed. The intervention approach, for instance looks at cultural competence from two ways of intervening. For instance, something as simple as conducting the intervention in the language of the client.

What is NTU Psychotherapy?

The term *NTU* (pronounced "in-too") is a BaNTU (central African) concept that describes a universal, unifying force that touches upon all aspects of existence (Jahn, 1961). NTU psychotherapy is based on the core principles of ancient African and

Afrocentric worldview, nurtured through African American culture, and augmented by concepts and techniques of Western psychology. NTU psychotherapy is spiritually based and aims to assist people and systems to become authentic and balanced within a shared energy and essence that is in alignment with natural order.

NTU Psychotherapy has two main goals. The first goal is to help the client systems to function harmoniously and authentically within themselves and in their relationships within the context of the natural order. The second goal is to ensure that client systems function well within the seven principles of Nguzo Saba or healthy living. These are namely; Unity, Self-determination, Collective Work Responsibility, Cooperative Economics, Purpose, Creativity and Faith.

In other words, in order for a person to be truly in harmony with themselves and with their environment they would be leading a healthy life that incorporates these values. Where the individual begins to experience challenges in healthy living, there are techniques available at the disposal of the therapist to help restore balance.

One unique characteristic of NTU psychotherapy is that its principles lend themselves to use across different psychological theories, be they Psychoanalytic, Cognitive-behavioral, humanistic and so forth. In this regard, it is referred to as pluralistic in orientation. NTU Psychotherapy is normally made up of five stages and these are:

1. Harmony is the initial phase and here the focus is on establishing a therapeutic bond between the clinician and the client
2. Awareness phase is where the client or the client system develops an initial recognition of his or her problem.

3. The alignment phase is the third phase and here the focus is to help the client uncover and reconcile their anxieties.
4. Actualization is the fourth stage here and this stage focuses on helping the client to practice and experiment with the new attitudes and behaviours in their regular environmental context.
5. The synthesis stage is the final stage and here the focus is on integrating the new cognitions, affects and behaviours learnt with their changing attitudes and beliefs in the real life. This stage allows the client to merge newly learnt behaviours with old healthy situations.

It is worthy of note that the five stages identified here appear to be in harmony with the works of Lo and Fung which also identified culturally competent psychotherapy as going through the five stages of pre-engagement, engagement, assessment and feedback, treatment, and termination.

One pertinent issue that may be raised is the relevance of NTU psychotherapy within a West African milieu. NTU psychotherapy has its roots in East African philosophy and belief systems but these do not differ significantly from West African concepts and belief systems. Indeed, Philips (1990) argues thus;

‘The principles of Nguzo Saba and indeed, NTU psychotherapy can be universally applied. That is they are equally applicable to European Americans, Hispanic Americans and others since the concepts are based on a spiritual connection that human beings have with the life force. The values that Nguzo Saba espouse are human survival values that speak to the healthy promulgation of the Human race. NTU psychotherapy is culturally sensitive and the specific techniques can be appropriately modified given the uniqueness of the person, his/her family and cultural background and the overall therapeutic needs of the client.’

An example of the principles of the Nguzo Saba will show a clear agreement between the seven principles and the same principles being applied and running across West African cultures. For instance, the concept of Umoja (Unity) is seen in the Akan belief in 'Nkabom' or 'Koroye.' Indeed the proverb of the broom is virtually inculcated into the mind of most West African children. As a single entity a broom stick can be broken into several pieces but when they are brought together to form a broom, not even one stick can be broken in two.

Again, collective work responsibility (Ujima) emphasizes the essence of co-operation at several levels; social, economic and so forth. This is also seen in the role of the 'koroyekuo' among the Akans as well as the 'asafo' groups who come together in times of crises and celebration to help each other out.

Similarities also exist between East African and West African culture. The belief in one all-powerful being runs alongside the belief in other forces. Both East and West African cultures are inherently polytheistic.

Previous Applications of NTU Psychotherapy

There are not that many academically documented studies on NTU psychotherapy. However, a few notable studies do indicate its effectiveness. Cherry et al, (1998) for instance, undertook a study aimed at reducing risk factors that predisposed African-American children in the 5th and 6th grade to substance abuse. The objectives of the NTU program were: 1) to improve knowledge of and increase intolerance of drugs; 2) to improve values; 3) to increase racial identity; 4) to improve self-esteem; 5) to increase knowledge of African culture; 6) to improve family communications; 7) to improve behaviors in school; and 8) to improve problem solving skills. Africentric philosophy and world-view provided the conceptual framework for the development of

intervention activities. Intervention components for 5th graders included a rites of passage program, a substance abuse education program, an Africentric education program, a parenting program, and a family therapy program. The results indicated significant program effects for protective factors including racial identity, knowledge of African culture, self-esteem, and school behaviours.

Previous Applications of NTU psychotherapy in an African context

NTU Psychotherapy is practiced in Ghana by the team of psychologists at Progressive Life Center, Accra. Perhaps, one of the best examples of how NTU psychotherapy has been used in an African scenario is a three month intervention program for former child soldiers of the Liberian Civil War. During the months of July, August and September 2008, a team of clinical psychologists from PLC Accra worked with Mediators Beyond Borders (MBB) a US- based, Non- Profit organization and helped retrain and rehabilitate about 75 ex-child soldiers prior to their return to Liberia. The intervention focused on trauma for that population and on some of the more common manifestations of that trauma, namely hostility, somatization, and panic attacks. It also focused on the expectations that they should have on their return to Liberia as well as how they could adjust to the environment again. Unfortunately, no publication came out of the said project.

This research would thus seek to expand on the previous project and see how culturally competent psychotherapy can be used to help treat psychological problems and aid socio-cultural development and re-assimilation.

Ghana does not have an official history of war and violence, with the exception of the occasional civil unrest and chieftaincy disputes such as the Dagbon crises and the Konkomba-Nanumba conflict, all of which have so far been successfully contained

internally. But Ghana has hosted refugees from several countries like Liberia, Sierra Leone and even Darfur. Most of them are actually catered for by the United Nations High Commission for Refugees, with Ghana serving as a host country. In Ghana, psychologists have often used western based styles and systems of therapy. Again, more often than not, most of the refugee camps have hosted several psychologists who have come there for research and data collection but largely from an American and Eurocentric perspective.

This study differs in the sense that firstly, it entails a psychological intervention that shall run for a period of between ten to twelve sessions for each individual, rather than just a series of interviews, questionnaires or just data collection. Secondly the intervention is a culturally competent intervention designed for persons of African origin.

Previous Systems of Intervention for Trauma

Traditionally, trauma has been managed using a wide variety of techniques. While it is not the aim of this study to investigate the superiority or preference of one system over another, it is worth our while to explore the more common systems of therapy and their relative strengths and weaknesses. Evidence exists to indicate that cognitive-behavioral therapy has been successful in the treatment of trauma (McCaffrey and Fairbank, 1985). Kilpatrick, Vernone & Resick (1982) also describe a system of therapy for rape-induced trauma that involves breathing and relaxation therapy and cognitive self-control strategies. Trauma has also been managed using supportive counselling (Neuner et al, 2005) and several other approaches.

Supportive Counselling

Supportive counselling has also been used in dealing with trauma. This is where victims of trauma in different forms (rape, armed robbery, accidents etc) have access to someone who they can talk to. Supportive counselling can also be held by a lay counsellor.

Supportive counselling often takes place after the initial crisis reaction has subsided and the victim perceives a need for additional emotional support (Young, 2001). The counselling may be provided by mental health specialists, but often is performed by trained lay victim counsellors. Supportive counselling is often “trauma specific”. This means that the counselling only addresses the crime that happened and any consequences or issues that arise in the aftermath of that crime. Keeping the counselling relationship focused on the crime helps ensure that the victim—with support—confronts the crisis reaction he or she experienced and begins the process of reconstructing their life. Focused counselling lessens the opportunity for long-term denial and repression to keep the healing process from progressing.

Jacobs and Reupert (2014) undertook a study on ‘The Effectiveness of Supportive Counseling Based on Rogerian Principles.’ In this study they undertook a meta-analysis of publications that investigated the effectiveness of supportive counselling using Rogerian principles. By undertaking a meta-analysis of 26 international papers and 2 Australian papers, they made two relevant discoveries; firstly, that there were differences in how supportive counselling was defined, implemented and compared to other therapies. Secondly, they discovered that supportive counselling was as effective as other systems of therapy; in their own words, ‘Overall, while a number of methodological issues preclude definitive claims, there is evidence to suggest that the

group of therapies often referred to as supportive are effective, and equally as effective as selected other therapies, in the treatment of adult depression.’

Jacobs and Reupert (2014) point out that there are slight variations in how Supportive counselling is defined and utilized. Winston (1986) in Jacobs and Reupert (2014) for instance points out that there might be some confusion regarding how the term supportive counselling may be operationalized as some employ the term supportive to refer to treatment objectives, while others may define it in terms of techniques being used.

However, it should be noted that the spectrum of human experiences is as fluid as the various interpretations that individuals may give to these experiences. Therapists, in responding to psychological problems would also need to be fluid and flexible in how they operate and use the systems of therapy to help their clients.

Jacobs and Reupert (2014) sum up their position in the following manner, ‘It is the belief in the value of the therapeutic alliance that motivates the person-centred counsellor, rather than a concern about specific counselling techniques (p.5).’ Supportive counselling is therefore a valid and widely accepted system of theory in the management of trauma (Jacobs and Reupert, 2014; Gillies et al, 2013)

Narrative Exposure Therapy

Narrative Exposure Therapy (NET) is a short-term approach based on cognitive-behavioral therapy and testimony therapy (Neuner et al, 2004). It is often conducted within six to ten sessions, each session lasting between one and two hours. Onyut et al (2005) also used KIDNET for children. Narrative Exposure Therapy places the sensory, cognitive, affective components of trauma into context, so that the victim may begin to better reconcile the chronology and context of the traumatic experience(s). Key

components of NET include empathetic listening, Active listening, congruency and unconditional positive regard. The patient is encouraged to describe and relive in detail, the traumatic experiences without losing their connection to the 'here and now' within which they are presently operating.. Gwozdziwycz and Mehl-Madrona (2013) undertook a meta-analysis on the research into Narrative Exposure Therapy among Refugee and found that total average effect size for all interventions was 0.63 (medium). Most studies on Narrative Exposure Therapy have however been on refugee populations and typically on very small sample sizes so there is not enough knowledge on the limitations of Narrative Exposure Therapy, particularly for larger populations (Gwozdziwycz and Mehl-Madrona, 2013).

In a similar study by Neuner et al (2005), they compared the efficacy of Narrative exposure therapy to supportive counseling and psychoeducation. Sudanese refugees living in a Ugandan refugee settlement (N = 43) who were diagnosed as suffering from posttraumatic stress disorder (PTSD) either received 4 sessions of NET, 4 sessions of supportive counseling (SC), or psychoeducation (PE) completed in 1 session. One year after treatment, only 29% of the NET participants but 79% of the SC group and 80% of the PE group still fulfilled PTSD criteria. This study is a similar efficacy and so shall follow a similar design.

Schaal, Elbert and Neuner (2009) also undertook another of such studies in which the aim of the study was to evaluate the efficacy of treatment modules for trauma spectrum disorders in a sample of Rwandan genocide orphans. The researchers selected 26 orphans and they were placed in two separate group adaptation of interpersonal psychotherapy (IPT, n = 14) was compared to individual narrative exposure therapy

(NET, n = 12). At post-test, there were no significant group differences between NET and IPT on any of the examined outcome measures. At 6-month follow-up, only 25% of NET, but 71% of IPT participants still fulfilled PTSD criteria.

Again, this demonstrated the effectiveness of NET as a system of therapy for trauma management. Although it might however be useful to have a study that employs a much larger sample size this does not negate the findings from several studies that have shown the effectiveness of Narrative Exposure Therapy. (Zang, Hunt and Cox, 2013; Schaal, Elbert and Neuner, 2009; Bichescu, Neuner, Schauer and Elbert, 2007)).

Cognitive Behavioural Therapy

Cognitive Behaviour Therapy (CBT). Cognitive Behavioural Therapy is founded on the premise that an individual's affect and behaviour are largely shaped by their perception of the world around them and how they relate to it (Kar and Misra, 2008). It typically consists of talking to persons with trauma and focusing on restructuring how they think and perceive the traumatic events (cognitive restructuring) and how they end up behaving in response to these memories. There are several studies that confirm the effectiveness of CBT among refugee populations (Paunovic and Ost 2001; Palic, and Elklit, 2010). CBT has also been shown to be quite effective across cultures, but there has been the need to make adaptations to reflect the social and cultural dimensions within such milieus (Otto, Hinton, and Korbly, 2003; Udomratn, 2008).

Multicomponent CBT has also been shown to be quite successful in managing combat induced PTSD. This was done by increasing the level of social engagements and psychosocial functioning among veterans (Beidel et al, 2011; Arens, 2014). This is quite important because the fourth stage of NTU psychotherapy (the actualization stage)

also requires clients to begin to experiment with new attitudes and behaviours that will achieve the desired outcomes. Other studies however reveal that non-response to CBT can be as high as 50%. This may be attributed to other related factors such as comorbidity and other characteristics of the population undergoing the CBT (Kar, 2011; Lonergan, 2014). The major limitation with CBT though, is that it emphasises reliving the traumatic experience. This may provoke the very anxiety that the therapy is supposed to be trying to suppress (Gaston, 2015).

Loss among Refugees

The concept of loss among refugees may be difficult to fully exhaust and analyze. In a study by Miller et.al (2002), they discovered that the primary sources of exile-related distress included social isolation and *the loss* of community, separation from family members, the loss of important life projects, a lack of environmental mastery, poverty and related stressors such as inadequate housing, and *the loss* of valued social roles(emphasis mine). The authors used semi-structured interviews to examine exile-related stressors affecting a sample of 28 adult Bosnian refugees in Chicago. The interviews covered 3 areas: life in pre-war Bosnia, the journey of exile, and life in Chicago.

In another study, Phillips (2011), asserted that, ‘Gender, culture, religion and society shape responses to loss.’ Phillips undertook a study of the Hazara Shiites from Afghanistan and their challenges in adapting to life in Australia, very much like refugee communities in Ghana. Her study primarily used a qualitative focus to gain in-depth information on their experiences. Within the refugee experience, conflicting emotions of ‘hope and grief’ are common. While Hazaras hold hopes for their future wellbeing

and sometimes achieve joyful family reunions, grief can continue or re-emerge for numerous reasons. The fate of many family members often remains unknown as their homeland, also lost to them, continues to be war-torn. It is this sense of loss that continues to perpetuate the psychotrauma and other challenges that refugees may continue to face, even in the relative safety of exile.

A Brief History of Refugee Camps in Ghana

There is a special reason why it is necessary to discuss the history of refugee camps in Ghana. Ghana is still relatively new to the concept of hosting refugees in camps and the medium to long -term effects that go with it. This has implications both for Ghana as a host country and the refugees who are accommodated.

Indeed, it could be argued that it is more appropriate to discuss a history of Ghana as a host to war-torn refugees. This becomes necessary because most of the refugee camps in Ghana do not ‘fit-in’ with the structure of most refugee camps worldwide. One is less likely to see the white tents of the UNHCR surrounded by barbed wires. Rather the refugee camps in Ghana are like semi-settlements. Often, they are made up of brick houses or mud-brick houses, commonly known as ‘atakpame’ in Ghana. It therefore becomes necessary that one investigates how the refugee camps evolve into settlements.

According to Essuman-Johnson (1992), when Liberian refugees first began to trickle in around 1989, Ghana did not have a Refugees Act or Refugees board. ‘The government was not prompt in seeking international assistance for the refugees. So in the early and subsequent years, assistance for refugees fell largely on the institutions of civil society, the generosity of ordinary Ghanaian families, especially the host traditional rulers

obligated by custom to provide help to strangers in their midst, the Christian Council of Ghana and other philanthropists.’(Boamah-Gyau, 2008).

But even more interestingly and yet still more dramatically, Owusu (2000) asserts that, “The refugees were driven by their faith in God; they were willing to bury the internecine feuds, ethnic sectarian and factional hostilities that intensified the unprecedented brutalities of war that claimed over lives, caused inestimable property and environmental damage and forced hundreds of thousands from their homeland.” This is in itself a testimony to the resilience that Bonano (2004) discusses and this has helped several refugees to survive thus far on their own.

It therefore becomes significant that at the very least from an exploratory dimension, the study must seek to measure and utilize those essential Africentric values (of which spirituality is a part) that have helped the people survive these trying times.

The State of Refugees in Ghana

On World Refugees Day in June, 2013, the Chairman of the Ghana Refugee Board, Mr Ken Dzirasah pointed out that since 2010, the Refugee Board has received some nineteen thousand (19,000) applications from Ivorian refugees who were on the (Ampain) camp. In addition to this, there were eighteen thousand (18,000) asylum seekers from twenty-nine different countries from as far away as Iraq and others as close Sierra Leone and Togo. Of this number, 4,000 of the asylum seekers have also applied to become citizens of Ghana. This confirms the fact that Ghana is a decent host country to refugees.

A critical review of the literature however brings to light several key issues here. Firstly, it can be established that although a decent amount of work has been done around the lives of refugees in Ghana, most of the documented work has been rather exploratory

and descriptive in nature (Boamah-Gyau,2008; Essuman-Johnson,1992; and Owusu, 2000).

In Ghana there are only a handful of published works that document active psychological interventions that have been used in helping refugees, but there is no doubt that these interventions do occur. It is therefore expected that this research shall add to the action research that focuses on refugees. The lack of a documented and published intervention appears to strip the work of a local reference point against which this present study could be compared. Nonetheless, this present study still derives motivation from other researchers like Neuner et al (2004b), and Somasundaram (2002).

Again, several of the interventions appear to focus on specific sub-groups of refugees, such as women and children, particularly within the African context (Wessells, 2008; Allen, 1996; Amnesty International, 2000). This particular study actually tests a psychological intervention across a wider variety of refugees; of different genders, age groups, religious orientations and nationalities.

Furthermore, the historical trauma transmission model was originally developed to fit the experiences of children of holocaust survivors and survivors of Japanese concentration camps in the second world war (Rakoff, 1966; Danieli, 1998). The question arising is whether the same experiences can be seen within the African setting, particularly as we have not had a war on the same level as world war II. However, some literature exists to suggest that secondary trauma does exist in the African setting and there are also individuals who have experienced historical trauma on such a level (Machel, 2001; Ndengeyingoma et al, 2013).

A critical review of the literature brings to light several key issues here. Firstly, it can be established that although a decent amount of work has been done around the lives of refugees in Ghana, most of the documented work has been rather exploratory and descriptive in nature (Boamah-Gyau, 2008; Essuman-Johnson, 1992; and Owusu, 2000). In Ghana in particular, there are only a handful of published works that document active psychological interventions that have been used in helping refugees, but there is no doubt that these interventions do occur. It is therefore expected that this research shall add to the action research that focuses on refugees.

Expected Outcomes

Philips (1990), argues that the ultimate aim of NTU psychotherapy is to empower the individual to be in alignment with natural order, that is to say that they must be in harmony with their environment. It is expected that at the end of the therapy the client must leave with a sense of being more keenly aware of themselves and others. They must also leave equipped with skills and knowledge to help them better identify and manage problems not just in their lives but also in that of significant others. The study therefore seeks to investigate the effectiveness of NTU psychotherapy not just as a psychological intervention but also as a tool for transformation of traumatized families and by extension, communities.

Statements of Hypotheses

Hypothesis One: NTU Psychotherapy will lead to a decline in PTSD.

Hypotheses Two: NTU psychotherapy will lead to an improvement in psychosocial adjustment.

Hypothesis Three: NTU psychotherapy will lead to Greater Africentric Consciousness

Hypothesis Four: NTU psychotherapy will lead to a significant decline in hostility.

Hypothesis Five : Significant differences would exist in treatment scores among the three camps as participants go through the interventions

Efficacy Research: What is it?

Efficacy is concerned with the questions, ‘Does the investigational treatment cause an effect?’, ‘And can this treatment work under ideal circumstances?’ (Winstein and Lewthwaite, 2004). The study seeks to investigate if NTU psychotherapy can cause an improvement in the psychological well-being as well as social adaptability among refugees who are living in a somewhat controlled environment. Hence the study is an efficacy study. Efficacy studies are often higher in internal validity than effectiveness studies. Typically, effectiveness studies would have a more relaxed inclusion criteria, and thus, a less controlled environment.

The study was deliberately designed as an effectiveness study because it is aimed at investigating whether Ntu psychotherapy does work. Only a handful of research has been done in the field of Ntu psychotherapy (Philips (1990; Gregory and Harper, 2001). There is therefore a need to establish the fact that it works first. Then secondly it can be compared to other systems of psychotherapy to investigate if it works better than other established systems of psychotherapy. It should also be noted that the participants are from diverse backgrounds, with diverse experiences and have been refugees for different periods of time.

Summary of the Literature Review

This study seeks to investigate the effectiveness of NTU psychotherapy in the management of trauma among refugees. NTU psychotherapy is a culturally competent system of psychotherapy that firstly seeks to help the individual deal with their personal psychological problems and secondly to be able to function in a healthy manner in the community.

The study is guided by three theories namely Lo and Fung's model of cultural competence (2003), the biopsychosocial-spiritual model (Engels, 1977) and the Historical Trauma Transmission model (Wesley-Esquimaux and Smolewski, 2004).

Lo and Fung's model identifies that in culturally competent therapy there are two essential components; the ability to respond to the different issues that arise during the therapeutic process (generic competence) and the ability of the therapist to use the appropriate skill set and techniques to help the client while being mindful of their own bias or limitations as therapists (specific competence). The historical trauma transmission model explains how trauma can be passed from one generation to the other, thereby crippling an entire community even though the second generation might not have personally experienced the trauma.

In management of the trauma therefore, the biopsychosocial spiritual model (Engels, 1997) advocates that effective treatment must cover the four main domains of functioning. These are the biological which focuses on physical health, the psychological which focuses on mental health, the social which concerns primarily with our social functioning and the spiritual which focuses on our spiritual beliefs and the ability to draw strength from a higher power.

The concept of PTSD however needs to be well-explained and the DSM-V helps to emphasize the subjective nature of the individual experience that gives rise to a diagnosis of PTSD. Furthermore both the DSM-V and DSM-IV-TR underscore the role of cultural effect in giving rise to PTSD. Hence in order for persons with PTSD to receive the needed support, PTSD must be understood within the personal and cultural context in which it occurs and so treatment must be guided by the culture of the person struggling with PTSD.

Although NTU psychotherapy has been widely used for a variety of psychological disorders, there are not that many studies measuring its effectiveness. This study seeks to investigate the effectiveness of NTU psychotherapy as a culturally competent system of therapy and in consonance with the biopsychosocial-spiritual model.

Traditionally, trauma has been managed using other systems of therapy like supportive counselling, narrative exposure therapy and cognitive behaviour therapy, however NTU psychotherapy by its nature is not only curative but restorative in the sense that it aims at promoting healthy functioning and personal growth within the environment.

Competencies and Qualifications of the Principal Researcher

The NTU Psychotherapy training program was developed by Dr. Frederick Philips and the staff of The Progressive Life Center, USA. The training program requires that the candidate must have a Masters degree or be a graduate student in Psychology, Social Work or any other related discipline. The NTU certification course requirements are as follows:

1. Regular attendance to training programs that does not exceed three absences

2. Written essay or book report of three to five pages that examines issues relevant to the NTU approach to health and healing (i.e. Africentric thought, African philosophy, cultural competence, spirituality comparative treatment models) and demonstrates critical thinking and reflective processing
 3. A passing grade of 80 or more in the final written examination
 4. A written case presentation in the prescribed NTU format
 5. The presentation of a video or audio tape which shows a competent demonstration of the NTU approach to heal and healing with an actual client
- (NTU Psychotherapy Counseling Certification Training Program Manual, 2008).

The researcher underwent training in NTU psychotherapy in 2008 as a staff of PLC, Ghana. The principal instructors were Dr. Frederick B. Philips and Dr. W. Henry Gregory. This was prior to serving as a therapist, but more relevant to this study, a coordinator and psychologist on a trauma management project for former child soldiers of the Liberian Civil War in the Budumburam refugee camp. The program was run by PLC Ghana through its client organization, Mediators Beyond Borders (MBB) for former child soldiers of the Liberian Civil War.

Chapter Three

Research Design and Methodology

Introduction

This chapter seeks to outline the research design and methodology employed in this study in order to achieve the objectives of this research. Thus, this chapter shall seek to clearly identify the population, sample size and technique and it shall also outline the procedures involved in how the data was collected.

The study seeks to investigate the efficiency of NTU psychotherapy in the management of trauma among refugee population. The study focused on three major refugee camps. Budumburam, Ampain and Krisan were chosen because of the differences that the three camps appear to represent. One has a homogenous population, the other a highly diverse one, and the third has a homogenous population that has evolved into a melting point of sorts; one camp is a mini town, the other just doesn't seem to be able to grow and the third camp is yet too young to have assumed a 'complete identity' of its own.

Design

The design of the study is a multiple baseline design. A multiple baseline study is one that tracks more than one subject, behaviour, or setting over time and following a baseline (pre-intervention) condition, intervenes in each case but at somewhat different ('staggered') times (White, 2010).

In this study we can see how the three separate groups were treated and assessed at different times. We see an example of this in the results on the PTSD scale as shown below:

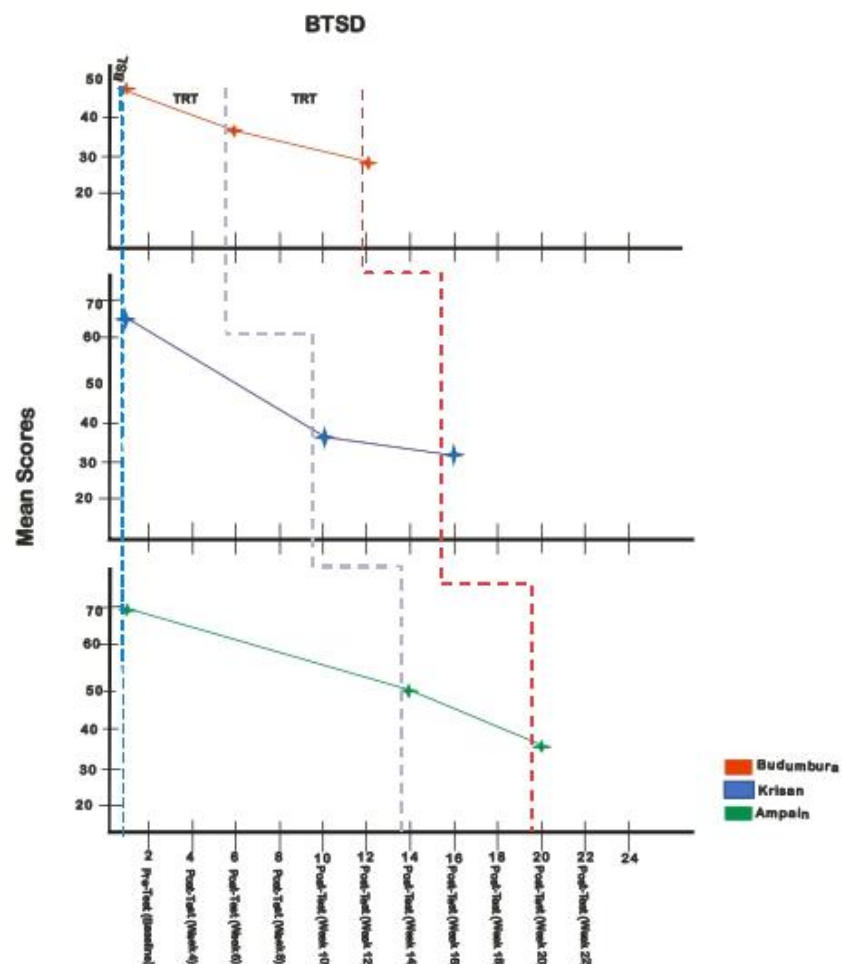


Figure 3. 1: Multiple Base Line Scores Across the Camps

From the table it can be seen that the three groups were each assessed at different intervals. Subjects in Budumburam were assessed first, began the intervention, and were assessed again and finally a third time. Subjects in Krisan began their intervention four weeks after the subjects in Budumburam and subjects in Ampain began their intervention four weeks after subjects in Krisan. This means that subject in the first group were assessed and their first scores (pre-test) were compared to the first post and the second post-test in order to measure if there were any changes in scores as the intervention progressed. At a different interval, the second group in Krisan began their intervention with a pre-test then a post test and then at another interval a second post test.

In a “multiple baseline” study, the word ‘baseline’ has two meanings; Firstly, as with all designs, it refers to pre-treatment or existing conditions — the conditions that existed before the intervention or new treatment is measured before the intervention begins. Subsequently different subjects (or, as in the case of this study, different groups) are measured at different times. Hence, each group has its own baseline score by which changes are measured. Secondly it refers to a particular subject, behaviour, or setting that will be tracked throughout the study, independent of other “baselines. Hence each group serves as its own control and throughout the study the different groups are measured at intervals.

There are several reasons and merits for using this particular research design.

- Firstly, every participant serves as his/her own control. The study therefore examines the changes in each participant independently.
- It also helps the study to avoid the challenge of dealing with a control group who might have to undergo the intervention for ethical reasons, once the effectiveness of the intervention has been confirmed.

Rhoda et al. (2011) asserts that, ‘The MBD makes repeated measurements over a period of time and introduces a sustained intervention on a staggered schedule; intervention effects synchronized with the staggered start times provide evidence for causal inference.’ Hawkins et al (2007) also argue that the multiple baseline design is quite useful in demonstrating that a change has been caused by an intervention. They also argue that it can serve as an alternative to randomized control trials which may sometimes present with limitations on practicality, ethical considerations and even cost implications when doing studies with population-based interventions.

Indeed, these were some of the challenges that guided the preference for a multiple baseline approach in this study.

Population

The population of interest for the study is that of refugees within the Budumburam, Krisan and Ampain refugee camps. These three camps offer a diversity of populations. Budumburam is largely home to a homogenous Liberian population. An estimated number of 45,000 people reside in the camp.

Krisan refugee camp is home to less than one-twentieths of that number; it houses approximately 1,100 refugees from different countries.

At this point, it is necessary to provide some background information on the various refugee camps. Each of them is unique in its own history and other demographic properties, for this reason, the needs of persons in each of the camps are different, both individually and collectively.

Budumburam refugee camp

As at 1992, two years after the Budumburam camp first opened, there were only about 8,000 refugees occupying it, but by 2007 there were about 45,000 persons in the camp (Romig, 2003).

Another noteworthy fact is that most of the refugees who came into the camp, back in those early days were educated, enterprising and professional young men and women, a rare case in most refugee camps in West Africa and globally according to Sanjugta, (2000) and Whitaker, (2003).

Over time several of the refugees have become economically independent. Most of the refugees are free to engage in one form of economic activity or the other. Most of them either farm or engage in some form of labour within the vicinity of the community.

This does not mean that the economic picture in the camp is a rosy one. Indeed, Boamah-Gyau (2008) asserts that ‘.....most of the refugees are unemployed. There are no facilities such as markets or factories that can trigger off a vibrant commercial society or even create job opportunities. A greater number of the refugees are idle and are involved in anti-social and criminal behaviours, especially the youth whose dream is to resettle in the United States of America or any European country. Well this may be their survival strategies. As such, it is not easy to find work as a youth who are living in the camp on their own effort without assistance from within the camp or relatives abroad.’ (p.49).

From a psychosocial perspective, he makes another interesting observation, ‘It is important to note that even though the Liberians at the camp are all refugees on foreign land, there is always tension between them. Many of them are quick tempered and

individualistic. It came up that for some, no day is successfully spent without inter personal fights, clashes over issues or differences and theft cases among others.’ Of course, hostility, suspiciousness and inter-personal challenges are all symptomatic of some forms of PTSD, and there is the danger of residents in the environment also developing some form of inter-generational or secondary trauma.

Krisan Refugee Camp

Krisan presents a stark contrast to Budumburam camp. It is located roughly forty-eight kilometres(48km) away from Elubo, the Ghana-Ivorian border and is about three hundred kilometres (300km) away from Accra. This is roughly a six-hour drive away from the capital city Accra. It is situated in the Ellembelle District of the Western Region of Ghana about 2 kilometers from Eikwe, and a kilometer away from Sanzule. Krisan has an estimated population of 1,500 people majority of whom are of the Nzema tribe. Krisan camp has hosted refugees from a wider variety of countries, namely Burundi, Democratic Republic of the Congo, Republic of Congo, La Côte d'Ivoire, Rwanda, Sierra Leone, Somalia, Sudan, South Sudan, Togo, Ethiopia, Eritrea and Liberia (UNHCR, 2003). Several languages are also spoken in the environment of the camp and these include English, French, Arabic and a smattering of several other dialects and foreign languages. Ironically however, in such a multi-cultural environment it lacks the industry seen in Budumburam, though UNHCR has taken steps to get refugees involved in income-generating activities. The hustle and bustle of Budumburam is absent from Krisan. At the entry to the Budumburam camp is a busy bus station which speaks volumes about the industry present there, but when one walks even a hundred metres into the Krisan camp one may at first be tempted into thinking that the place has been semi-deserted.

This is a point of interest for the researcher, because implicit in the aims of NTU is harmony and balance within the natural order. The fact that refugees in this camp are not in alignment with their environment means that they are having problems adjusting to the situation there and one of the ways this manifests itself is in economic hardship. This would also have its implications for their economic and social development.

The UNHCR representative in Ghana, Aida Haile Mariam asserts that, "Krisan's lack of vitality shows it is difficult to turn townspeople and intellectuals into farmers". Currently, Krisan is a temporary home to less than 1,000 (approximately 847) people searching for the sustainability of a new home, (UNHCR, 2012).

Ampain Refugee Camp

The Ampain refugee camp is the youngest of all the camps. It is also approximately 300 kilometers away from Accra and just about three miles away from Krisan refugee camp. It was established in March 2011, following the Ivorian crisis. As at April 2011, it was home to about 1,700 refugees. Most of the refugees still live in make-shift tents walled by bamboo sticks. The majority of the population appear to be mostly from the West and Southern parts of Ivory Coast.

Inclusion Criteria

Individuals who shall meet the inclusion criteria shall be individuals who experienced first-hand some form of violent conflict, forced removal, loss of property or loss of loved one in their countries of origin.

- i. Individuals must score above normal on either the BSI or the PTSD inventory
- ii. Individuals must score clinically significant levels on at least two items of the hostility inventory

- iii. Individuals must have been personally exposed to some measure of violence, loss, or threat of violence or forced removal during the civil war(s) in their country of origin

Exclusion Criteria

- i. Participants must not be mentally retarded (i.e. they must be capable of undergoing personal therapy and also partaking in group therapy).
- ii. Participants must be available for a period of at least eight to twelve weeks.

Sampling

A total number of twenty-four (24) persons took part in the study. This sample size was based on power analysis by Faul, Erdfelder, Lang, and Buchner (2007). Specifically, a priori type of power analysis was chosen for repeated measures (within factors) ANOVA statistical test. Input parameters were set at accepted conventional values of 0.25 for effect size (medium), alpha value of 0.05, power of 0.8, a single group, 3 number of measurements, a value of 0.6 chosen as the correlation among repeated measures, and a nonsphericity correction ϵ of 1. The output parameters revealed that the most appropriate sample size for the set input parameters was 23. Thus, a sample size of 24 is acceptable for this study. Participants were purposively and conveniently sampled from the population within the three camps. Although an initial target of about fifteen persons were targeted from Budumburam, only eight people met the inclusion criteria. During the course of the intervention two persons withdrew without any excuse. In Krisan, the study began with about twenty persons. Five withdrew after the initial screening. In Ampain, fifteen persons in all took part in the study, but eleven completed satisfactorily.

Sampling procedure

Although the same method was used in sampling and selection of participants there were slight variations in the numbers.

Figure 3. 2:

Breakdown of Participants in the Various Camps

	No. that expressed interest in the study	Final No. of participants in camp
Budumburam	8	6
Krisan	20	7
Ampain	25	11
Total	45	24

The study began in the Budumburam refugee camp. The researcher carried an introductory letter from the psychology department of the University of Ghana with which he went to the Ghana Refugee Board, the government agency with oversight responsibility for the management of refugees in Ghana. The Ghana Refugee Board gave permission for the data collection and intervention. They then furnished the researcher with a letter of introduction to the camp managers in the various refugee camps.

Budumburam

In Budumburam, announcements were sent out calling for respondents to take part in the program. Most of the individuals who were interested met with the researcher on an arranged day where he explained the aims of the study to them and what it would entail. Eight were able to meet the inclusion criteria to take part in the study.

There are about three apparent reasons why the number could have been so low in Budumburam. Firstly most of the refugees have been living there for between ten to twenty years and have had some exposure to previous systems of intervention including even counselling from religious leaders. Secondly most of them are able to go about their businesses relatively freely and so the initial tell-tale signs and symptoms of trauma could have been significantly reduced. A third reason could be that most residents of the camps were either indifferent to taking part of the study. Indeed, after not less than five announcements had gone round for over two weeks prior to the start of the intervention, less than twenty persons showed up. Interestingly enough, halfway through the intervention more people began to show up, expressing an interest in taking part. Eventually six people completed the program in Budumburam.

Krisan

In Krisan twenty persons expressed interest to take part in the program. This comprised 15 males and 5 females. Krisan however had the highest attrition rate. Again, this could be explained by economic factors. Most of the residents were engaged in such menial yet tasking jobs like cutting bamboo from the forest to sell or going to the seaside to draw fishing nets. A few also left to Accra on other personal businesses. For most of them therefore their participation was erratic. Eventually it was twelve persons who went through the intervention but seven completed satisfactorily.

Ampain

In Ampain, a total of about twenty-four people enrolled to take part in the program. This was by far, the largest number of participants in any of the camps. There are of course a few reasons that can best account for this.

- i. Ampain is the youngest of the three camps, having been established in 2010. It is just a little over two years.
- ii. Ampain has the most recent cases of trauma among the three refugee camps, since the Ivorian conflict is the most recent
- iii. Ampain residents are the least mobile of the three refugee populations, since they are relatively new and still do not know their way around the country.

In all, a total number of twenty-five expressed interest after the screening but a final number of eleven finished. One participant also dropped because he did not meet the minimum age requirements for the study.

Instrumentation

There were four main instruments used in assessment for this study. These are the Brief Symptom Inventory, The Buss-Durkee Hostility Inventory, The PTSD Checklist – Civilian Version, and the Belgrave Africentrism Worldview Scale

The Brief Symptom Inventory

The Brief Symptom Inventory (BSI) was developed by Leonard R. Derogatis (1975). It is a brief psychological self-report scale that measures for psychological distress within nine sub-scales. The test is a 53 item self-report scale that uses a five point Likert scale. It takes approximately four minutes to administer. The test can be administered to individuals 13 years and older. It measures along nine clinical sub-scales namely:

- i. Somatisation
- ii. Obsessive-Compulsive Disorder
- iii. Interpersonal Security
- iv. Depression
- v. Anxiety
- vi. Hostility
- vii. Phobic Anxiety
- viii. Paranoid ideation
- ix. Psychotism

The authors report good internal consistency and reliability for the nine dimensions, ranging from .71 on psychotism to .85 on depression. Good internal consistency reliability is supported by several other independent studies (Aroian and Patsdaughter, 1989 in Derogatis 1993; Croog et al, 1986). Many other studies have also demonstrated the utility of the measure in accurately identifying distress in samples from various ethnic backgrounds. Internal consistency estimates and triangulation of individual BSI global and sub-scores with verbal and self reports and clinical assessments demonstrate that the BSI is a relatively reliable and valid cross-cultural measure of global psychological distress (Aroian, Patsdaughter, Levin & Gianan, 1995).

The Buss-Durkee Hostility Inventory (BDHI)

The Buss-Durkee Hostility inventory (BDHI) (Buss and Durkee, 1957) is designed to measure individual differences in trait hostility (66 items) and guilt (9 items). The Inventory is thus made up of 75 items which measure hostility along 7 sub-scales or better yet, it investigates how hostility may be expressed in seven different ways.

- i. Assault

- ii. Indirect Hostility
- iii. Irritability
- iv. Negativism
- v. Resentment
- vi. Verbal Hostility
- vii. Suspiciousness

The test has been shown to have good internal reliability and test-retest reliability. An early study reported good Kuder-Richardson 20 reliability for measures of overt and covert hostility (.76 and .72 respectively; Bendig 1962). Two week test-retest data also appears to be adequate (total scale .82 with subscales ranging from .64 - .78, Biaggio et al, 1981).

With regards to the validity of the BDHI, Matthews and Saal (1978) found that there was a high correlation between the BDHI score and that of other self-report scales for anger measurement.

The PTSD Checklist-Civilian version

The PTSD Checklist-Civilian Version (Weathers, Litz, Huska & Keane, 1994) consists of 17 questions. Responses are scored according to a five-point likert scale. The instrument was originally designed to measure symptoms of post traumatic stress among Vietnam veterans (PCL-M). In a sample of forty motor vehicle accident and sexual assault victims, Blanchard, Alexander, Buckley and Forneris (1996) found an Alpha of .94 and an overall correlation of .93 between the PCL-C and the CAPS (Clinician administered PTSD Scale). The researcher undertook a pilot study with respondents from the general population within the Tema area and an alpha co-efficient of .903 was obtained.

Ventureyra, Yao and others (2002) undertook a study to validate the French version of the BSI. In their study, 113 patients suffering from PTSD were compared to 31 persons within the normal population. In their study they found that the internal consistency of the PCL-C was good. An internal consistency score with a Cronbach α 0.86. Test-retest reliability scores of 0.80 were also obtained for the test.

The Belgrave Africentric Worldview Scale

This scale consists of 23 items that can be subdivided into six factors of Spirituality, INTUition, Sensitivity, Respect for Elders, Communalism and Orality. It was developed by Belgrave et al (1997) to assess Africentric values of African Americans. Items in the scale correspond to the seven principles of Nguzo Saba (fellow feeling) which are unity, self determination, collective work and responsibility, cooperative economics, purpose, creativity and faith. It includes questions such as, ‘my successful achievements are due to the support of significant others’, and ‘I can tell when a close friend is in trouble or feels bad’. Cronbach’s alpha for the scale is .63 (Belgrave, 1997). The researcher undertook a pilot study to measure the reliability of the BAWS. The initial Alpha value gotten was .534. Hence, item 9 was first deleted to yield an Alpha value of .571 since it contributes most negatively to the scale. When item 7 was also deleted, it had an Alpha value of .593 followed by item 3 which yielded an Alpha value of .602. This correlates rather closely with the co-efficient obtained by Belgrave (1997) herself.

The Belgrave Africentrism Worldview scale has come under some criticism in some academic circles. For instance, there are those who argue that the scale appears to measure more of African-American culture than it does measure African cultural values or Africentric worldview. A few factors need to be noted here.

The continent of Africa is made up of several cultures and in fact even races. As a matter of fact, Africa, has an estimated 3,000 ethnic groups that speak approximately 2,000 dialects. For instance in the Northern part are the Maghreb who are more of Arab descent and then south of the Sahara are the negroes who can further be broken down into other sub-groupings. Some of them are nomadic, others are peasant farmers and others are yet still desert dwellers. Each grouping has a distinct language or dialect, distinct foods native to where they reside and distinct rites of passage, marriage, religious beliefs dressing and so forth, all of which are largely influenced by the location, history, and experiences of the people. It is therefore the values and belief systems of the people that defines Africans. Such beliefs, for instance, have transcended the continent of Africa, and even in the Americas and isles of the West Indies, one still sees these values at play. Unity, self-determination, collective work and responsibility, cooperative economics, purpose, creativity and faith are all values that most African communities and persons of African origin try to inculcate in their children and transmit to the society. It is these values that the Belgrave Africentrism Worldview scale seeks to measure and not necessarily an individual's skin coloration or for that matter geographical location. Indeed, one may argue that there are people today who may be of African descent and may have been born and raised in Africa but shy away from such traditional values. From a very subjective perspective, one may argue that such people may be losing their identity. It would not be the first time in the history of the world or even in the history of the continent that such has happened.

Ethical Clearance

Ethical Clearance was sought from the Institutional Review Board (IRB) of the Noguchi Memorial Institute for Medical Research. The researcher was granted clearance and provided an annual report to the IRB for the duration of the study till the

intervention was completed. Individuals who agreed to take part in the study had to fill a consent form which was available in both English and French. Both languages were made available to the IRB for approval. A copy is attached in the appendix section of this work.

Interpreter

The services of an interpreter was used in the Ampain and Krisan refugee camp. This is because the camp was comprised of Ivorian refugees most of whom could not speak English. A few of them could speak a smattering of Twi, but most of them were more comfortable in French. The interpreter, Mr. Jacob Francis Ahoua is one of the liaisons between the camp authorities and the refugee community. He holds a Bachelors Degree in English studies and prior to being engaged in this program he had already worked with OXFAM on the camp and in the camp manager's office as an interpreter.

The use of interpreters in research has been a major cause for concern because of associated challenges with how they affect the validity of the information given by participants. This concern is more apparent in qualitative research (Plumridge et al, 2012). The accuracy of the information being transmitted by an interpreter between the researcher and the respondent can not be completely free of bias (Squires, 2008). Even when other researchers who are bilingual in the language of the respondents and the researcher have reviewed responses there are still variations between their interpretations and that of the interpreter. However it appears there are no firm and clear rules as to how interpreters should be used especially in clinical or qualitative research (Kapborga and Bertero, 2002; Plumridge et al, 2012; Jentsch, 1998).

Plumridge et al (2012) however set out some general guidelines in the use of interpreters in research. Firstly interpreters must be prepared prior to undertaking the research. They

need to understand the aims of the study, their roles to play and other such relevant issues like client confidentiality and so forth. Secondly they recommend that the seating arrangements should be in a triangular form to ensure that there is eye contact among all participants namely the researcher the interpreter and the respondent(s). In addition to this, the researcher must still strive to build a personal relation with the participants as this will still influence their willingness to open up on issues of significance to the study. Non-verbal information is also important. The researcher must be aware of non-verbal cues and should be able to read them as they can be quite instructive. It should however be noted that in spite of all these efforts to ameliorate the impact of the role of interpreters there will still be challenges.

After the researcher met and introduced him to the aims of the study, Mr. Ahoua agreed to help by being both an interpreter and a liaison in the camp. He also proved to be quite helpful in organizing schedules for participants in the camp.

Prior to any session with the participants in the study, the researcher met with the interpreter to explain what was to take place in the session. The objectives of the session were explained and the interpreter was equipped with the necessary skill set to convey the intended message. Such techniques as empathetic listening, tone of voice, and reflective listening were all part of the training he received so as to enhance the therapeutic process.

Pan (2007) argues that in the uses of interpreters for survey interviews there are certain issues that must be taken into cognizance. Firstly, there is the issue of the competence of the interpreter. The next issue is to determine what level of training the interpreter needs. This is in order to reduce errors of translation.

In as much as there is an inherent risk in the use of interpreters for research, it can be significantly reduced by adhering to the recommendations proposed by Plumbridge et al (2012) and Pan (2007) this does not mean that there will be uniformity of meaning but the key concepts are less likely to get lost. Indeed, as Plumridge et al (2012) put it, ‘even when bi-lingual colleagues have reviewed interview schedules and commented on any other potential difficulties before interviews have begun, interpreters can still identify other issues (p.192).’

Reliability of The Measures

A pilot study was conducted to examine the suitability of the instruments. The data collection was employed using 50 healthy controls. Among the healthy controls the youngest participant was 19 and the oldest was 51. 12 of the participants (24%) were female and 38 (76%) were males. The analyses revealed an alpha for PTSD questionnaire was .888, BSI questionnaire was .950, BAWS questionnaire was .611 among the clinical samples. Among the healthy samples, Cronbach Alpha for PTSD questionnaire was .903, BSI questionnaire was .951, the BDHI was .72 and the BAWS questionnaire was .603. So far as the validity and reliability of the original scales as well as this pilot study are concerned, the measures and method of data collection are appropriate for this study. The table below shows alpha values from the pilot study and from other related studies as well.

Figure 3.3 Reliability of Instruments from Related Studies and Pilot Studies

Instrument	Reliability from related studies	Reliability from present study
BSI	.71-.85	.951-.754
BDHI	.76	.72
PCL-C	.94	.903
BAWS	.63	.602

For participants from Ampain, they used French versions of the questionnaire. The Cronbach Alpha for the BSI questionnaire was .979.

Procedure

The researcher received an introduction letter from the department of psychology of the University of Ghana, which he then presented to the Ghana Refugee Board. The board approved the study and gave the researcher three separate introduction letters to the managers of the various camps. One letter was addressed to the camp manager at Budumburam, in the central region. The second letter was addressed to the manager at the Krisan refugee camp in the western region and the third to the manager at the Ampain refugee camp also in the western region.

During the first visits in each camp the researcher was provided Liaisons in the camps. These individuals helped to disseminate information about the study and also help in the recruitment of participants. The main reason for this is that each camp is different in terms of geography and demographics and so reaching them requires some help, particularly from someone known and trusted. The liaisons sent out the message in each

of the camps and informed people of the incoming research. On an appointed day, the researcher met the interested parties and explained the aim of the study as well as the expected commitments for the study. They were also informed of the inclusion and exclusion criteria for the study.

Those who were interested in the study then came forward for the pre-screening. Individuals with clinically significant scores were then shortlisted and began the study.

The first part of the intervention comprised individual sessions and the latter part was made up of group sessions. All participants went through between ten to twelve sessions of therapy. A complete program of NTU culturally competent psychotherapy is made up of five phases namely Harmony, Awareness, Alignment, Actualization and Synthesis. Below is an in-depth description of what happened in each stage.

Harmony Phase

During the harmony phase the main objective is to develop a shared experience or consciousness with the client-system. The focus is for the therapist and the clinician to bond together. In this case, the researcher met each of the participants individually during the first session. Special attention was paid to bonding with them and this was through a variety of techniques such as humour, self-disclosure and discussing issues unrelated to their problems (sports, family, spirituality, etc.). The session also aimed at clarifying the aims of the intervention and establishing expected outcomes at the end of the intervention. The participants also opened up to the researcher and discussed the nature of their problems and the outcomes they expected to have at the end of the programme. This lasted for two sessions.

Awareness Phase

During the awareness phase, the main task is to help the client develop an initial recognition of their problem behaviour more or less from a cognitive perspective. During this phase the person is helped to recognize the presence of some destructive behaviours or patterns. During this phase, the participants (individually) met with the researcher and discussed their past experiences during the war and the present challenges they were facing. They also discussed the nature of their presenting complaints during the initial pre-screening phase. During these sessions, as they discussed their past experiences, the researcher explored with them how these experiences could have played a role in influencing their present circumstances. For instance, Celine's (real name withheld) husband suddenly disappeared during the war and she waited alone for him for days and days till other people fleeing the conflict convinced her to leave. She has since not returned to Liberia, not knowing whether any of her family are alive or not. She does not enjoy leaving the safety of the camp either, because she is more comfortable with having familiar faces around her. The Awareness stage lasted for two sessions.

Alignment Phase

During the alignment phase the main task is to help the client to uncover and reconcile his anxiety. Typically, issues in the alignment phase will emanate from those matters that were raised in the awareness phase. The majority of participants in the Krisan refugee camp, for instance were mostly worried about making ends meet to take care of their families, but genuinely felt powerless to do anything because they felt their host organization (The United Nations) had abandoned them. This is a very common issue

in most refugee camps. During the alignment phase, the respondents began to realize that they perceived the camp as a sort of safe zone for which most of them were not prepared to move out from. They were less adventurous in searching for means of a livelihood and were happily huddled among their peers in the camp. For this reason, they were resistant and uncomfortable about the prospects of moving out of the camp to even undertake or investigate a wider variety of economic activities or even tentatively initiate some commercial activities in the camp. This was now starting to affect their families and the quality of life they could otherwise have enjoyed.

In the words of one of the participants, ‘All of my family is gone; I have no mother, no father, no siblings. I am the only one left to continue the (family name) line and all my children are daughters.’

Others were also encouraged to start investing time, energy and other limited resources into other ventures such as market gardening and so forth. The Alignment stage lasted for three sessions.

Actualization Stage

In the actualization stage, the clients began to experiment with new techniques in approaching their problems. They then evaluate the success or otherwise of the experiments in their opinion. In Budumburam, for instance, the clients began to move out of the camp in order to fend for themselves and their families. They then began to evaluate the results of stepping out and seeing what results the external world had availed to them. Typically, the Actualization stage lasted for two stages.

Synthesis stage

This stage is the last stage of the NTU process. During this phase it is expected that the client should be able to fuse their understanding of themselves and the nature of their challenges with the changing behaviour and attitudes that they have acquired in their therapy sessions. At this stage the participants not only experience a solution to the initial challenge that brought them into therapy but they would also have developed other problem solving skills which they can also use to manage other future difficulties with a measure of reassurance.

In this stage the participants met to discuss how successful they had been in trying out some of the new techniques. The synthesis stage lasted for just one session.

It would be realized that these five stages of NTU psychotherapy appear to agree very much with Lo and Fung (2003) in their assertion that culturally competent psychotherapy would be made up of the five stages of pre-engagement, engagement, assessment and feedback, treatment, and termination.

The Duration of NTU Psychotherapy

Ntu psychotherapy by its very nature is highly responsive and guided by the needs of the client. Refugees by the very nature of their experiences are people who need a tremendous amount of help to deal with a variety of problems. According to Tyszka (2011) challenges that refugees will face include problems with integration, economic problems, language and communications difficulties just to name a few (Banki and Lang, 2008). On a sombre note, she asserts that ‘It is also important to note that not every refugee will resettle’. One must be prepared therefore to accept that some refugees will struggle to integrate with their fellow refugees and should they return home, they will struggle to fit in as well.

Against this background then it must be noted that one must not expect NTU psychotherapy to be able to fully resolve all or even the majority of challenges that refugees face every day. Realistically, therefore eight to twelve sessions of NTU psychotherapy cannot heal a refugee completely, but it can help deal with some of the biggest problems that they may be facing.

There are at least three ways in which this twelve-session intervention is expected to have helped the refugees.

- i. It has helped significantly reduce presenting physiological complaints such as headaches, insomnia, panic attacks and so forth.
- ii. It also helps deal with psychological pain and hurt such as sense of betrayal, abandonment and mistrust, all of which were major issues for most of the persons who took part in this study
- iii. It provides empowerment for participants by giving them insight into the nature of their problems and helping them to see themselves as agents of positive change in the (refugee) community by helping their families and communities with the skills, lessons and values acquired during the intervention.

Chapter Four

Study One

Introduction

The next three chapters seek to achieve the objectives of the study. Chapter four examines the qualitative component of the study. It seeks to speak to the first objective, i.e. to identify the main challenges among refugees in the camps

Chapter five is the quantitative component of the study and is committed to investigating the second and third objectives.

Chapter six discusses the results and findings of the research. In chapter six however, the study also discusses the main techniques that were used in the intervention process. It became necessary to discuss them in chapter six because the problems and challenges identified in chapter four were managed using a variety of techniques discussed in chapter six. These techniques evoked certain major responses among participants and they are discussed as themes mostly in response to the problems that they had identified in chapter four.

The Main Challenges of Concern Among Refugees in The Refugee Camps

As stated earlier, the main objective of this research was to investigate the effectiveness of NTU psychotherapy in helping refugees to manage trauma and the sense of loss they may have to deal with in the refugee camps.

For this matter, the specific objectives included to:

1. Identify the main psychological challenges of concern among refugees in the refugee camps

2. Investigate if NTU psychotherapy can lead to an alleviation of signs and symptoms of trauma
3. Investigate if differences will exist in the recovery levels among participants in different refugee camps

The objectives therefore necessitated a mixed method approach to the study. An exploratory/qualitative approach was used to investigate the first objective and a quantitative approach was used to investigate the second and third objectives.

Qualitative Study

Qualitative data was collected during the initial stages of the study. During this phase, each participant had four individual sessions with the researcher. This allowed the researcher to glean information from them regarding their present challenges and how past events may have contributed to them. The goal at this point was to identify the major challenges that each participant was specifically facing. Some of the conversations were audiotaped but other participants expressed discomfort with being audiotaped and so the researcher had to take notes.

Population

The target population for this study was of refugees who had been directly exposed to trauma and were presently residing in the refugee camps. Hence the study focused on persons who were dealing with primary trauma.

Inclusion Criteria

The inclusion criteria was that the person must be resident in any of the three refugee camps and must have directly experienced some traumatic experience during the

conflict in their home country. The individual must also be capable of narrating the experience and expressing their present fears and concerns that they are facing in the refugee camp

Exclusion Criteria

Participants must not be mentally retarded or suffering such impairment as to render them incapable of such cognitive functioning that they could understand or respond to interactions either individually or in group therapy were excluded from this study. Individuals who had not personally experienced any traumatic or violent events were also excluded from the study.

Demographic Analysis

An analysis of the respondents showed that of the 24 participants 15 were men (62.5%) and 9 were women (37.5%). The youngest participant was 14 years old and the oldest was 67 years old. Two of the participants were below sixteen years of age and therefore classified as children. The two children were all located in Ampain refugee camp.

A demographic analysis showed that of the twenty -four participants who agreed to take part in this study, nineteen were Christians and five were Muslims. All the five Muslim participants were from Krisan camp.

Thematic Results and Discussion

By focusing on dominance, frequency and intensity of the problem as reported by participants, three dominant themes were identified. These were primarily grouped into economic challenges, assimilation challenges, and challenges based on recalled experiences.

Dominant Themes

Subordinate Themes

Economic Challenges

Ability to cater for one's basic needs

Ability to cater for daily family's needs

Getting a sustainable livelihood

Access to healthcare

Assimilation Challenges

Challenges living with ethnic groupings
in the camp responsible for their trauma

Challenges adjusting with indigenous
culture

Challenges of Recalled Experiences

Challenges with reliving traumatic
experiences

Challenges with remembering unpleasant
memories

Economic Challenges

Although this was not one of the main issues that the study was concerned with, it kept resurfacing persistently. NTU psychotherapy aims at ensuring harmony between the individual and the environment. It is for this reason that NTU psychotherapy identifies the tenet of cooperative economics (Ujaama) as one of its core goals. This advocates

that the individual must see money as a tool of personal development and not a source of pleasure (Philips, 1990). Thus, individual wealth grows and sufficiency grows as the common economy develops. As has been stated earlier, quite a number of persons who had even earlier expressed interest in the study pulled out upon realizing that there was no financial reward involved in the study. Financial security is therefore a highly placed need within the refugee camps

This should come as no surprise. Although a lot of literature expresses safety concerns as a major concern for refugees, that hardly surfaced as an issue in this study. Ghana being a relatively peaceful country, the refugees have very little fear of being attacked and so they enjoy relative safety.

In Budumburam and Krisan, the two oldest camps it became clear that most of the participants in the study had been in the camp for a number of years, ranging from between five to fifteen years. Most of them therefore felt relatively safe in the camp. Some of them venture out of the camp for the occasional menial job but most of them are unable to hold onto sustainable, long term jobs. Refugees in Krisan, for instance would travel all the way to Accra to work as labourers on projects. Economic concerns permeate virtually every challenge that refugees go through. Within the context of economic concerns three main concerns kept coming up: ability to cater for their own basic needs, ability to cater for the needs of their dependants, access to healthcare and access to sustainable livelihood.

Ability to Cater for One's Basic Needs.

For most refugees, the basic needs of concern are food and medical care. The UNHCR and World Food Programme (WFP) work together to ensure that dietary needs are met.

Since 1997, the policy has been that for refugee situations of less than 5,000 people the UNHCR can manage them, but beyond that number, the WFP intervenes and both organizations work together hand in hand. Unfortunately, the WFP is not always timely in supplying food to the camps. In the case of Budumburam, most of them have stopped receiving rations and so they are compelled to find other ways to get food. This can be quite challenging.

SC lives in budumburam with her daughter and three grandchildren and puts it like this,

‘when we first came here they were giving us rations. It wasn’t too much but it was still something. Now the UN has abandoned us. They don’t care if we live or die. Sometimes my daughter has to leave the camp and spend three days outside before she can bring us something to eat. And the small food you get you must first consider the little ones. Exile is not a good thing, my brother. We didn’t choose this life. Sometimes you go for days with just little bread and water.’

Access to Healthcare

Most of the refugee camps have clinics located within, but they are equipped to respond to the most basic needs. Although refugees have access to major clinics within the locality it can prove rather challenging and most of them have piled up huge debts.

Below are excerpts from two of such situations:

GCE was 12 years old at the time of the study and is one of the youngest participants in this study. He was also suffering from Asthma and eye problems. Apparently, however he did not have an inhaler to help him manage the asthma.

Another participant from Sudan also expressed his frustrations with getting access to healthcare.

“I was shot in the groin in Sudan as I was running away from soldiers. They did an operation on me, but you see in Sudan the hospitals are not good. They could not remove the whole bullet and I still have some stuck in me. I went to Ekwe hospital and they said it was not there. Then I went to 37 (military hospital) and they also said it was not there, but I still feel it. I know that if I have the money I can pay for them to remove it at 37” (BA, Krisan)

Ability to Cater for One’s Dependants

Most participants measure their ability to cater for their family in certain areas: food, education, accommodation and health.

Some of the refugees arrived in the camp with their families and others have started families in the camps. Some of the refugees in Budumburam for instance have been in Ghana for over twelve years. Although the UNHCR does make arrangements to ensure that the children’s education for instance goes uninterrupted it is apparent that most parents try to take their children to private schools believing they offer higher standards of education.

MZ lives in Budumburam with his two sons. His wife left him because he was having difficulties providing for them. He expressed his opinion in the following words, ‘I have to make sure that the boys have a more secure future than me. It’s not easy but that’s why I put them in private school. The schools in the camp are just not good and I want a better life for them. Sometimes I pay part of their school fees and there’s nothing left for food. But if things will work I don’t know how. I don’t even know what job I can do to survive but the boys education is the most important.’

Access to Sustainable Livelihood

Of all the three camps, the Budumburam camp is the one closest to Accra. Nonetheless, a lot of the refugees have problems getting access to jobs. Several of the refugees have received training in different skills including some even as complex as Information Technology and Computer Competence (ICT), Soap Making, design of elephant pit latrine and so forth. They however report that they cannot gain employment with these skills. CW, a 46 year old woman put it thus,

‘They came to teach us how to make soap, but they didn’t give us any money that we can start with. The few of us who tried to make the soap, nobody would buy it. How can you keep doing the soap if you can’t sell it?’

AKS, a 34-year-old man had used his initiative to independently study ICT at an ICT training centre at a nearby suburb of Accra but three years after having completed it he was still struggling to get a job even as an attendant at an internet café.

There is no doubt that these individuals have a desire to be responsible citizens making a decent and honest living, but the challenges highlighted here raise several questions; what informed the choice of the skills training that were made available? Did the UNHCR or other supervising agency undertake any sort of market analysis before deciding what kind of training they needed? How easy would it be for them to transfer these skills to their home countries upon their return?

The acquisition of these skills raises the optimism of these refugees in their hope to cater for themselves and their families. When these skills fail to open work opportunities it enhances their despondence. It is therefore commonplace to hear the refugees expressing a lot of frustration especially with the UNHCR.

Assimilation Challenges

Broadly speaking, assimilation challenges were of two types. The first was to do with living on the camp with people from diverse groupings, some of whom had visited violence on others at the peak of the war. The second was to do with adapting with the local indigenes in the areas surrounding the refugee camps.

Challenges of Adapting with indigenes

This refers to challenges in mingling with the local indigenes in the various communities where refugees find themselves. From the interactions with the respondents it became apparent that some of them still struggled from a strong sense of alienation even in the host country (Ghana). SC has been resident in Budumburam since 1999, but according to her, ‘Anytime I leave the camp I become so uncomfortable. In the ‘trotro’ (the bus) the people are speaking and I don’t understand what they are saying. I can’t even do business with them because I don’t understand them and they don’t understand me.’

Most Liberians speak English, but the Liberian accent is not easily understood by most Ghanaians and obviously, not only does this affect their ability to undertake basic transactions, but it also hinders their ability to relate well with local people who could be of tremendous help in several ways.

In Krisan, the same problem was also apparent. During the fishing season, one of the most common economic activities was to go to the nearby town of Eikwe to help in pulling of fishing nets. This is however a social activity that entails a lot of communication. For those who are able to relate well with the people, they are able to get the opportunity to work with them and they normally get some fish to take home.

A few others have not had such luck and complain that the people are not interested in working with them. Most of the persons who had such problems were unable to communicate in basic English or any other local language.

Another common belief is also that their refugee/foreigner status prevents them from getting jobs. Most of the refugees even in Krisan and Budumburam can only speak a smattering of the local languages and so they stick out as refugees when they go seeking employment. This may create uncertainty among local employers who may feel that they may not be able to work well with them or they might even have some mistrust for them.

It is therefore quite common to find refugees who have lived in the country for over a decade and yet have made very little headway with acclimatizing to the Ghanaian terrain. At this point however, one can not say that mastering the local dialects or even being able to communicate with indigenes would automatically help one assimilate but it would go a long way to helping the refugees feel more at home.

Challenges of Coexisting with Members from Other Ethnicities

This was also another major challenge. In Budumburam, for instance, refugees are from one ethnic group or another. The dominant groupings in the camp are the Krahn and Americo-Liberians. Although most of them have managed to get along quite well with each other, there are still a few persons known to have been involved in the fighting during the civil war. Some of the respondents suffered personally at the hands of such individuals and have not forgotten them. As a result of this, there is a lot of petty quarrelling within the camps. Of course, aggression is also a sign of trauma and so people constantly fighting and bickering could be a larger symptom of trauma. But it

also goes to show that there is still a lot of unforgiveness, anger and bitterness among the refugees.

In a related encounter, the researcher had the privilege of meeting one of the refugees who fought on three different sides during the war as a child soldier. That is to say, he fought with three different factions depending on wherever he found himself. Although he declined to take part in the study, he indicated that he tried to get along well with everyone but generally kept to himself because he felt sure that he had done some harm either directly or indirectly to someone in the camp. This particular experience suggests that

This challenge however did not appear too strongly in either Krisan or Ampain. Krisan hosts refugees from several different African nations and from several backgrounds. It would appear however that most of them have created bonds along the lines of language and religion. Although several of the refugees speak a smattering of English, most of them appear to communicate among themselves using Arabic and French. The few however who were in the minority, did not express having significant problems but it was apparent that they did not generally mingle much. Although the English-speaking refugees and French-Arabic speaking refugees reported no tensions among themselves Interestingly, these refugees who could speak English had managed to secure some more stable employment within the surroundings of the camp and so spent more time outside.

Challenges with recall of Unpleasant Experiences

Flashbacks and recall of past experiences are a common symptom of PTSD (Kulka, et al, 1990). Apparently the more intense the experience, the more likely the individual will encounter these challenges of recall. These memory flashes have a way of

interfering with the functioning of the individual struggling with PTSD. Generally, they were identified in two ways among participants. There were those who were reliving past experiences as if they were occurring again and there were those who kept having disturbing images flashing up every now and then.

Reliving Traumatic Experiences

During the interviews some of the participants intimated that they were having constant bouts of panic and anxiety. Most of these episodes were brought on by cues associated with their experiences during the conflict. In the words of MZ 39, from Liberia,

‘Anytime I have to go to town, it can be really hard for me. Anytime we get to a security check point and I see people with uniforms and machine guns my heart begins to pound. I remember the soldiers who used to attack us back in Monrovia.’

JC, a 38-year-old man also from Liberia told us about the things that trigger his recollection. ‘I hate the forest. I hate bushes, I hate being alone in the bush.’ JC narrated that during the Liberian civil war he spent long periods in the forest area on the run from rebel forces. Eventually, when he got caught he had to serve as a child soldier, carrying food, weapons and other logistics for fighters. He was never sure when or where the next attack would come from and so the forest became a very uncertain and fearsome place for him.

MZ also talks of having recurrent dreams in which he sees his beheaded uncle.

‘He took care of me after my died. He was my father. I think I was around nine years old at the time. When they cut his head, they made me hold his head and they took photos. I know them. I know their faces and that is why I can’t go back to Liberia.’

As a result of this, he struggles with bouts of insomnia. These recurring flashbacks are a common symptom of PTSD. What is remarkable however is that for Liberian refugees, most of these experiences are at least fifteen years old. The DSM-V however, does accept that in some cases the onset of PTSD may be several years after the actual event.

Intrusion symptoms are a key symptom of PTSD as identified by the APA (2013) in the DSM-V but it is remarkable that for refugees who have lived in the relative safety of a peaceful host nation, they still continue to struggle with some of these things.

Challenges with Recall of Unpleasant Memories

Beyond the traumatic events of the war, participants also struggle with recollections of unpleasant personal experiences. Some of these experiences have led to blame, feelings of guilt and anger as well as loss.

YK (67 years old) used to live in France, but had to come down for her sister's funeral. That was when the war broke out and she could not return. Her brother was a colonel in the Ivorian army but was killed when the fighting broke out. Although she has family in France who can help her, it appears they've all abandoned her and she's alone in Ghana. This has left her feeling angry and depressed.

TS (19 years old) was in school when peacekeepers came driving through their town in a convoy. Behind them was a huge crowd of people. At a security barrier a white soldier shot one of the youth and a fight ensued. Her best friend's father who was also a soldier was kidnapped and never seen again. They ran away from the town with her boyfriend. After they ran out of food, her boyfriend went with some friends for food and that was the last time she ever saw him. Since then she continues to struggle with feelings of

guilt, self-blame and depression. Not only has this affected her ability to function in the present but this feeling of guilt and doubt make it difficult for her to plan for the future.

From the above, it can be seen that past and present challenges being faced by the refugees are not only influencing their present circumstances but it has the ability to influence their future.

CHAPTER FIVE

Study Two

The Effectiveness of Ntu Psychotherapy in Alleviation of Symptoms of Trauma

This chapter focuses on the second and third objectives of the study and seeks to investigate them by undertaking a quantitative study. The second and third specific objectives of the study were as follows:

1. Investigate if Ntu psychotherapy will lead to an alleviation of signs and symptoms of trauma
2. Investigate if differences will exist in the recovery levels among participants in different refugee camps

To pursue these objectives, there are four main hypotheses that were investigated. These are as follows:

Hypothesis One: Ntu Psychotherapy will lead to a decline in PTSD among refugees.

Hypothesis Two: Individuals who undergo Ntu psychotherapy will show significant improvement in psychosocial adjustment

Hypothesis Three: Individuals who undergo Ntu psychotherapy will demonstrate a greater awareness and consciousness of their africentrism.

Hypothesis Four: Individuals who undergo NTU psychotherapy will show a significant decline in hostility over time

Hypothesis Five: Significant differences would exist in treatment scores among the three camps as participants go through the interventions

The One-Way Analysis of Variance (ANOVA), One-Way and Two-Way Repeated-Measures Analysis of Variance (ANOVA) were mainly used in this current study to analyse these various hypotheses. In addition, where significant difference exists for the main effects, the Bonferroni test was used as a post hoc test to determine the exact group difference. The twenty-second version of the IBM Statistical Product and Service Solutions (SPSS) software was used in analysing the data.

Demographic Characteristics of Participants

The study used a total of twenty-four (24) participants with a mean age of 36.17 years, standard deviation of 13.7 years, and an age range of 14-66 years. These include 13 (54.2%) males and 11 (45.8%) females. Further details of the demographic characteristics are presented in Table 5.0.

Table 5. 0: Demographic Characteristics of Participants

Groups/Sex	Frequency			Percentage		
	Males	Females	Total	Males	Females	Total
Krisan	6	1	7	46.2%	9.1%	29.2%
Budumburam	4	2	6	30.8%	18.2%	25.0%
Ampain	3	8	11	23.1%	72.7%	45.8%
Grand Total	13	11	24	100.0%	100.0%	100.0%

Hypothesis One: NTU Psychotherapy Will Lead to a Decline in PTSD

The first hypothesis stated that individuals who undergo NTU psychotherapy would have a significant decline in PTSD over time. This was assessed using the PTSD Checklist Civillian Version (PCL-C). The Two-Way Repeated-Measures ANOVA was

used to analyse this hypothesis and its salient results are presented in Tables 5.1.1 to

5.1.3

Table 5.1. 1: Descriptive Statistics of Participants on Post-Traumatic Stress Disorder (PTSD) Scores

Time	Group	Mean	SD
Pretest	Total	62.92	17.11
	Budumburam	48.67	7.29
	Krisan	65.14	22.55
	Ampain	69.27	13.10
1st Post-test	Total	43.42	12.40
	Budumburam	38.33	8.57
	Krisan	37.43	13.29
	Ampain	50.00	11.07
2nd Post-test	Total	31.88	6.30
	Budumburam	29.67	6.47
	Krisan	31.29	5.94
	Ampain	33.46	6.58

Examining the means in Table 5.1.1 reveal a gradual decrease in the mean score of PTSD from the pre-testing period to the second post-testing period. The means were then subjected to Mauchly's test to test the sphericity assumption. Summary of the findings are presented in Table 5.1.2

Table 5.1.2: Summary of Findings on Sphericity for PTSD Scores

	Mauchly's W	p	Greenhouse-Geisser ϵ	Huynh-Feldt ϵ
Time	0.732	0.044	0.788	0.841

Mauchly's test (Table 5.1.2) revealed that the assumption of sphericity had been violated, $X^2(2) = 6.253$, $p < .05$. The Two-Way Repeated-Measures ANOVA was then used to establish whether a significant difference exists between the 3 means using the Huynh-Feldt (as sphericity is $\epsilon > .75$). Summary of the findings are presented in Table 5.1.3.

Table 5.1. 2: Two-Way Repeated-Measures ANOVA on PTSD

	Sphericity Correction	Sum of Squares	df	Mean Square	<i>F</i>	<i>p</i>	η^2
Time	Sphericity Assumed	10099.129	2.000	5049.564	84.942	< .001	0.749
	Greenhouse-Geisser	10099.129	1.577	6405.357	84.942	< .001	0.749
	Huynh-Feldt	10099.129	1.683	6001.175	84.942	< .001	0.749
Time * Group	Sphericity Assumed	894.187	4.000	223.547	3.760	0.011	0.066
	Greenhouse-Geisser	894.187	3.153	283.568	3.760	0.018	0.066
	Huynh-Feldt	894.187	3.366	265.675	3.760	0.016	0.066
Residual	Sphericity Assumed	2496.785	42.000	59.447			
	Greenhouse-Geisser	2496.785	33.110	75.409			
	Huynh-Feldt	2496.785	35.340	70.650			

Results in Table 5.1.3, using the repeated-measures ANOVA with a Huynh-Feldt correction, revealed that a significant difference exists between at least two of the three means of the PTSD scores [$F(1.683, 35.340) = 84.942, p < .001$]. Hence, post hoc test, the Bonferroni correction, was used to find the exact difference between the three means of the PTSD scores. The analysis is presented in Table 5.1.4

Table 5.1. 3: Summary of the Bonferroni Correction on PTSD

	Pre-Test	1 st Post-Test	2 nd Post-Test
Pre-Test	—	19.107*	29.558*
1 st Post-Test		—	10.452*
2 nd Post-Test			—

* $p < .001$

Results in Table 5.1.4 reveal that there is a significant difference between all the three means of the PTSD. Therefore, with reference to Table 5.1.1, it is evident that

respondents during the pretesting period ($M = 62.92$, $SD = 17.11$) had significantly more PTSD scores than during the first post-test ($M = 43.42$, $SD = 12.40$) and second post-test ($M = 31.88$, $SD = 6.30$). Furthermore, respondents, during the first post-test ($M = 43.42$, $SD = 12.40$) have significantly more PTSD scores than during the second post-test ($M = 31.88$, $SD = 6.30$).

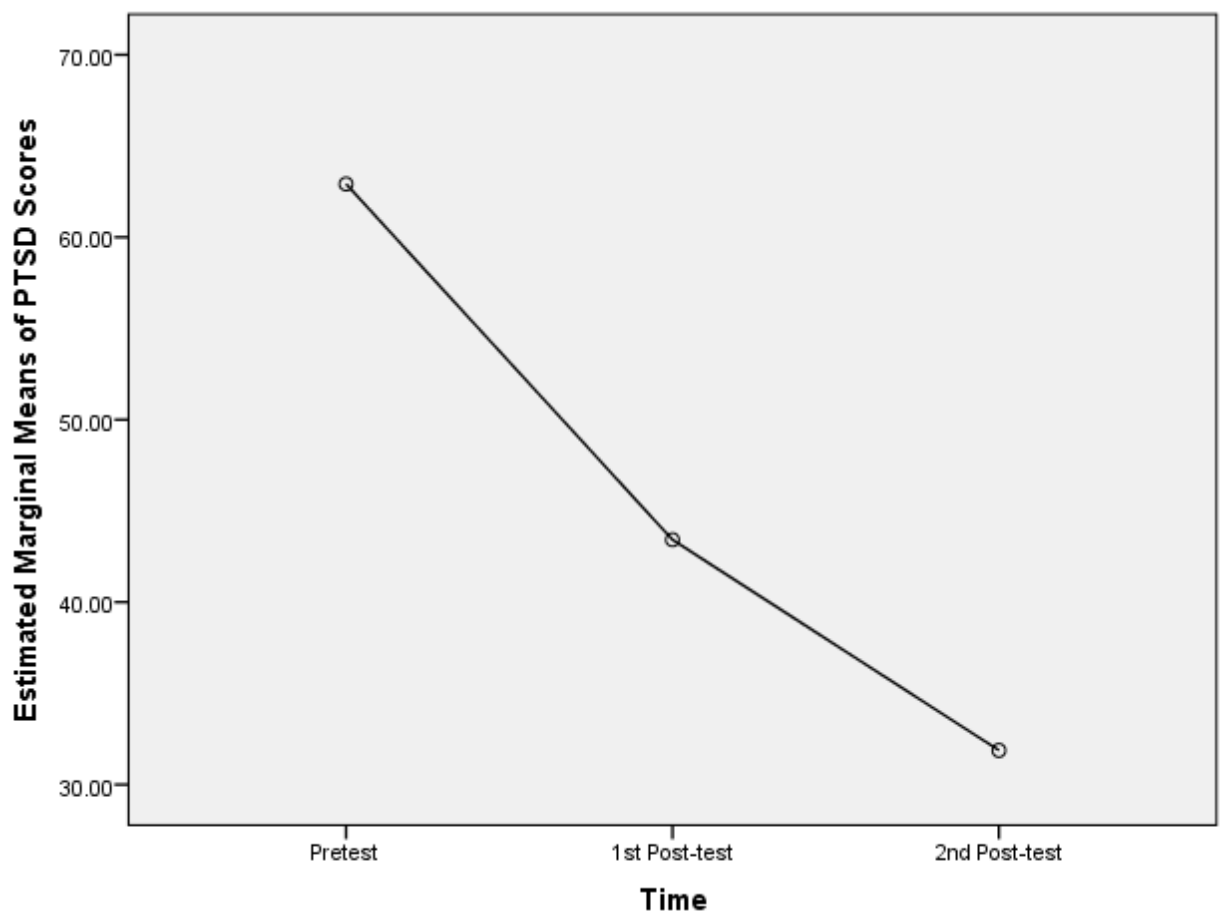


Figure 5. 1: Profile Plot of the Three Tests of PTSD

Figure 5.1 reveals that there was a steeper decline from pretest to 1st post-test but the line slightly slanted onward to 2nd post-test. This further indicates that the NTU Therapy had more effect on an individual with a PTSD condition from pretest to 1st post-test than from 1st post-test to 2nd post-test.

Therefore, in general, the analyses revealed that indeed a significant difference exist between the three PTSD tests with respondents having declined signs and symptoms of PTSD with increasing time of NTU psychotherapy. This suggests that participants respond more rapidly during the earlier sessions than the later sessions. Hence, the hypothesis that individuals who undergo NTU psychotherapy would have a significant decline in PTSD over time was supported by the data.

Hypothesis Two: Individuals Who Undergo NTU Psychotherapy Will Show Significant Improvement in Psychosocial Adjustment

The second hypothesis stated that individuals who undergo NTU psychotherapy would show significant improvement in psychosocial adjustment. To investigate this, the mean scores of participants on subscales of the Brief Symptom Inventory (BSI) was analysed. The Two-Way Repeated-Measures ANOVA was used to analyse this hypothesis and its salient results are presented in Tables 5.2.1 to 5.2.3

Table 5.2. 1: Descriptive Statistics of Participants on Psychosocial Adjustment

Time	Mean				SD			
	Bud.	Kris.	Amp.	Total	Bud.	Kris.	Amp.	Total
Pretest Global Severity Index (GSI)	1.55	1.87	1.88	1.79	.74	.60	.77	.70
1 st Post-test Global Severity Index (GSI)	1.36	1.50	1.43	1.43	.59	.66	.63	.60
2 nd Post-test Global Severity Index (GSI)	.88	.81	.66	.76	.59	.34	.30	.39

Examining the mean scores in Table 5.2.1. (using the “Total” column) reveal a gradual decrease in the mean score of BSI (especially the Global Severity Index (GSI); see Appendix B Table 5.2.1 for the full results including the subscales) from the pre-testing period to the second post-testing period. These means were further subjected to

Mauchly's test to test the sphericity assumption. Summary of the findings are presented in Table 5.2.2.

Table 5.2. 2: Test of Sphericity on Psychosocial Adjustment

		Mauchly's W	p	Greenhouse-Geisser ϵ	Huynh-Feldt ϵ
Time	Global Severity Index (GSI)	.588	.005	.708	.817
	Somatisation	.989	.896	.989	1.000
	Obsessive-Compulsive	.850	.197	.870	1.000
	Interpersonal-Sensitivity	.533	.002	.681	.782
	Depression	.912	.397	.919	1.000
	Anxiety	.931	.487	.935	1.000
	Hostility	.956	.639	.958	1.000
	Phobic Anxiety	.641	.012	.736	.853
	Paranoid Ideation	.778	.081	.818	.963
	Psychoticism	.926	.465	.931	1.000

Mauchly's test (Table 5.2.2.) revealed that the assumption of sphericity for GSI [$X^2(2) = 10.608$, $p < .01$] had been violated as well as for the following subscales; Interpersonal-Sensitivity [$X^2(2) = 12.603$, $p < .01$], and Phobic Anxiety [$X^2(2) = 8.883$, $p < .05$]. All the other subscales did not violate the assumption of sphericity. The Two-Way Repeated-Measures ANOVA was then used to establish whether a significant difference exists among these 3 means. Hence, for GSI, and the subscales (Interpersonal-Sensitivity and Phobic Anxiety) that violated assumption of sphericity, the Greenhouse-Geisser or Huynh-Feldt (when sphericity is $\epsilon < .75$ or $\epsilon > .75$ respectively) were used to ascertain whether a significant difference exist between the means. Summary of the main findings are presented in Table 5.2.3 (see Appendix B Table 5.2.3 for the full results).

Table 5.2. 3: Two-Way Repeated-Measures ANOVA on Psychosocial Adjustment

	Sphericity Correction	Sum of Squares	df	Mean Square	F	p	η^2
Time	Sphericity Assumed	11.195	2	5.598	45.217	< .001	0.659
	Greenhouse-Geisser	11.195	1.417	7.902	45.217	< .001	0.659
	Huynh-Feldt	11.195	1.490	7.516	45.217	< .001	0.659
Time * Group	Sphericity Assumed	0.583	4	0.146	1.177	0.335	0.034
	Greenhouse-Geisser	0.583	2.834	0.206	1.177	0.334	0.034
	Huynh-Feldt	0.583	2.979	0.196	1.177	0.334	0.034
Residual	Sphericity Assumed	5.199	42	0.124			
	Greenhouse-Geisser	5.199	29.753	0.175			
	Huynh-Feldt	5.199	31.280	0.166			

Results in Table 5.2.3, using the repeated measures ANOVA with Greenhouse-Geisser estimates of sphericity [as $\epsilon (.71) < .75$] revealed that a significant difference exists between at least two of the three tests on GSI (Psychosocial Adjustment) [$F(1.417, 29.753) = 45.217, p < .001$]. At the subscale levels, there was a significant difference between at least two of the three tests on somatisation [$F(2, 42) = 33.837, p < .001$], Obsessive-Compulsive [$F(2, 42) = 26.477, p < .001$], Interpersonal-Sensitivity [$F(1.363, 28.621) = 6.321, p < .05$], Depression [$F(2, 42) = 46.858, p < .001$], Anxiety [$F(2, 42) = 50.892, p < .001$], Hostility [$F(2, 42) = 39.578, p < .001$], Phobic Anxiety [$F(1.472, 30.913) = 11.777, p < .01$], Paranoid Ideation [$F(2, 42) = 10.990, p < .001$], and Psychoticism [$F(2, 42) = 8.401, p < .01$]. Hence, post hoc test, the Bonferroni correction, was used to find the exact difference between the three tests especially, on GSI (Psychosocial Adjustment). The analysis is presented in Table 5.2.4 (and for the subscales, see Appendix B Tables 5.2.5 to 5.2.13).

Table 5.2. 4: Summary of the Bonferroni Correction on Psychosocial Adjustment (GSI)

	Pre-Test	1 st Post-Test	2 nd Post-Test
Pre-Test	—	0.335*	0.982*
1 st Post-Test		—	0.647*
2 nd Post-Test			—

*p < .001

Results in Table 5.2.4 revealed that there is a significant difference between all the three means on psychosocial adjustment (GSI). Therefore, with reference to Table 5.2.1, it is evident that participants during the pretesting period ($M = 1.79$, $SD = 0.70$) reported higher scores for psychosocial problems than during the first post-test ($M = 1.43$, $SD = 0.60$) and second post-test ($M = 0.76$, $SD = 0.39$). Furthermore, respondents, during the first post-test ($M = 1.43$, $SD = 0.60$) also reported more psychosocial problems than during the second post-test ($M = 0.76$, $SD = 0.39$).

Inspection at the sub-scale levels (see Appendix B Table 5.2.3) revealed that a significant difference exists between the three means on Somatisation. Hence, a post hoc analysis (Bonferroni Correction) was used to determine the exact significant difference. The findings are presented in Table 5.2.5.

Table 5.2. 5: Summary of the Bonferroni Correction on Somatisation

	Pre-Test	1 st Post-Test	2 nd Post-Test
Pre-Test	—	0.373*	1.043**
1 st Post-Test		—	0.670**
2 nd Post-Test			—

*p < .05, **p < .001

Results in Table 5.2.5 revealed that there is a significant difference between all the three means on somatisation. Therefore, with reference to the descriptive statistics (see Appendix B Table 5.2.1) it is evident that during the pretesting period (M = 1.70, SD = 0.80) have significantly more somatisation problems than during the first post-test (M = 1.37, SD = 0.66) and second post-test (M = 0.68, SD = 0.43). Furthermore, during the first post-test (M = 1.37, SD = 0.66) participants had significantly more psychosocial problems than during the second post-test (M = 0.68, SD = 0.43).

The ANOVA results (see Appendix B Table 5.2.3) revealed that a significant difference exists between the three means on obsessive-compulsive. Therefore, the Bonferroni Correction was used to determine the exact difference. Summary of findings are presented in Table 5.2.6.

Table 5.2. 6: Summary of the Bonferroni Correction on Obsessive-Compulsive

	Pre-Test	1 st Post-Test	2 nd Post-Test
Pre-Test	—	0.147 ^{ns}	0.875*
1 st Post-Test		—	0.728*
2 nd Post-Test			—

*p < .001, ns: not significant

Findings in Table 5.2.6 revealed that there is a significant difference between all the three means on obsessive-compulsive except between the pretest and first post-test. Therefore, with reference to the descriptive statistics (see Appendix B Table 5.2.1), it is evident that during the pre-testing period ($M = 1.55$, $SD = 0.82$) have significantly more obsessive-compulsive problems than during the second post-test ($M = 0.64$, $SD = 0.47$). Furthermore, participants, during the first post-test ($M = 1.40$, $SD = 0.62$) have significantly more obsessive-compulsive problems than during the second post-test ($M = 0.64$, $SD = 0.47$).

The ANOVA results (see Appendix B Table 5.2.3) revealed that a significant difference exists between the three means on interpersonal sensitivity. Therefore, the Bonferroni Correction was used to determine the exact difference. Summary of findings are presented in Table 5.2.7

Table 5.2. 7: Summary of the Bonferroni Correction on Interpersonal Sensitivity

	Pre-Test	1st Post-Test	2nd Post-Test
Pre-Test	—	0.111 ^{ns}	0.613 ^{ns}
1st Post-Test		—	0.502*
2nd Post-Test			—

* $p < .05$, ns: not significant

Results in Table 5.2.7 revealed that there is a no significant difference between the three means on interpersonal sensitivity except between the first post-test and the second post-test. Therefore, with reference to the descriptive statistics (see Appendix B Table 5.2.1), it is evident that participants, during the first post-test ($M = 1.15$, $SD = 0.72$) had

significantly more interpersonal sensitivity problems than during the second post-test ($M = 0.64$, $SD = 0.54$).

A significant difference was observed between the three means on depression (see Appendix B Table 5.2.3). Therefore, the Bonferroni Correction was used to determine the exact difference. Summary of findings are presented in Table 5.2.8.

Table 5.2. 8: Summary of the Bonferroni Correction on Depression

	Pre-Test	1 st Post-Test	2 nd Post-Test
Pre-Test	—	0.744**	1.429**
1 st Post-Test		—	0.685*
2 nd Post-Test			—

* $p < .01$; ** $p < .001$

Results in Table 5.2.8 revealed that there is a significant difference between all the three means on depression. Therefore, with reference to the descriptive statistics (see Appendix B Table 5.2.1), it is evident that participants during the pretesting period ($M = 2.46$, $SD = 0.79$) had significantly more depression than during the first post-test ($M = 1.59$, $SD = 0.85$) and second post-test ($M = 0.89$, $SD = 0.61$). Furthermore, respondents, during the first post-test ($M = 1.59$, $SD = 0.85$) had significantly more depression than during the second post-test ($M = 0.89$, $SD = 0.61$).

A significant difference exists between the three means on anxiety (see Appendix B Table 5.2.3). Therefore, the Bonferroni Correction was used to determine the exact difference. Summary of findings are presented in Table 5.2.9.

Table 5.2. 9: Summary of the Bonferroni Correction on Anxiety

	Pre-Test	1 st Post-Test	2 nd Post-Test
Pre-Test	—	0.933**	1.620*
1 st Post-Test		—	0.687*
2 nd Post-Test			—

*p < .001

Results in Table 5.2.9 revealed that there is a significant difference between all the three means on anxiety. Therefore, with reference to the descriptive statistics (see Appendix B Table 5.2.1), it is evident that participants during the pretesting period (M = 2.57, SD = 0.75) have significantly more anxiety than during the first post-test (M = 1.66, SD = 0.77) and second post-test (M = 0.99, SD = 0.63). Furthermore, participants, during the first post-test (M = 1.66, SD = 0.77) have significantly more anxiety than during the second post-test (M = 0.99, SD = 0.63).

A significant difference exists between the three means on hostility (see Appendix B Table 5.2.3). Therefore, the Bonferroni Correction was used to determine the exact difference. Summary of findings are presented in Table 5.2.10.

Table 5.2. 10: Summary of the Bonferroni Correction on Hostility

	Pre-Test	1 st Post-Test	2 nd Post-Test
Pre-Test	—	0.724**	1.368**
1st Post-Test		—	0.643*
2nd Post-Test			—

*p < .01, **p < .001

Results in Table 5.2.10 revealed that there is a significant difference between all the three means on hostility. Therefore, with reference to the descriptive statistics (see

Appendix B Table 5.2.1), it is evident that participants during the pretesting period ($M = 2.19$, $SD = 0.70$) had significantly more hostility than during the first post-test ($M = 1.40$, $SD = 0.80$) and second post-test ($M = 0.73$, $SD = 0.63$). Furthermore, participants, during the first post-test ($M = 1.40$, $SD = 0.80$) have significantly more hostility than during the second post-test ($M = 0.73$, $SD = 0.63$).

A significant difference exists between the three tests on phobic anxiety (see Appendix B Table 5.2.3). Therefore, the Bonferroni Correction was used to determine the exact difference. Summary of findings are presented in Table 5.2.11.

Table 5.2. 11: Summary of the Bonferroni Correction on Phobic Anxiety

	Pre-Test	1 st Post-Test	2 nd Post-Test
Pre-Test	—	0.077 ^{ns}	0.549*
1 st Post-Test		—	0.626**
2 nd Post-Test			—

* $p < .05$, ** $p < .001$; ns: not significant

Results in Table 5.2.11 revealed that there is a significant difference between all the three means on phobic anxiety except between the pre-test and first post-test. Therefore, with reference to the descriptive statistics (see Appendix B Table 5.2.1), it is evident that respondents during the pretesting period ($M = 1.41$, $SD = 0.82$) had significantly more phobic anxiety than during the second post-test ($M = 0.76$, $SD = 0.48$). Furthermore, respondents, during the first post-test ($M = 1.41$, $SD = 0.63$) had significantly more phobic anxiety than during the second post-test ($M = 0.76$, $SD = 0.48$).

A significant difference exists between the three means on paranoid ideation (see Appendix B Table 5.2.3). Therefore, the Bonferroni Correction was used to determine the exact difference. Summary of findings are presented in Table 5.2.12.

Table 5.2. 12: Summary of the Bonferroni Correction on Paranoid Ideation

	Pre-Test	1st Post-Test	2nd Post-Test
Pre-Test	—	0.009 ^{ns}	0.654*
1st Post-Test		—	0.664*
2nd Post-Test			—

*p < .01; ns: not significant

Results in Table 5.2.12 revealed that there is a significant difference between all the three means on paranoid ideation except between the pre-test and first post-test. Therefore, with reference to the descriptive statistics (see Appendix B Table 5.2.1), it is evident that participants during the pretesting period (M = 1.44, SD = 0.78) had significantly more paranoid ideation than during the second post-test (M = 0.74, SD = 0.40). Furthermore, respondents, during the first post-test (M = 1.45, SD = 0.80) had significantly more paranoid ideation than during the second post-test (M = 0.74, SD = 0.40).

A significant difference exists between the three means on psychoticism (see Appendix B Table 5.2.3). Therefore, the Bonferroni Correction was used to determine the exact difference. Summary of findings are presented in Table 5.2.13.

Table 5.2. 13: Summary of the Bonferroni Correction on Psychoticism

	Pre-Test	1st Post-Test	2nd Post-Test
Pre-Test	—	0.118 ^{ns}	0.600**
1st Post-Test		—	0.482*
2nd Post-Test			—

*p < .05, **p < .01; ns: not significant

Results in Table 5.2.13 revealed that there is a significant difference between all the three means on psychoticism except between the pretest and first post-test. Therefore, with reference to the descriptive statistics (see Appendix B Table 5.2.1), it is evident that participants during the pretesting period (M = 1.41, SD = 0.79) had significantly more psychoticism than during the second post-test (M = 0.76, SD = 0.48). Furthermore, respondents, during the first post-test (M = 1.29, SD = 0.58) had significantly more psychoticism than during the second post-test (M = 0.76, SD = 0.48).

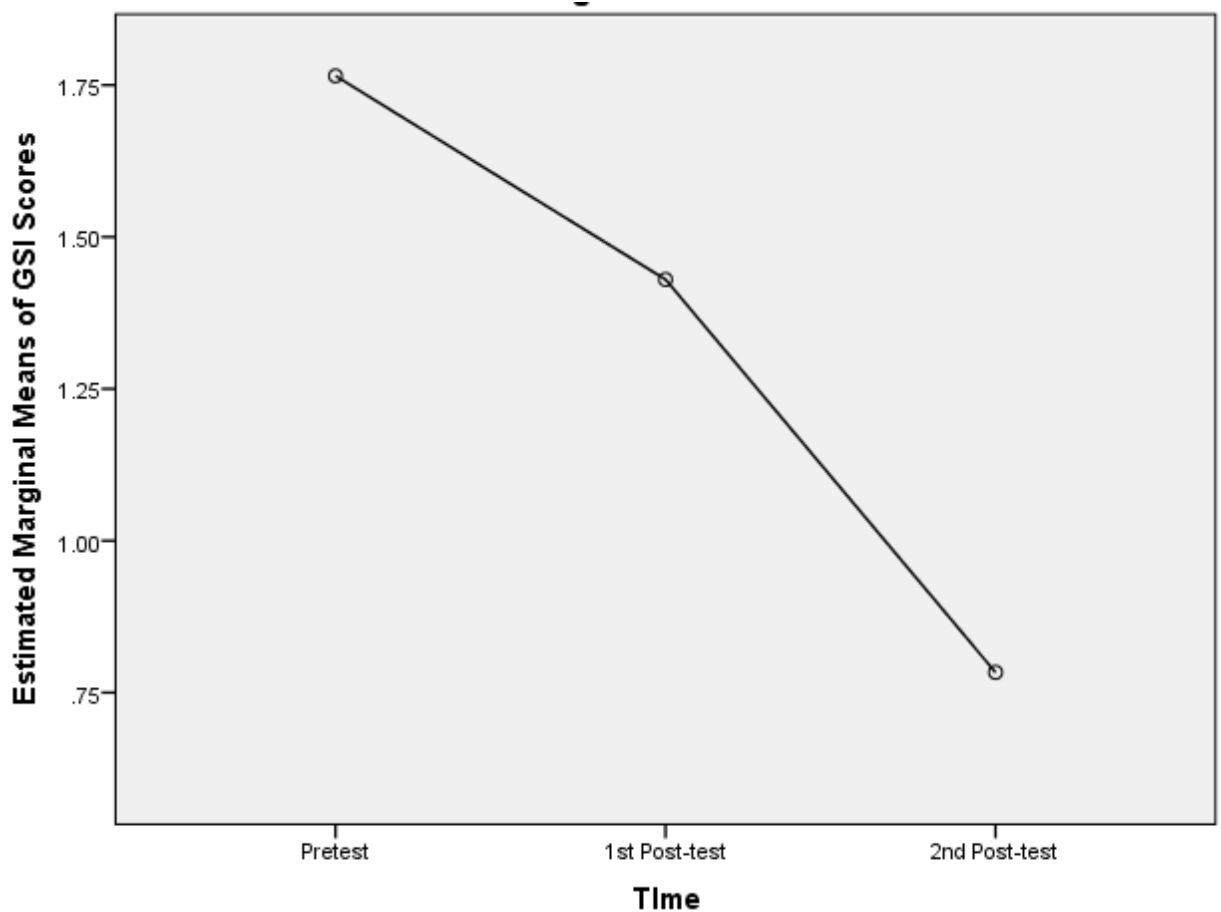


Figure 5. 2: Profile Plot of the Three Tests on Psychosocial Adjustment (GSI)

Figure 5.2 revealed that there is comparatively, a gentler decline from pretest to 1st post-test but became steeper onward to 2nd post-test. This further indicates that the NTU psychotherapy had more effect on an individual with Psychosocial Adjustment problems over a longer time period.

Therefore, the hypothesis that individuals who undergo NTU psychotherapy would show significant improvement in psychosocial adjustment was supported by the data.

Hypothesis Three: Ntu Psychotherapy Would Lead to Greater Africentric Consciousness

The third hypothesis stated that individuals who undergo NTU psychotherapy would demonstrate a greater consciousness and awareness of their africentrism than previously. The One-Way Repeated-Measures ANOVA was used to analyse this hypothesis and its salient results are presented in Tables 5.3.1 to 5.3.3

Table 5.3. 1: Descriptive Statistics of Respondents on Africentrism

	N	Mean	Standard Deviation
Pretest	24	92.54	10.30
1 st Post-Test	24	96.04	9.62
2 nd Post-Test	24	99.04	8.28

Examining the means in Table 5.3.1 revealed an increase in the mean score of Africentrism from the pretesting period to the second post-testing period. The means were subjected to Mauchly's test to test the sphericity assumption. Summary of the findings are presented in Table 5.3.2.

Table 5.3. 2: Test of Sphericity on Africentrism

	Mauchly's W	p	Greenhouse-Geisser ϵ	Huynh-Feldt ϵ
Time	0.893	0.288	0.903	0.976

Mauchly's test (Table 5.3.2) revealed that the assumption of sphericity had not been violated, $X^2(2) = 2.487$, $p > .05$. The One-Way Repeated-Measures ANOVA was then used to establish whether a significant difference exists among these 3 means. Summary of the findings are presented in Table 5.3.3.

Table 5.3. 3: One-Way Repeated Measures ANOVA on Africentrism

	Sphericity Correction	Sum of Squares	df	Mean Square	<i>F</i>	<i>p</i>	η^2
Time	Sphericity Assumed	508.000	2	254.000	12.934	< .001	0.360
	Greenhouse-Geisser	508.000	1.807	281.150	12.934	< .001	0.360
	Huynh-Feldt	508.000	1.952	260.273	12.934	< .001	0.360
Residual	Sphericity Assumed	903.333	46	19.638			
	Greenhouse-Geisser	903.333	41.558	21.737			
	Huynh-Feldt	903.333	44.891	20.123			

Results in Table 5.3.3 show that using the repeated measures ANOVA with a Sphericity assumed determined that a significant difference exists between at least two of the three means on Africentrism [$F(2, 46) = 12.934, p < .001$]. Hence, post hoc tests using the Bonferroni correction was used to find the exact difference between the three means on Africentrism. The analysis is presented in Table 5.3.4.

Table 5.3. 4: Summary of the Bonferroni Correction on Africentrism

	Pre-Test	1 st Post-Test	2 nd Post-Test
Pre-Test	—	3.500*	6.500**
1st Post-Test		—	3.000*
2nd Post-Test			—

* $p < .05$, ** $p < .01$

Results in Table 5.3.4 revealed that there is a significant difference between all the three means on Africentrism. Therefore, with reference to Table 5.3.1, it is evident that participants during the pretesting period ($M = 92.54, SD = 10.30$) had significantly lower Africentric scores than during the first post-test ($M = 96.04, SD = 9.62$) and second post-test ($M = 99.04, SD = 8.28$). Furthermore, participants, during the first post-test ($M = 96.04, SD = 9.62$) had significantly lower Africentric scores than during the second post-test ($M = 99.04, SD = 8.28$).

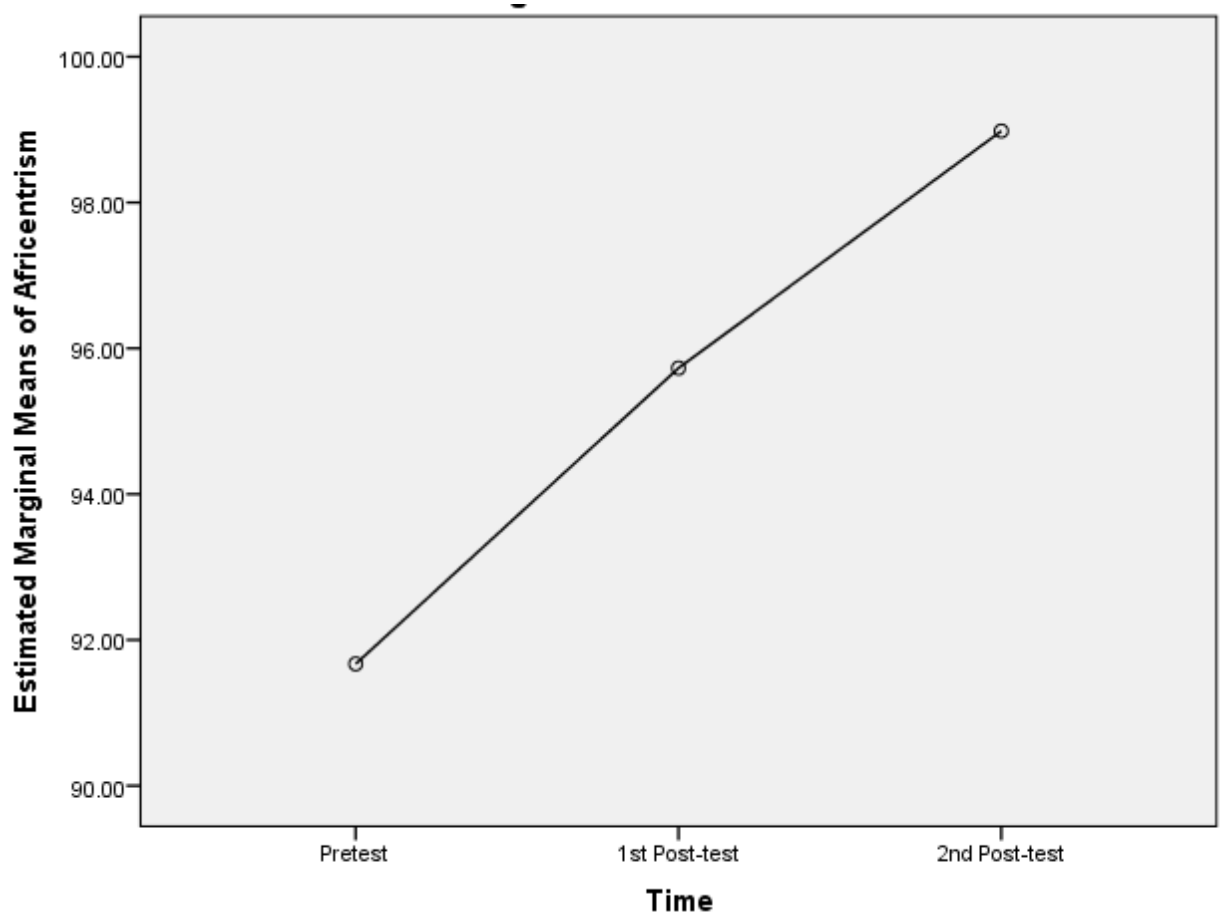


Figure 5. 3: Profile Plot of the Three Tests on Africentrism

Figure 5.3 revealed that there was a steep upward progression from pretest to 1st post-test onward to 2nd post-test. This further indicates that the NTU psychotherapy improves individual's afri-centric view over time. Hence, the hypothesis that individuals who undergo NTU psychotherapy would demonstrate a greater consciousness and awareness of their afri-centricism was supported by the data.

Hypothesis Four: NTU Psychotherapy would Lead to a Decline in Hostility

The fourth hypothesis stated that individuals who undergo NTU psychotherapy would have a significant decline in hostility over time. The One-Way ANOVA was used to analyse this hypothesis and its salient results are presented in Tables 5.4.1 to 5.4.3.

Table 5.4. 1: Descriptive Statistics of Participants on Hostility

	N	Mean	Standard Deviation
Pretest Hostility	24	34.71	9.12
1 st Posttest Hostility	24	36.75	9.14
2 nd Posttest Hostility	24	27.83	5.47
Pretest Negativism	24	3.21	1.14
1 st Posttest Negativism	24	3.25	1.15
2 nd Posttest Negativism	24	2.92	1.02
Pretest Resentment	24	4.21	1.84
1 st Posttest Resentment	24	4.38	1.56
2 nd Posttest Resentment	24	3.58	1.10
Pretest Indirect Hostility	24	4.92	2.12
1 st Posttest Indirect Hostility	24	4.92	1.84
2 nd Posttest Indirect Hostility	24	3.88	1.23
Pretest Assault	24	4.13	1.80
1 st Posttest Assault	24	4.29	1.92
2 nd Posttest Assault	24	3.21	.78
Pretest Suspicion	24	6.50	1.93
1 st Posttest Suspicion	24	7.13	1.80
2 nd Posttest Suspicion	24	4.42	1.25
Pretest Irritability	24	4.42	1.72
1 st Posttest Irritability	24	4.92	1.89
2 nd Posttest Irritability	24	4.33	1.76

Pretest Verbal Hostility	24	7.33	2.01
1 st Posttest Verbal Hostility	24	7.67	1.93
2 nd Posttest Verbal Hostility	24	5.42	1.64

Examining the means in Table 5.4.1 revealed an increase of the mean score of Hostility (and its subscales) from the pretesting period to the first post-testing period then a decrease to the second post-testing period. The means were subjected to Mauchly's test of sphericity assumption. Summary of the findings are presented in Table 5.4.2.

Table 5.4. 2: Test of Sphericity on Hostility

	Mauchly's W	p	Greenhouse-Geisser ϵ	Huynh-Feldt ϵ
Hostility	.703	.021	.771	.816
Negativism	.462	.000	.650	.673
Resentment	.664	.011	.749	.789
Indirect	.922	.411	.928	1.000
Assault	.236	.000	.567	.576
Suspicion	.982	.818	.982	1.000
Irritability	.531	.001	.681	.709
Verbal	.577	.002	.703	.735

Mauchly's test (Table 5.4.2) revealed that the assumption of sphericity for Hostility had been violated, $X^2(2) = 7.756$, $p < 0.05$; as well as for the following subscales, Negativism [$X^2(2) = 16.978$, $p < .001$], Resentment [$X^2(2) = 9.006$, $p < .05$], Assault [$X^2(2) = 31.797$, $p < .001$], Irritability [$X^2(2) = 13.906$, $p < .01$], and Verbal Hostility [$X^2(2) = 12.083$, $p < .01$]. The One-Way Repeated-Measures ANOVA was then used to establish whether a significant difference exists among these 3 means. Hence, for Hostility, and its subscales that violated assumption of sphericity, the Greenhouse-Geisser or Huynh-Feldt (when sphericity is $\epsilon < .75$ or $\epsilon > .75$ respectively) were used to ascertain whether a significant difference exist between the means. Summary of the findings are presented in Table 5.4.3.

Table 5.4. 3: One-Way Repeated Measures ANOVA on Hostility

	Sphericity Correction	Sum of Squares	df	Mean Square	F	p	η^2
Hostility	Sphericity Assumed	1047.528	2	523.764	41.794	< .001	.645
	Greenhouse-Geisser	1047.528	1.542	679.372	41.794	< .001	.645
	Huynh-Feldt	1047.528	1.631	642.122	41.794	< .001	.645
Negativity	Greenhouse-Geisser	1.583	1.301	1.217	3.286	.070	
Resentment	Greenhouse-Geisser	8.361	1.497	5.585	4.340	<.05	
Indirect Hostility	Sphericity Assumed	17.361	2	8.681	10.159	< .001	
Assault	Greenhouse-Geisser	16.333	1.134	14.409	10.339	< .01	
Suspicion	Sphericity Assumed	96.528	2	48.264	40.509	< .001	
Irritability	Greenhouse-Geisser	4.778	1.362	3.508	2.542	.111	
Verbal Hostility	Greenhouse-Geisser	70.778	1.406	50.344	42.965	< .001	

Results in Table 5.4.3 show that using the repeated measures ANOVA with Huynh-Feldt sphericity [as $\epsilon (.816) > .75$] correction, a significant difference exists between at least two of the three means on Hostility (in general) [$F(1.631, 37.521) = 41.794, p < .001$]. At the subscale levels, there was a significant difference between at least two of the three means on Resentment [$F(1.497, 34.433) = 4.340, p < .05$], Indirect Hostility [$F(2, 46) = 10.159, p < .001$], Assault [$F(1.134, 26.072) = 10.339, p < .01$], Suspicion [$F(2, 46) = 40.509, p < .001$], and Verbal Hostility [$F(1.406, 32.335) = 42.965, p < .001$]. However, there was no significant difference existing between at least two of the three means on Negativity [$F(1.301, 29.913) = 3.286, p = .070$] and Irritability [$F(1.362, 31.324) = 2.542, p = .111$]. Hence, post hoc tests using the Bonferroni correction was used to find the exact difference between the three means especially, on Hostility (and its subscales). The analysis is presented in Table 5.4.4 (and for the subscales, Tables 5.4.5 to 5.4.9).

Table 5.4. 4: Summary of the Bonferroni Correction on Hostility

	Pre-Test	1 st Post-Test	2 nd Post-Test
Pre-Test	—	2.042*	6.875**
1 st Post-Test		—	8.917**
2 nd Post-Test			—

* $p < .001$

Results in Table 5.4.4 revealed that there is a significant difference between all the three means on Hostility. Therefore, with reference to Table 5.4.1, it is evident that participants had significantly less Hostility during the pretesting period ($M = 34.71$, $SD = 9.12$) as compared to 1st post-testing ($M = 36.75$, $SD = 9.14$) but more Hostility compared to the second post-test ($M = 27.83$, $SD = 5.47$). Furthermore, respondents, during the first post-test ($M = 36.75$, $SD = 9.14$) had significantly more Hostility than during the second post-test ($M = 27.83$, $SD = 5.47$).

Inspection at the sub-scale levels in Table 5.4.3 revealed that a significant difference exists between the three means of Resentment. Hence, a post hoc analysis (Bonferroni Correction) was used to determine the exact significant difference. The findings are presented in Table 5.4.5.

Table 5.4. 5: Summary of the Bonferroni Correction on Resentment

	Pre-Test	1 st Post-Test	2 nd Post-Test
Pre-Test	—	0.167 ^{ns}	0.625 ^{ns}
1 st Post-Test		—	0.792*
2 nd Post-Test			—

* $p < .05$; ns: not significant

Results in Table 5.4.5 revealed that there is a significant difference between only the first and second posttest on Resentment. Therefore, with reference to Table 5.4.1, it is evident that participants had significantly more Resentment during the first post-test ($M = 4.38$, $SD = 1.55$) than during the second post-test ($M = 3.58$, $SD = 1.00$).

Findings in Table 5.4.3 revealed that a significant difference exists between the three means of Indirect Hostility. Therefore, the Bonferroni Correction was used to determine the exact difference. Summary of findings are presented in Table 5.4.6.

Table 5.4. 6: Summary of the Bonferroni Correction on Indirect Hostility

	Pre-Test	1st Post-Test	2nd Post-Test
Pre-Test	—	0.000 ^{ns}	1.042*
1st Post-Test		—	1.042*
2nd Post-Test			—

* $p < .01$, ns: not significant

Findings in Table 5.4.6 revealed that there is a significant difference between all the three means on Indirect Hostility except between the pretest and first post-test. Therefore, with reference to Table 5.4.1, it is evident that participants had significantly more Indirect Hostility during the pretesting period ($M = 4.92$, $SD = 2.12$) than during the second post-test ($M = 3.88$, $SD = 1.23$). Furthermore, participants, during the first post-test ($M = 4.92$, $SD = 1.84$) had significantly more Indirect Hostility than during the second post-test ($M = 3.88$, $SD = 1.23$).

Results in Table 5.4.3 revealed that a significant difference exists between the three means on Assault. Therefore, the Bonferroni Correction was used to determine the exact difference. Summary of findings are presented in Table 5.4.7.

Table 5.4. 7: Summary of the Bonferroni Correction on Assault

	Pre-Test	1 st Post-Test	2 nd Post-Test
Pre-Test	—	0.167 ^{ns}	0.917 ^{ns}
1 st Post-Test		—	1.083*
2 nd Post-Test			—

* $p < .01$, ns: not significant

Findings in Table 5.4.7 revealed that there is a significant difference between first and second post-tests. Therefore, with reference to Table 5.4.1, it is evident that participants had significantly more Assault Hostility during the first post-test ($M = 4.29$, $SD = 1.92$) than during the second post-test ($M = 3.21$, $SD = 0.78$).

Findings in Table 5.4.3 reveal that a significant difference exists between the three means on Suspicion. Therefore, the Bonferroni Correction was used to determine the exact difference. Summary of findings are presented in Table 5.4.8.

Table 5.4. 8: Summary of the Bonferroni Correction on Suspicion

	Pre-Test	1 st Post-Test	2 nd Post-Test
Pre-Test	—	0.625 ^{ns}	2.083*
1st Post-Test		—	2.708*
2nd Post-Test			—

* $p < .001$, ns: not significant

Findings in Table 5.4.8 revealed that there is a significant difference between all the three means on Suspicion except between the pretest and first post-test. Therefore, with reference to Table 5.4.1, it is evident that participants had significantly more Suspicion during the pretesting period ($M = 6.50$, $SD = 1.93$) than during the second post-test ($M = 4.42$, $SD = 1.25$). Furthermore, participants, during the first post-test ($M = 7.13$, $SD = 1.80$) had significantly more Suspicion than during the second post-test ($M = 4.42$, $SD = 1.25$).

Results in Table 5.4.3 revealed that a significant difference exists between the three means on Verbal Hostility. Therefore, the Bonferroni Correction was used to determine the exact difference. Summary of findings are presented in Table 5.4.9.

Table 5.4. 9: Summary of the Bonferroni Correction on Verbal Hostility

	Pre-Test	1st Post-Test	2nd Post-Test
Pre-Test	—	0.333 ^{ns}	1.917*
1st Post-Test		—	2.250*
2nd Post-Test			—

* $p < .001$, ns: not significant

Findings in Table 5.4.9 revealed that there is a significant difference between all the three means on Verbal Hostility except between the pretest and first post-test. Therefore, with reference to Table 5.4.1., it is evident that participants had significantly more Verbal Hostility during the pretesting period ($M = 7.33$, $SD = 2.01$) than during the second post-test ($M = 5.42$, $SD = 1.64$). Furthermore, participants, during the first post-test ($M = 7.67$, $SD = 1.93$) had significantly more Verbal Hostility than during the second post-test ($M = 5.42$, $SD = 1.64$).

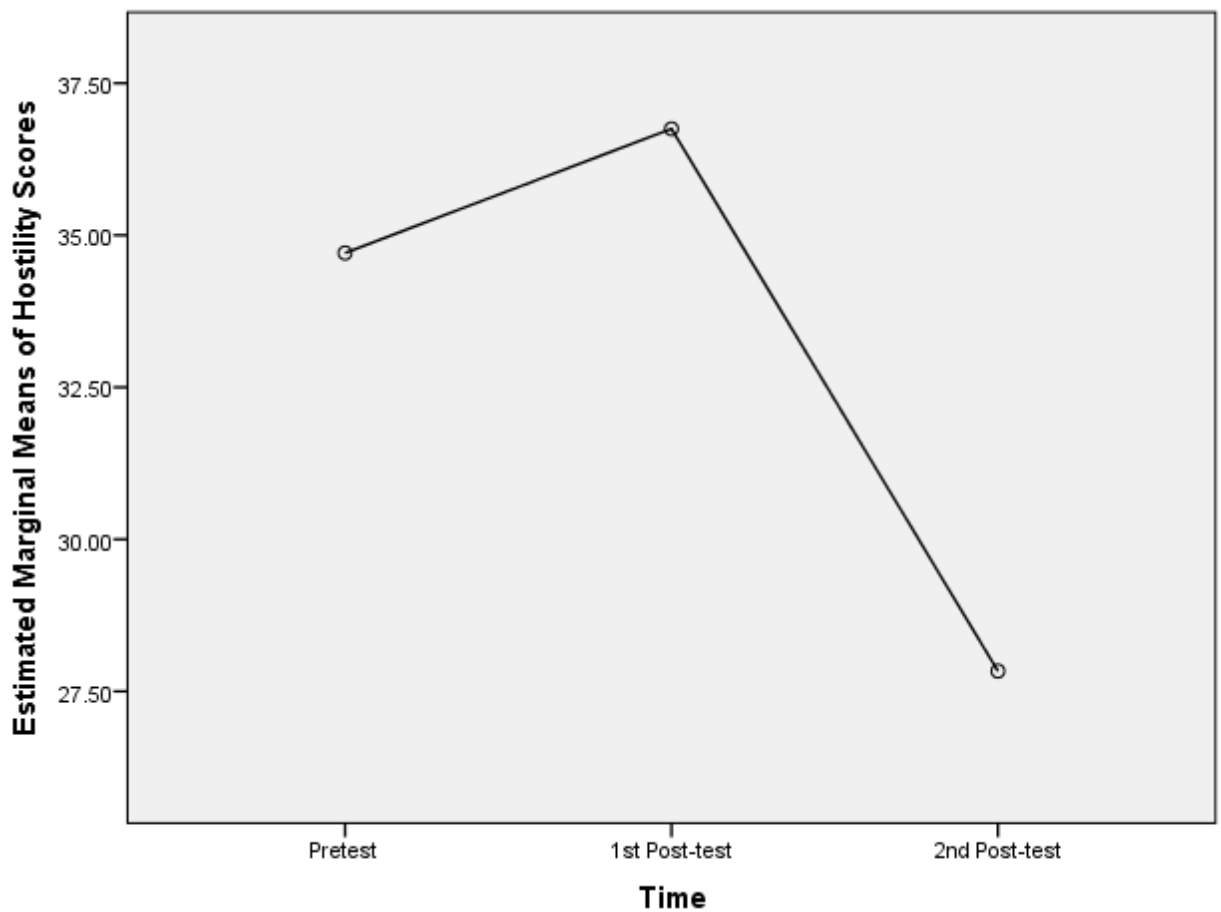


Figure 5. 4: Profile Plot of the Three Tests on Hostility

Figure 5.4 revealed that there was a steep upward progression from pretesting period to 1st post-testing followed by a steeper decrease to 2nd post-test. This further indicates that the NTU Psychotherapy improves individual's hostility over time.

Hence, the hypothesis that individuals who undergo NTU psychotherapy would have a significant decline in hostility over time was supported by the data.

Hypothesis Five: Differences will exist in the recovery levels among participants in different refugee camps

a. Comparison between groups on PTSD scores

The fifth hypothesis was that differences would exist in recovery levels among the refugee camps.

To fully examine the differences between the groups on PTSD, three different analyses were done including the One-Way ANOVA for comparing the groups during pretest/2nd post-test, Two-Way Repeated-Measures ANOVA for ascertain whether an interaction effect exist (groups changes with time), and One-Way Repeated-Measures ANOVA for ascertaining effect of time within each group (with Bonferroni corrected alpha level to 0.017).

One-Way ANOVA was used to ascertain whether differences exist between the groups on PTSD before the commencement of the NTU psychotherapy.

Table 5.5.a. 1: Summary of ANOVA results on Pretest scores of Post-Traumatic Stress Disorder (PTSD)

	Sum of Squares	<i>df</i>	Mean Squares	<i>F</i>	<i>p</i>	η^2
Between Groups	1697.461	2	848.731	3.542	.047	0.252
Within Groups	5032.372	21	239.637			
Total	6729.833	23				

Table 5.5.a1 revealed that a significant difference exist between the groups [$F(2, 21) = 3.542, p < .05$] hence, the post hoc (Tukey) was used to ascertain this difference.

Table 5.5.a. 2: Summary of the Tukey test on PTSD (Pretest)

	Budumburam	Krisan	Ampain
Budumburam	—	16.476 ^{ns}	20.606*
Krisan		—	4.130 ^{ns}
Ampain			—

* $p < .05$

Table 5.5.a2 revealed that there was a significant difference between Budumburam and Ampain. With reference to Table 5.1.1, Ampain participants ($M = 69.27$, $SD = 13.10$) had significantly more PTSD as compared to Budumburam participants ($M = 48.67$, $SD = 7.29$). The Two-Way Repeated-Measures ANOVA was used to test the differences and interactions between Groups and time. Summary of the findings are presented in Table 5.5.a3.

Table 5.5.a. 3: Two-Way Repeated-Measures ANOVA on PTSD

	Sphericity Correction	Sum of Squares	<i>df</i>	Mean Square	<i>F</i>	<i>p</i>	η^2
Time	Sphericity Assumed	10099.129	2	5049.564	84.942	< .001	0.749
	Greenhouse-Geisser	10099.129	1.577	6405.357	84.942	< .001	0.749
	Huynh-Feldt	10099.129	1.683	6001.175	84.942	< .001	0.749
Time * Group	Sphericity Assumed	894.187	4	223.547	3.760	0.011	0.066
	Greenhouse-Geisser	894.187	3.153	283.568	3.760	0.018	0.066
	Huynh-Feldt	894.187	3.366	265.675	3.760	0.016	0.066
Residual	Sphericity Assumed	2496.785	42.000	59.447			
	Greenhouse-Geisser	2496.785	33.110	75.409			
	Huynh-Feldt	2496.785	35.340	70.650			

Results in Table 5.5.a3, using the repeated-measures ANOVA with a Huynh-Feldt correction, revealed that a significant interaction effect between Time and Group on

PTSD scores [$F(3.366, 35.340) = 3.760, p < .05$]. Hence, three separate One-Way Repeated-Measures ANOVA tests [with Bonferroni correction ($0.05/3 = 0.017$)], was used to find the exact difference between the three means of the PTSD scores of each of the three groups. The results are presented in Tables below.

Table 5.5.a. 4: Test of Sphericity on PTSD

	Mauchly's W	p	Greenhouse-Geisser ϵ	Huynh-Feldt ϵ
Budumburam	0.882	0.778	0.895	1.000
Krisan	0.516	0.192	0.674	0.799
Ampain	0.859	0.504	0.876	1.000

Table 5.5.a4 revealed that the assumption of sphericity had not been violated for Budumburam group [$X^2(2) = 0.501, p = .778$], Krisan group [$X^2(2) = 3.305, p = .192$], and Ampain [$X^2(2) = 1.368, p = .504$].

Table 5.5.a. 5: One-Way Repeated Measures ANOVA on PTSD

	Sphericity Correction	Sum of Squares	df	Mean Square	F	p	η^2
Budumburam	Sphericity Assumed	1085.778	2	542.889	20.651	< .001	0.805
Krisan	Sphericity Assumed	4554.952	2	2277.476	18.370	<.001	0.754
Ampain	Sphericity Assumed	7069.818	2	3534.909	94.747	<.001	0.905

The One-Way repeated measures ANOVA was then used to ascertain the whether a significant difference exists between at least two of the three means on PTSD among each of the three groups (Budumburam, Krisan, and Ampain). Results (Table 5.5.a5) revealed that a significant difference exists among these 3 means on PTSD for Budumburam [$F(2, 10) = 20.651, p < .001$], Krisan [$F(2, 12) = 18.370, p < .001$], and

Ampain [$F(2, 20) = 94.747, p < .001$]. The post hoc with a Bonferroni Correction of 0.017 is presented in the Tables below.

Table 5.5.a. 6: Summary of the Bonferroni Correction on PTSD (Budumburam Group)

	Pre-Test	1st Post-Test	2nd Post-Test
Pre-Test	—	10.333 ^{ns}	19*
1st Post-Test		—	8.667 ^{ns}
2nd Post-Test			—

* $p < .017$

Results in Table 5.5.a6 revealed that there is a significant difference between only the pretest and 2nd post-test. Therefore, with reference to Table 5.1.1, it is evident that Budumburam participants had significantly more PTSD scores during the pretesting period ($M = 48.67, SD = 7.29$) than during the second post-test ($M = 29.67, SD = 6.47$).

Table 5.5.a. 7: Summary of the Bonferroni Correction on PTSD (Krisan Group)

	Pre-Test	1st Post-Test	2nd Post-Test
Pre-Test	—	27.714*	33.857*
1st Post-Test		—	6.143 ^{ns}
2nd Post-Test			—

* $p < .017$

Results in Table 5.5.a7 revealed that there is a significant difference between all the three means except between first and second post-test. Therefore, with reference to Table 5.1.1, it is evident that Krisan participants had significantly more PTSD scores during the pretesting period ($M = 65.14, SD = 22.55$) than first post-test ($M = 37.43, SD = 13.29$) and second post-test ($M = 31.29, SD = 5.94$).

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Table 5.5.a. 8: Summary of the Bonferroni Correction on PTSD (Ampain Group)

	Pre-Test	1st Post-Test	2nd Post-Test
Pre-Test	—	19.273*	35.818*
1st Post-Test		—	16.545*
2nd Post-Test			—

* $p < .017$

Table 5.5.a8 reveal that there is a significant difference between all the three means on PTSD. Therefore, with reference to Table 5.1.1, it is evident that Ampain participants had significantly more PTSD score during the pretesting period ($M = 69.72$, $SD = 13.10$) than during the first post-test ($M = 50$, $SD = 11.07$) and second post-test ($M = 33.46$, $SD = 6.58$). Furthermore, participants, during the first post-test ($M = 50$, $SD = 11.07$) had significantly higherse PTSD scores than during the second post-test ($M = 33.46$, $SD = 6.58$).

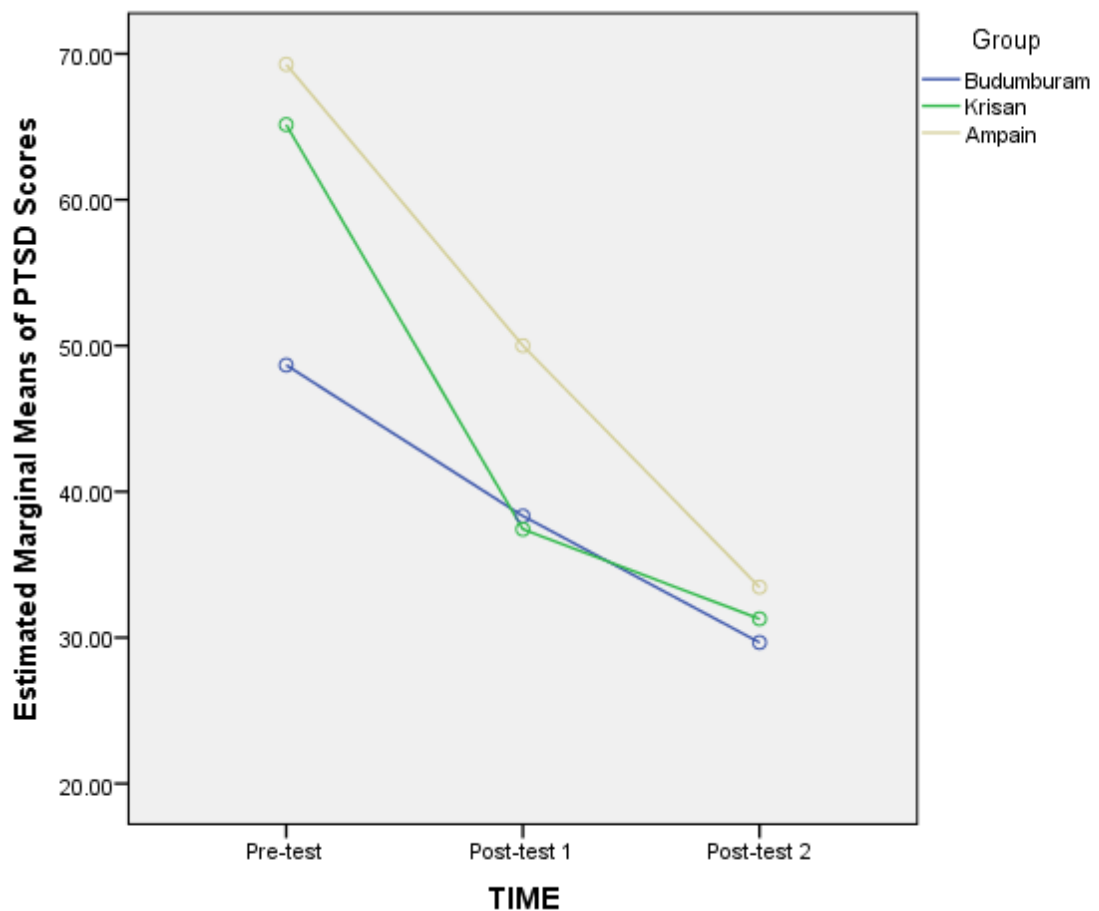


Figure 5.5 a. : Profile Plot of the Interaction Effect on PTSD

Figure 5.5a revealed that, in all, there were steeper decline of the lines from pretest to 1st post-test to 2nd post-test especially for the Krisan group. It can also be noted that there is a big difference (gap) between the Ampain and Budumburam groups during the pretesting period but a very close difference (gap) between the groups during the 2nd post-testing.

This further indicates that the NTU psychotherapy have more affect on an individual with a PTSD condition from point 1 to point 2 than from point 2 to point 3.

Therefore, in general, the analyses revealed that although a significant difference existed between the groups during the pretesting period, this was not noticed during the

second post-testing period. This suggests that NTU psychotherapy worked at least by the later sessions as it nullified the differences that existed during the pretesting period. Hence the hypothesis that differences will exist in the recovery levels among participants in different refugee camps

b. Comparison between groups on Psychosocial Adjustment

To fully examine the differences between the groups on PTSD, three different analyses were done including the One-Way ANOVA for comparing the groups during pretest/2nd post-test, Two-Way Repeated-Measures ANOVA for ascertain whether an interaction effect exist (groups changes with time), and One-Way Repeated-Measures ANOVA for ascertaining effect of time within each group (with Bonferroni corrected alpha level to 0.017).

One-Way ANOVA was used to ascertain whether differences exist between the groups on psychosocial adjustment (Global Severity Index, GSI) before the commencement of the NTU psychotherapy.

Table 5.5.b. 1: Summary of ANOVA results on Pretest scores of Global Severity Index (GSI)

	Sum of Squares	df	Mean Squares	F	p
Between Groups	0.488	2	0.244	0.470	.632
Within Groups	10.899	21	0.519		
Total	11.386	23			

Table 5.5.b1 revealed that no significant difference exist between the groups [$F(2, 21) = 0.470, p = .632$] hence, it indicates that the groups are the same during pretesting of Global Severity Index. Furthermore, the interaction effect of Two-Way Repeated-

Measures ANOVA was not also significant. Summary of the results are presented in Table 5.5.b2 below.

Table 5.5.b. 2: Two-Way Repeated-Measures ANOVA on Psychosocial Adjustment							
	Sphericity Correction	Sum of Squares	df	Mean Square	F	p	η^2
Time	Sphericity Assumed	11.195	2	5.598	45.217	< .001	0.659
	Greenhouse-Geisser	11.195	1.417	7.902	45.217	< .001	0.659
	Huynh-Feldt	11.195	1.490	7.516	45.217	< .001	0.659
Time * Group	Sphericity Assumed	0.583	4	0.146	1.177	0.335	0.034
	Greenhouse-Geisser	0.583	2.834	0.206	1.177	0.334	0.034
	Huynh-Feldt	0.583	2.979	0.196	1.177	0.334	0.034
Residual	Sphericity Assumed	5.199	42	0.124			
	Greenhouse-Geisser	5.199	29.753	0.175			
	Huynh-Feldt	5.199	31.280	0.166			

Table 5.5.b2 revealed that there is no interaction effect (Time X Group) on Global Severity Index. In general, the results indicate that during pretest there was no difference between the groups on psychosocial adjustment hence it reflected across the three testing periods (interaction of Time and Group).

Table 5.2 1: Descriptive Statistics of Participants on Psychosocial Adjustment

Time	Mean				SD			
	Bud.	Kris.	Amp.	Total	Bud.	Kris.	Amp.	Total
Pretest Global Severity Index (GSI)	1.5459	1.8729	1.8764	1.7927	.74481	.60240	.77123	.70361
1 st Post-test Global Severity Index (GSI)	1.3603	1.5010	1.4287	1.4327	.58793	.66062	.63248	.60474
2 nd Post-test Global Severity Index (GSI)	.8761	.8136	.6602	.7589	.58648	.33812	.29810	.39036
Pretest Somatisation	1.7431	1.7805	1.6284	1.7014	1.09700	.70882	.74853	.80075
1 st Post-test Somatisation	.9812	1.6581	1.3946	1.3681	.69644	.63276	.61309	.66204
2 nd Post-test Somatisation	.6240	.7193	.6803	.6776	.63030	.36886	.36751	.42645
Pretest Obsessive-Compulsive	1.2272	1.6240	1.7020	1.5606	.91692	.56695	.92442	.82337
1 st Post-test Obsessive-Compulsive	1.0606	1.5764	1.4747	1.4008	.52352	.64447	.64039	.62325
2 nd Post-test Obsessive-Compulsive	.5883	.7431	.5959	.6369	.56519	.59982	.35248	.47135
Pretest Interpersonal-Sensitivity	1.1300	1.3264	1.2777	1.2550	1.06946	.93223	.93845	.92959
1 st Post-test Interpersonal-Sensitivity	.6717	1.6121	1.1186	1.1508	.51640	.93382	.49198	.71823
2 nd Post-test Interpersonal-Sensitivity	.3800	.8979	.6186	.6404	.41079	.69007	.45227	.53659
Pretest Depression	1.9494	2.4574	2.7323	2.4564	.85418	.72466	.73133	.79473
1 st Post-test Depression	2.0050	1.4574	1.4444	1.5883	.53748	.79765	1.00076	.85126
2 nd Post-test Depression	1.4217	.7431	.6868	.8869	.86120	.39508	.39759	.60887
Pretest Anxiety	2.3939	2.7669	2.5505	2.5744	.95258	.76894	.66287	.75007
1 st Post-test Anxiety	2.0606	1.3860	1.6262	1.6647	.77936	.46859	.88848	.77316
2 nd Post-test Anxiety	1.4494	.9812	.7474	.9911	.95839	.50395	.34451	.63306
Pretest Hostility	2.1383	2.0050	2.3323	2.1883	.60222	.69282	.77600	.69761
1 st Post-test Hostility	1.6383	1.4050	1.2595	1.3967	.86178	.93095	.73262	.80321
2 nd Post-test Hostility	1.0717	.8050	.4959	.7300	1.04817	.32660	.40362	.62918
Pretest Phobic Anxiety	.8383	1.4621	1.6959	1.4133	.73121	.75467	.81665	.82458
1 st Post-test Phobic Anxiety	1.2050	1.6907	1.3323	1.4050	.57966	.67188	.62784	.63246
2 nd Post-test Phobic Anxiety	.9717	.7193	.6595	.7550	.52789	.44508	.49064	.48365
Pretest Paranoid Ideation	1.1383	1.4907	1.5686	1.4383	.58878	.73808	.91572	.78390
1 st Post-test Paranoid	1.2050	1.4336	1.5868	1.4467	.50596	.96904	.84121	.79559

2 nd Post-test Paranoid Ideation	.7050	.8336	.6959	.7383	.57619	.40708	.30151	.39855
Pretest Psychoticism	1.0383	1.6621	1.4595	1.4133	.92448	.52554	.84896	.79231
1 st Post-test Psychoticism	1.2717	1.1479	1.3868	1.2883	.27325	.65027	.67796	.58060
2 nd Post-test Psychoticism	.7717	.9479	.6414	.7633	.69761	.32071	.42725	.47905

Bud. = Budumburam; Kris. = Krisan; Amp. = Ampain

Table 5.2 2: One-Way Repeated Measures ANOVA on Psychosocial Adjustment

Measure			SS	df	MS	F	Sig.	Partial Eta Squared
Time	GSI	Sphericity Assumed	13.804	2	6.902	57.157	.000	.704
		Greenhouse-Geisser	13.804	1.397	9.880	57.157	.000	.704
		Huynh-Feldt	13.804	1.457	9.475	57.157	.000	.704
	Somatisation	Sphericity Assumed	12.551	2	6.276	33.837	.000	.617
	Obsessive-Compulsive	Sphericity Assumed	9.874	2	4.937	26.477	.000	.558
	Interpersonal-Sensitivity	Greenhouse-Geisser	4.791	1.363	3.515	6.321	.011	.231
	Depression	Sphericity Assumed	22.967	2	11.483	46.858	.000	.691
	Anxiety	Sphericity Assumed	25.890	2	12.945	50.892	.000	.708
	Hostility	Sphericity Assumed	21.045	2	10.523	39.578	.000	.653
	Phobic Anxiety	Greenhouse-Geisser	5.234	1.472	3.556	11.777	.001	.359
	Paranoid Ideation	Sphericity Assumed	6.509	2	3.254	10.990	.000	.344
	Psychoticism	Sphericity Assumed	4.538	2	2.269	8.401	.001	.286
Time * Group	GSI	Sphericity Assumed	.583	4	.146	1.177	.335	.101
		Greenhouse-Geisser	.583	2.834	.206	1.177	.334	.101
		Huynh-Feldt	.583	3.268	.178	1.177	.335	.101
	Somatisation	Sphericity Assumed	.918	4	.230	1.238	.310	.105
	Obsessive-Compulsive	Sphericity Assumed	.564	4	.141	.757	.559	.067
	Interpersonal-Sensitivity	Greenhouse-Geisser	.934	2.726	.343	.616	.595	.055
	Depression	Sphericity Assumed	5.483	4	1.371	5.593	.001	.348
	Anxiety	Sphericity Assumed	2.603	4	.651	2.558	.052	.196
	Hostility	Sphericity Assumed	1.597	4	.399	1.502	.219	.125
	Phobic Anxiety	Greenhouse-Geisser	3.259	2.944	1.107	3.667	.023	.259
	Paranoid Ideation	Sphericity Assumed	.509	4	.127	.430	.786	.039
	Psychoticism	Sphericity Assumed	1.454	4	.363	1.346	.269	.114
Error (Time)	GSI	Sphericity Assumed	5.199	42	.124			
		Greenhouse-Geisser	5.199	29.753	.175			
		Huynh-Feldt	5.199	34.319	.152			
	Somatisation	Sphericity Assumed	7.789	42	.185			
	Obsessive-Compulsive	Sphericity Assumed	7.831	42	.186			
	Interpersonal-Sensitivity	Greenhouse-Geisser	15.915	28.621	.556			
	Depression	Sphericity Assumed	10.293	42	.245			
	Anxiety	Sphericity Assumed	10.683	42	.254			
	Hostility	Sphericity Assumed	11.166	42	.266			
	Phobic Anxiety	Greenhouse-Geisser	9.333	30.913	.302			
	Paranoid Ideation	Sphericity Assumed	12.436	42	.296			
	Psychoticism	Sphericity Assumed	11.343	42	.270			

Chapter Six

Discussion, Conclusion and Recommendations

Introduction

This chapter examines the findings emanating from study one and study two. It also discusses the techniques used within the various stages of NTU psychotherapy. The chapter ends with conclusions and recommendations on further applications of NTU psychotherapy and other areas of potential research into this promising system of psychological intervention.

Discussion of Findings

The study set out to investigate the effectiveness of NTU psychotherapy as a system of therapy for the management of trauma. The results of this study by and large demonstrated that indeed, NTU psychotherapy is quite a useful tool in the managing trauma.

This study grew out of the need to investigate the possibility of a system of intervention that is both culturally competent and responsive to the needs of clients, but is also reformative in that it helps clients to restore their alignment with their community and become agents of change.

The first major objective of this study was to investigate how successful NTU psychotherapy is in the treatment of trauma and to ascertain if NTU psychotherapy can lead to an alleviation of signs and symptoms of trauma. The study revealed that NTU psychotherapy is highly effective in trauma management. This agrees very much with the work done by other researchers who investigated the effectiveness and uses of NTU psychotherapy in other different areas. For instance, Cherry, Belgrave, Jones, Kennon,

Gray &Phillips, (1998) demonstrated that NTU intervention is quite effective in managing drug related behavior. A general examination of the four main statements of hypothesis quantitatively demonstrated the effectiveness of this system of intervention

Does NTU Psychotherapy lead to a Decline in PTSD?

The first statement of hypothesis was that individuals who had undergone NTU psychotherapy would show a significant decline in overall PTSD over time. The hypothesis was confirmed. The PCL-C is a self-report inventory that allows respondents to subjectively report on how they are feeling at any point in time.

Psychology Beyond Borders (2008) has already identified some forms of therapy that are evidence-based and have been proven to work with cases of trauma among former child soldiers. Some of the forms they identified included:

- Group Interpersonal Therapy (IPT-G), a structured, time-limited therapy developed for the treatment of depression symptoms
- Group interventions focused at developing mind-body techniques (including meditation) to reduce posttraumatic stress reactions
- A group therapy developed for victims of torture which integrates components of a number of supportive group psychotherapy and cognitive behavioral techniques
- An individual intervention: Trauma Focused Therapy/ Narrative Exposure Therapy (NET) – a short-term therapeutic intervention that integrates components of cognitive behavioral therapy and storytelling.

Since NTU psychotherapy is somewhat eclectic in orientation it adopts a few of the various techniques. Within the framework of NTU psychotherapy each of the following techniques were used to a certain extent within the course of the therapy.

Another point of interest in this study is the fact that NTU Therapy appears to have more effect on an individual with a PTSD condition from point 1 to point 2 than from point 2 to point 3. From the initial pretesting period to the first post-test is where the first three stages of harmony awareness and actualization are utilized. It should come as no surprise, because during these early stages most clients are often prone to showing rapid signs of decline of symptoms.

The harmony stage is the first stage and it is at this stage that the therapeutic bond is established between the client and the clinician. Harmony goes beyond just the client opening up and warming up to the clinician; it also includes creating an ambient environment where the client feels safe to unburden themselves and lower their defences even as they respond to the clinician. Within the framework of NTU psychotherapy, the therapist is a medium guiding the client to express their deepest fears and anxiety and it is of the utmost importance. Some of the major techniques used in this phase included prayer, humour, and self-disclosure

In the awareness stage clients re-examined their experiences and those aspects that might have contributed to the development and perseveration of the presenting complaints. To become aware in the therapeutic context is to experience connectedness of the various components of oneself or the family system, and to be able to distinguish between one's needs and boundaries and the needs and boundaries of others (Philips,1992). In the earlier phase of awareness, a lot of the clients for instance, participants from Ampain camp had complained about the lack of basic support from the UNHCR and how things were hard for them as compared to their homeland. But

during the awareness stage they had to deal with the reality that they were still largely responsible for their lives and they had managed to do a fantastic job, firstly by staying alive and secondly by having their significant others still around them even though they were taking it one day at a time.

What this also appears to suggest is that for most clients, they are likely to report a rapid decline in symptoms during the early part of therapy, especially after sharing their experiences in an environment of safety and harmony with the therapist. As one participant from the Krisan camp puts it, ‘it feels so good to have someone travel all the way from Accra to come and help us. It feels so relieving to talk to someone who wants to hear our story.’ The process therefore of just opening and recounting the experiences though frightening at first is a very key first step in helping the participants to recover. The main technique that was used at this level was reframing. Reframing is a technique by which a client’s cognitive appraisal of a situation is slightly modified in order to have a particular effect.

Where reframing takes place, an individual recounts the experience that they have had from the conflict. During this period of recounting the experience the therapist is on the journey with them, helping them to re-examine some of these experiences. As they re-examine some of the issues they are made aware of their fears and anxieties and how these have continued to plague and haunt them even in the safety of the home country (Ghana).

It is mostly at the awareness stage, when respondents become *aware* of the dimensions of their problems that they become to feel the burden unfold. This is the likeliest

explanation for the initial sharp decline in symptoms noticed during the first few sessions. This conclusion is consistent with research in related areas. Stability and trustfulness of the relationship between patient and therapist are probably the most influential factors for psychotherapeutic treatment success.

Would Ntu Psychotherapy lead to Decline in Symptoms of Trauma

The second hypothesis stated that individuals who undergo NTU psychotherapy should show an improvement in symptoms of trauma over time. Again this finding was confirmed. The BSI measures along eight clinical scales which also manifest in psychosocial functioning. Such scales as paranoid ideation, interpersonal sensitivity, anxiety and psychotism are all important units of measure of an individual's psychosocial functioning.

Again, another factor worthy of note was that over a period of time, the respondents showed a more marked level of improvement. This agrees with the works of previous researchers. Indeed, previous studies have consistently shown for instance that individuals who had access to a more individualized

System of support such as personal counselling or even individual cognitive behavioural therapy actually showed a faster rate of improvement than others who did not.

Does NTU Psychotherapy Increase Africentric Awareness

The third statement of hypothesis was that "Individuals who undergo NTU psychotherapy shall demonstrate a greater awareness and consciousness of their africentrism." Again, this was confirmed by the data. During early sessions, most of the respondents had expressed disdain and, to put it more strongly, disgust for African values and 'the black man' as they often put it. As one of the participants from the

Budumburam camp put it, ‘everything about the black man is black; black skin, black sense, black brains.’ Another person quoted an often used refrain; ‘if we take all the black people to Europe and all the white people to Africa and give them a few years you’ll come back and see Africa would have flourished and Europe would be totally messed up.’ Of course, not everyone agreed with these statements but the general consensus was that the destruction of their various nations had been brought about by their own kith and kin. The intervention itself however focused on some of the positive traits that they as Africans had that helped them to go on even in the face of their harsh conditions. Some of the main techniques that were used to help them to re-establish a more positive afri-centric outlook included guided visualization, libation (prayer) and genograms. A more vivid description of these techniques will be provided in the next chapter.

The confirmation of this hypothesis is also in tandem with the work of Cherry et al (1998) that showed that following an NTU intervention there were improvements in knowledge and consciousness of African American youth as well as an improvement in self-esteem and school behaviours. Unsurprisingly it can then be implied that where an individual is more comfortable with their identity then it should be easier for them to draw strength firstly from themselves and from the community in a bid to deal with the trauma that they may be experiencing. O’Neil and Spybey (2003) report that a refugee’s identity reformation are the opinions and perspectives forced or imposed upon them by society due to their refugee status.

Is Ntu Psychotherapy Associated with a Decline in Hostility?

The fourth hypothesis stated that individuals who undergo NTU psychotherapy shall show a decline in hostility over time. Again, this statement of hypothesis was confirmed. Hostility is a major issue among populations that have experienced trauma. It is often expressed in several different ways, as manifested by the Buss-Durkee Hostility Inventory (BDHI). Emerging studies point out that although a lot emphasis has been placed on fear, anxiety and helplessness among people struggling with PTSD, not enough attention has been paid to anger among persons struggling with PTSD. Orth and Weiland (2006) undertook a meta-analysis of 39 published studies that explored the strength of the association between anger and PTSD and hostility and PTSD.

The results of the meta-analysis showed that 'anger and hostility are substantially associated with PTSD among trauma-exposed adults.' Effect sizes did not differ significantly for anger and hostility, and the authors thus combined the findings for both, producing a large effect size of .48. the studies covered a wide variety of traumatic experiences such as technological disasters, criminal victimization and military experiences. The fact that the studies varied so widely, but all produced results of this order, 'strengthens the generalizability of the results.' These findings also indicate a stronger correlation between 'anger in' and PTSD than with 'anger out', and show a large negative correlation between anger control and PTSD. This suggests that strong post traumatic stress reactions 'reduce the ability of an individual to control anger by decreasing mental resources.'

‘Anger in’ refers to anger that is kept bottled inside; persons typically manifest this anger in such covert ways as passive-aggressive behaviour or suspiciousness. ‘Anger out’ refers to the kind of anger that is typically expressed in a more overt manner such as physical and verbal assault.

It also further demonstrates that most people shall express their anger in more hostile and internalized ways rather than externalized. Hence the study showed that people on the average reported higher scores for suspiciousness, indirect hostility and verbal hostility than for physical assault. People therefore tended to internalize the anger and hostility more often than they externalized it. This appears to fall in line with other previous studies.

The study also quite interestingly showed an increase in scores of respondents between the pretest and the first post-test. Although this is a rather uncomfortable development it was not entirely suprising. This situation is almost akin to transference in psychodynamic intervention. In a previous unpublished intervention undertaken in budumburam refugee camp for Liberian former child soldiers, the same trend was also observed. There is however an argument that such heightened emotions and even symptoms are part of the therapeutic process (Greenberg & Pascual-Leone, 2006). In a series of studies on behavioral exposure (Foa, Riggs, Massie, & Yarczower, 1995; Jaycox, Foa, & Morral, 1998), argued that in managing PTSD, a positive outcome for persons who had been raped was predicted by aroused expression of fear while retelling trauma memories during the first exposure session and by the attenuation of distress during exposures over the course of therapy. In addition to this, Paivio, Hall, Holowaty, Jellis, & Tran (2001) further assert that emotional arousal during therapy is also part of the healing process.

At this point the another explanation for this, short of any extreme intervening variables, could be that the NTU intervention often creates a heightened awareness, especially between the awareness and alignment stages where participants become more conscious of their feelings and behaviours. Hence emotions that they had previously

been suppressed or even expressed as ‘anger in,’ are now more heightened and seen to be problematic by the respondents. One can only infer that an issue like suspiciousness for instance tends to be viewed as a positive thing till persons struggling with PTSD are confronted with how suspiciousness tends to affect their daily lives. In all the camps for instance, during the first encounter before the screening exercise exhaustive meetings took place mostly aimed at ensuring the participants that the primary researcher was not from one organization or the other that was not looked favourably upon the residents of the camps.

The issue of a rise in symptoms during the course of the intervention is however something that calls for further investigation. Unfortunately, it also appears that there is not too much research available on that matter.

Will Differences Exist in Recovery Levels among The Camps?

The fifth statement of hypothesis was that differences would exist in recovery levels among the refugee camps. This was also confirmed. Residents of the various camps have lived in the relative safety of the host country for different periods. Some residents of Budumburam have lived there for almost two decades while residents of Ampain had lived there for less than four years. With the passing of time, the traumatic experiences and symptoms may tend to become less intense and distressful (Bonano, 2004).

Higher differences existed between the groups than they did within the groups. Members of the same camps thus tended to have similar levels of trauma. This was further confirmed by the fact that the greatest differences were noted between the oldest and the youngest camps (Budumburam and Ampain) which had the least recent to the most recent survivors of trauma.

Furthermore, it was observed that the camps with the highest levels of PTSD also showed the sharpest levels of decline. This was especially noticed during the period between the pre-test and first post-test. Thus we see a sharp level of recovery during the early stages of therapy and then the clients move into a more ‘gentle and stabilizing period’.

A Vivid Description of the Stages and Techniques Used in the Intervention

As has been discussed previously, NTU psychotherapy is broadly divided into five main parts. This section aims at providing a description of the various stages and the activities that were undertaken at each stage as well as the main techniques that were used.

Pre-Screening

Before the intervention began the primary investigator met all individuals who were willing to take part in the program at the various camps. Although the meetings were largely held with groups, several of the members still chose to meet with the researcher on an individual basis. Again in such camps as Ampain and krisan, most of the participants could not speak English. Interpreters were heavily relied on therefore for this research. The pre-screening stage is very important because it is where the tone is set for the research. One of the most common expectations among refugees entering any program is what they expect to benefit. Due to the endemic poverty and lack of resources in the camp, most persons expect to derive some material benefits from such programs. It was therefore essential that the researcher explain some key issues:

1. What type of research is being done
2. It is not sponsored by any external organization

3. The research was primarily for academic purposes
4. There were no material benefits like money etc to be gained from participation
5. The study was for persons who had been directly experienced to traumatic experiences from their countries of origin that was still having a debilitating effect on them
6. Participants had to be prepared to commit for a period of up to three months for the intervention

These were some of the major issues that arose from the pre-screening interactions with the potential participants. Understandably, after this there were a few individuals who left for a number of apparent reasons. Firstly, was the lack of financial rewards. For many refugees in the camps one of the biggest concerns is getting enough food and other essentials to get by. Any non-resident offering them something else is perceived as a waste of time. This falls in line with long-held attitudes towards psychotherapy particularly among Ghanaians.

Others also pulled out because they felt that they were not really in need of such psychological help. This was particularly true in the case of budumburam where many of the refugees had been living in the country for years and so felt they really didn't need any psychological support. In the case of budumburam refugee for camp for instance, several of the residents had been exposed to one form of psychological support or the other.

Screening

Screening or pre-testing was another very important part of the program. The screening process is used to establish whether would-be participants satisfy the inclusion criteria.

Individuals were screened by using the four main psychological tests. Those who had significant scores on the tests were then shortlisted for the intervention program itself.

Harmony Phase (Phase One)

This phase was conducted on a one-on-one basis. As discussed earlier, the main focus of the harmony stage is the creation of a shared experience through which a therapeutic bond can be established. The main techniques used at the harmony phase were humour and self-disclosure. During these sessions the researcher tried to identify things he had in common with each participant. Authenticity (being as ‘real’ as possible) is also a very essential part of the therapeutic process. During these early sessions one of the issues that emerged especially among those in the two westernmost camps of Ampain and Krisan was a sense of abandonment by the host organizations and a sense of gratitude for the intervention even though it was largely academic in orientation. For this matter, the researcher received very little resistance from participants. A sense of humour was also generally established.

Self-disclosure can be defined as a process whereby a therapist gives information about themselves to a client (Zur, 2011). It can be of four main types namely deliberate, unavoidable, accidental and client’s deliberate actions. For the purposes of this study, however it was only deliberate self-disclosure as well client’s deliberate actions that occurred.

In deliberate disclosure the therapist (in this case the researcher) disclosed personal details about himself and his family roots which helped the participants develop the needed bond

Awareness Phase (Phase Two)

This covered the second to sixth sessions roughly. During the awareness phase, the main aim was to help participants develop a deeper understanding of the connectedness of the various components of their lives. For most of the participants, the process of reliving their painful experiences was something they had shied away from for a very long time. According to Philips (1990), Awareness implies recognition. Thus it is at the awareness phase that most participants begun to recognize some of the negative patterns of thinking and behaviour and how these had contributed to their present state of trauma and its associated challenges. During this phase, clients were made to see how their past experiences had contributed to their present sense of suspiciousness as well as other presenting complaints. As has been discussed previously in chapter two, most of the experiences of the participants were highly subjective in nature. However during these sessions as the participants met the researcher on an individual basis they were each helped to develop an awareness of their personal situations.

Techniques Used

The main techniques used during this phase included the awareness wheel, relaxation techniques and guided visualization.

Relaxation techniques are a series of exercises aimed at helping patients to deal with anxiety and bodily tension. Breathing for instance has been found to be highly effective in dealing with anxiety, depression, irritability, muscular tension and fatigue (Davis, Eshelman and McKay, 1988). However during this study, the two main relaxation techniques used were deep breathing and progressive muscle relaxation. For those who are well-versed in its use, deep breathing can offer one a quick respite from bouts of

anger, anxiety, hostility, tension and depression just to name a few. Healthwise Staff (2012) state some of the more obvious advantages of deep breathing:

‘Deep breathing is one of the best ways to lower stress in the body. This is because when you breathe deeply, it sends a message to your brain to calm down and relax. The brain then sends this message to your body. Those things that happen when you are stressed, such as increased heart rate, fast breathing, and high blood pressure, all decrease as you breathe deeply to relax.

- The way you breathe affects your whole body. Breathing exercises are a good way to relax, reduce tension, and relieve stress.
- Breathing exercises are easy to learn. You can do them whenever you want, and you don't need any special tools or equipment to do them.
- You can do different exercises to see which work best for you.’

Progressive Muscle Relaxation

Davis, Eshelman and McKay (1988) assert that, ‘you cannot have the feeling of warm well-being in your body and at the same time experience psychological stress.’ According to them progressive relaxation is quite effective in managing a wide variety of problems including muscular tension, anxiety, insomnia, depression, fatigue irritable bowel syndrome high blood pressure and mild phobias just to name a few. Progressive muscle relaxation provides a way of identifying particular muscles and particular muscle groups and distinguishing between feelings of tension and deep relaxation. Thus, by putting participants in this state of relaxation it helps them deal with some of their more immediate physiological symptoms. Being in a state of relaxation is also essential for successful guided visualization.

Guided Visualization

Guided visualization or imagery is a technique that is used to help bring people into a state of relaxation. But it is a lot more than that; it is a powerful technique that can be used to help people confront unpleasant experiences and seek answers to problems in ways that they emanate from themselves. Emil Coue (1857-1926) is one of the principal pioneers of visualization, asserting that we are the products of what we think. For instance, when a person thinks sad thoughts they become unhappy and when they think anxious thoughts, they become tense. To counter this, Coue had his patients repeat to themselves at least 20 times a day, the phrase, 'Every day in every way I am getting better and better.' Further to this, he recommended that as they were going to sleep, just before they entered unconsciousness they should introduce into their minds desirable ideas.

Guided visualization however as used in NTU psychotherapy appears to be more consistent with Carl Jung's method of active imagination. Patients were allowed to meditate without any specific goal. Images would then come to mind as well as thematic issues related to these images, which would then be explored. Jung used active imagination to help the individual appreciate his or her own life and learn to draw on their own healing power in times of stress. Gawain (1978, 1985) asserts that visualization is a form of energy that creates life and life's happenings. It is our mind that creates our world for us.

With Guided Visualization, the client is encouraged to visualize a scene that they are comfortable with. The therapist's involvement is rather limited to the first few scenes and a collection of rather neutral cues. The patient's mind does the rest and from there it finds its own path. After this, the patient then explores the experience with the

therapist (in this case the researcher) in order to find out what major thematic issues are emanating from the experience. It is important that during this process, the therapist does not try to introduce their own subjective interpretation to whatever experience the client might have had. It is the clients' experience and it is for them to discover what their inner voice is trying to say to them.

Guided visualization has been proven to be useful in managing specific and general anxieties, headaches, chronic pain and many stress-related as well as physical illnesses (Davis, Eshelman and McKay, 1988).

With regards to this study more specifically, Guided visualization was used to help the participants explore their inner emotions and discover what hidden anxieties and conflicts had been keeping them pinned down. In broad detail, the major issues that arose were to do with forgiveness, reconciliation with family and achieving self-sufficiency. These were further explored and confronted at the alignment phase (phase three).

Awareness Wheel

Awareness wheel is a very useful tool not just in psychotherapy, but even in communication. The awareness is used to establish a relationship between an individual's senses, thoughts, feelings, desires and actions. Miller, Sherod and Phyllis (2014) gave a tabular representation of the various segments of the awareness wheel. It is presented on the next page

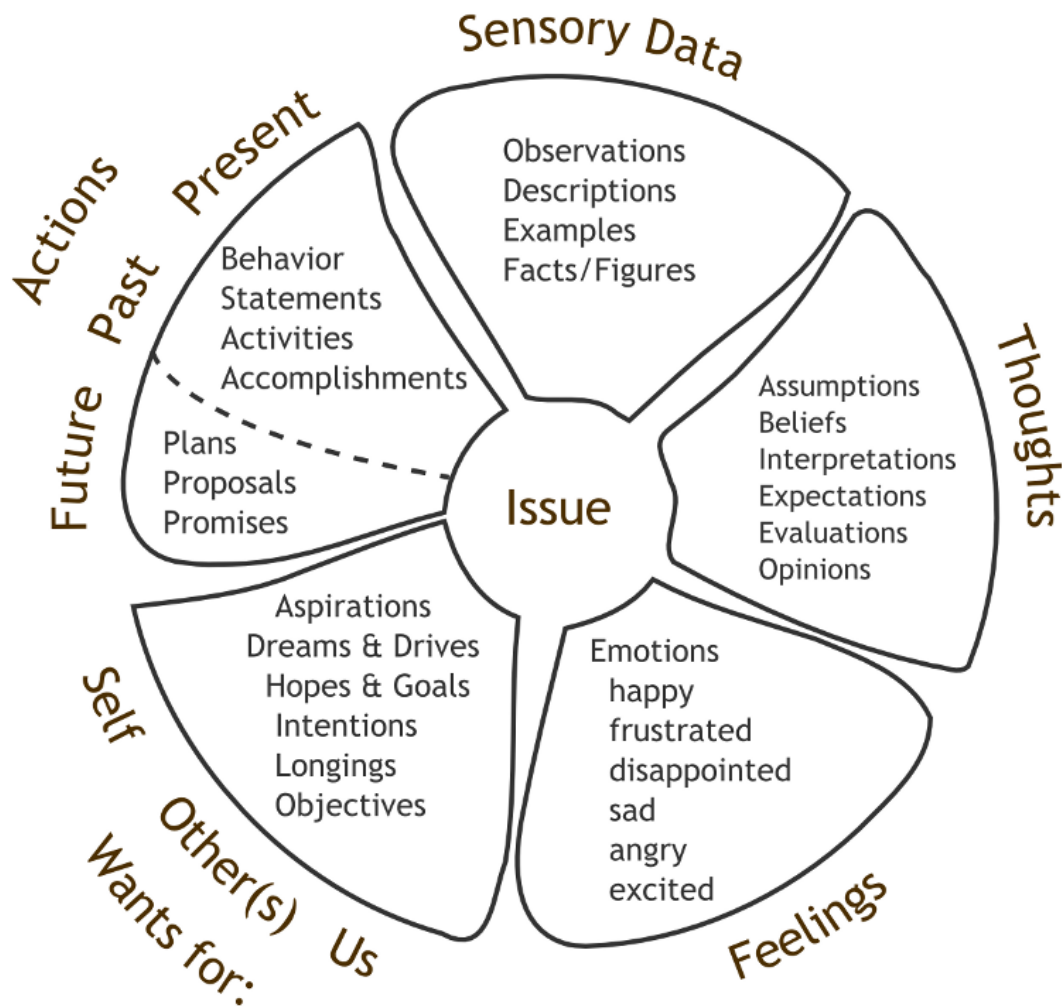
Sensory Data	What have I seen, heard?
Thoughts	What do I think is going on? What are the stories in my head? Beliefs, judgments, influences
Feelings	How am I feeling? Mad, Sad, Glad, Afraid, Surprised, Disgusted
Wants	What do I want? For myself, for others, for stakeholders What are my intentions, desires, hopes
Actions	What will I do (future)? What have I been doing (past and current)?

(Miller, Sherod and Phyllis, 2014)

Table 6. 1: Awareness Wheel

Typically, however the awareness wheel is often represented as seen on the following page;

Awareness Wheel



Miller, Sherod and Phylis (2014).

Figure 6. 1: Awareness Wheel

The awareness circle helps the client to develop a better understanding of the interaction between their experiences, their perception of these experiences, their response to the experiences and how these experiences in turn influence other future behaviours.

Thus using the awareness wheel, participants were helped to see that their actions (as could be seen from the diagram) had been primarily influenced by their past experiences which had coloured their senses, their thoughts and their feelings firstly of themselves

as well as what they believed others expected from them. At every point on the awareness wheel, participants discussed the various responses they had so far been eliciting in response to their personal traumatic experiences. For instance in the case of one of the refugees at the budumburam camp, he ended a session by saying, ‘I now realize that I have been wasting so much time feeling sorry for myself that I seem to have forgotten that I have a family that I am responsible for; even ideas appear to have been running away from me now (MZ).’

Other techniques included empathetic listening, reflection and reframing.

Empathetic Listening

Empathetic Listening is a very important tool in NTU psychotherapy. Also sometimes referred to as active listening, it is a method of listening that involves understanding both the content of a message as well as the intent of the sender and the circumstances under which the message is given. Empathetic listening allows the listener to reach out to the heart of the talker. This is a very important skill because people need to feel, not only that they are being heard or understood, but also that their emotions (be it pain, anger, regret, etc) are also being understood. According to Burley-Allen (1995), empathetic listening includes such factors as being aware, being in the present moment, acknowledging the other, resisting distractions, paying attention to verbal and non-verbal communications, and being empathetic to the speaker’s thoughts and feelings. Stewart and Logan (2002) identified three essential components of empathetic listening namely, focusing, encouraging and reflection.

Focusing allows the listener to pay rapt attention to the speaker and keep a focus on them. It includes such factors as maintaining good eye contact and reading body language.

Encouraging skills is the process of encouraging the speaker to talk more. This can be achieved using the listener's body language. Such things as nodding (or shaking) of the head or even mirroring the speaker's words are all part of encouraging skills.

Reflective skills are seen in a listener's ability to reflect the message that the speaker is seeking to communicate. In the words of Cuny et al, 'To listen effectively one needs to check understanding regularly by summarizing and paraphrasing what the other has said. After summary one must wait for feedback. Following feedback, the consultant needs to either confirm that they share understanding, or offer clarification of what the speaker might have intended.'

Alignment Phase (Phase Three)

The major task during the alignment phase is to help the client reconcile their anxieties or challenges. The major issue here is in helping the client to confront their core neurotic challenges in an environment that is safe and controlled. During this phase a lot of emphasis is placed on strong support from the therapist.

In the case of this study, the key techniques that were used at this point were guided narrations, progressive muscle relaxation and guided visualization. The main objective at this stage was to help the clients confront the core issues that had been stifling them.

During this phase, three major thematic issues kept surfacing in all the three refugee camps: forgiveness, reconciliation with family and self-sufficiency. Most of these issues seemed to appear in response to the earlier concerns of refugees living in the camps. These concerns were raised in chapter four of this study (please refer to pages 94-103). These issues came out as solutions or 'epiphanies' emanating from the sessions in response to the challenges that had been previously identified by the participants. Each of these three issues will be discussed briefly.

Major thematic issues emanating from alignment phase

It is in the alignment phase that most participants explore ways of dealing with their problems. For some it may come through a sense of epiphany; an awareness of why they are going through what they are going through. For others, it may come as a profound sense of relief from sharing which brings them a certain sense of renewal. Different people experience it in difference since no two problems began in the exact same way. As a result of this, it is at this stage that issues may arise in the form of resolutions or proposed paths that the individual must take if they are to enjoy healing. In the case of this research, some of the most important ones are presented below as thematic issues arising from this stage.

Forgiveness

Forgiveness was a major issue for several of the participants because most of them were still struggling with a sense of betrayal. It should not be forgotten that for most of these persons, several of them were from urban communities where they had previously co-existed with people from other tribes and ethnic groupings; the same ethnic groupings that had visited such tribulation, violence and hardship on them.

In the case of DS from Ivory Coast it was his neighbours who were from the southern part of the country who gave up his uncle to be executed. He was forced to kneel down and watch as his uncle was shot in the head. So although presently he lives less than two hours' drive away from his home country he can't go back.

For someone like this the guided visualization process helped him to come to terms with the fact that he has to forget the past and forgive what has happened to him. Although he has no immediate plans to return to his home country, he realized that he had to let go of the past and start preparing for a future, especially with his family.

Reconciliation with family

Most of the participants had also lost ties with family. For some of them, they had deliberately cut ties with family because during the course of the conflicts they had been abandoned to fate or placed in very tight corners by family members, especially extended family. In most African countries the extended family system plays a very important role. Mbiti (1969) asserts that “in traditional life, the individual does not and cannot exist alone except corporately. He owes his existence to other people... The community must therefore make, create or produce the individual... Only in terms of other people does the individual becomes conscious of his own being, his own duties, his privileges and responsibilities towards himself and towards other people”

Further to this, the extended family was as a means of mutual support. Since ‘one was because others were’, members of the extended family supported each other psychologically and practically, e.g. in farming, rearing of children, supporting elder persons and the sick. In case of any need, an individual could count on support within his extended family. It was also a means of ensuring security, since usually a number of members of the extended family would live in the same compound or close to each other.’

The Society for Community Research Action (SCRA) 2010, makes an interesting observation that during the early days of a disaster most people go the extra mile to help each other but as things wear on, relationships get strained and severed; people are removed from their social networks either as a result of death of some members (of family, for instance) or through relocation. The result is the anxiety, depression and other symptoms that are exacerbated by the lack of support.

What this means therefore is that for most of the participants, the extended family should have been a very important line of defence against trauma. For some of these, they were cut off from them in a rather abrupt manner. For others they were let down by them when it mattered most. Ultimately the consequence has been the same. A sense of separation and severance from these roots meant that most of them have been feeling extremely lonely and extremely vulnerable. CS from Liberia, for instance lost her husband in the early years of the war but by the time she found her way back to her family house, it had been reduced to rubble.

‘Everybody was gone,’ she said. ‘And now even if I get there I don’t think anyone might have returned. And if they have returned, who will know me? There’s nothing for me there now; my family is my daughter and my grandchildren; and they are all here.’

YK from Ivory Coast came for her brother’s funeral from France and before she could return the war broke out. Her two older brothers could have helped her get back to France from where she could have helped them but they did not. Now she is stranded in Ghana and estranged from her family who she has not reconciled with. Guided visualization helped these two persons to confront this problem and to come to terms with their present realities even as they plan ahead.

Self Sufficiency

Self-sufficiency has a lot to do with the sense of helplessness and anxiety that most refugees suffer. This sense of helplessness continues even after refugees have fled their countries of origin and are enjoying the relative safety of a refugee camp in a host country. Again SCRA (2010) have something quite poignant to say about this.

“The more that people can take charge of their own care and recovery, the more they will feel a sense of confidence in themselves, their families, and communities. Too much of a dependence on authorities and relief agencies can be counterproductive, making residents feel less rather than more capable.”

But for most of the refugees, especially among the participants it was realized that although they were eking a living, it was barely enough to go by. Most of them had lost so much self-confidence and self-esteem that they could hardly even see what opportunities were around them. It is worthy of note that although the UN and other agencies has invested so much in skills training for refugees, very few of them are actually able to harness the acquired skills to even raise their standard of living to even subsistence level. This is something that may require further research. It is unsurprising to meet a refugee who has been trained in basic plumbing, woodwork and computers (three unrelated fields) yet still cannot find a way to support his family. A woman might have been trained in soap-making and basket weaving yet may be struggling to get food for her family.

This does not mean that they are lazy; far from it. But in believing that they are not of the land and can not market their wares, they find safety and refuge in the camp and thus rarely venture out to sell their goods or experience life just outside the safety net of the camp. It should be pointed out that these camps have been in existence for years; Budumburam is almost twenty five years old and krisan is over fifteen years old. Clearly UNHCR is not in a position to give the same quality of care that was given in the early years, but the situation of refugees clearly still persists. Guided visualization helped them to come to terms with the realities of their present situation and also shift their focus from the present anxieties and fears. Participants opened up on their need to put the past behind them and start living their lives again.

Actualization Phase (Phase Four)

The actualization phase is the phase where the client or participant actually tries out new behaviours and attitudes within the environment that they function in. The main idea behind actualization is to put the ‘new person’ to practice and help them function in the authentic and well aligned manner that they are supposed to. Actualization can sometimes be something as simple as doing some homework or as complex as making a major life change. For some of the participants, the major assignment was stepping out of the safety and shelter of the camp and trying to mix with indigenous Ghanaians. As simple as this may sound, most of the participants had stated that some of the symptoms of anxiety, somatization and so forth were more pronounced outside the camp than inside. Some of the most common cues and triggers for anxiety episodes included the sight of check points, uniformed security personnel, guns and rifles, as well as struggling to communicate with Ghanaians when neither could understand the other. For this matter the camps had become more than just a place of residence for refugees; it had become an ivory tower, isolating them from the rest of the world and vice versa. It is insightful to note for instance, that in Ampain, the youngest of the camps, policemen on duty did not wear uniforms.

Mastery of deep breathing and relaxation techniques also proved to be very useful in helping the participants deal with the initial anxiety before undertaking some of these assignments.

Synthesis Phase (Phase Five)

During this phase, the main aim is to help the participant fuse the knowledge and lessons learned from awareness with the experiences and feedback from alignment. This is

expected to cover the three essential realms of the physical, psychological and spiritual aspects of the individual's life.

During the intervention, the synthesis phase was conducted in groups where participants reported on the homework they had been given and the challenges they experienced in dealing with those challenges. Most of them admitted that they had had initial apprehensions, but by undertaking the homework in little bits their confidence had grown and they were happy to follow through on bigger roles.

They thus reported lower and lower anxiety levels and less worry. Most of them also reported becoming less frustrated especially as they begun to develop a clearer picture of what their future could be both for themselves and their families.

The present study sought to investigate the effectiveness of NTU psychotherapy as an intervention for the management of trauma among refugees. Consequently, it established that indeed NTU psychotherapy could lead to a decline in symptoms of trauma. The study also further sought to investigate the possibility of NTU psychotherapy being used to establish a framework for the development of culturally competent systems of intervention.

Summary of Findings

From a quantitative perspective, all the four statements of hypotheses were proven.

- i. The first hypothesis that NTU Psychotherapy leads to a significant decline in signs and symptoms of trauma among refugees was confirmed. Indeed the study showed that NTU psychotherapy provides a steady but continuous decline in signs and symptoms of trauma.

- ii. The second statement of hypothesis was that Individuals who undergo NTU psychotherapy shall show significantly improving levels of psychosocial adjustment than previously was also confirmed.
- iii. The third statement of hypothesis was that Individuals who undergo NTU psychotherapy shall demonstrate a greater awareness and consciousness of their africentrism. This hypothesis was also supported.
- iv. The fourth statement was that Individuals who undergo NTU psychotherapy would show a significant decline in hostility over time. This was also supported by the study.
- v. The fifth hypothesis was that differences would exist in the recovery levels among participants from the camps. This was supported by the study

All the five statements of hypotheses were therefore supported by the study.

A closer examination of the NTU process itself also brought some issues to light. The study also begun with some key aims and objectives and it is necessary at this point to establish whether those aims and objectives were achieved.

The key objectives were as follows:

1. The first goal was to assess how successful NTU psychotherapy is in the treatment of psychotrauma. From the quantitative research, it can be deduced that NTU psychotherapy is quite effective in the treatment of trauma. Unfortunately, however the present study does not attempt to compare NTU psychotherapy with other systems of therapy that have traditionally been used in the management thus it is not possible using the present study to conclude that NTU psychotherapy is better than any other system of intervention.

2. To ascertain if NTU psychotherapy can lead to an alleviation of signs and symptoms of trauma. Again the study has confirmed that NTU psychotherapy is quite useful in alleviating signs and symptoms of trauma. With specific regards to participants' reports on the BSI it was noted that symptoms steadily reduced over time.
3. The third goal was to investigate if NTU psychotherapy works as a therapeutic tool for re-establishing sense of identity and communal values within a traumatized community. Although the study has shown that NTU works as an effective system of therapy, the design of the study has shown that participants are now better able to relate to their family and immediate community. This does not mean that life has become easier for the refugees but at least they are presently more in control and can relate better to other people.
4. To help establish a baseline by which an Africentric system of therapy can be further adapted and developed to meet the needs of the populace.

The study also confirmed that NTU shows promise in providing a framework for a system of therapy that is guided by African values and beliefs. The use of such techniques as libation, genogram, and guided visualization enable the respondents to dig into their personal value system and belief systems as well as their sense of self-esteem. Participants self-esteem is largely dependent on their communal identity. Ndengeyingoma and Miron (2013) have already established that personal characteristics, environmental factors and personal relationships are among the strongest factors that influence the development of personal identity.

Weaknesses of the Study

Perhaps one of the biggest issues with this research is that it is an *effectiveness study* but not an *efficacy study*. The study did not seek to compare NTU psychotherapy with any other form of therapy. It simply sought to investigate whether or not NTU psychotherapy does work for persons suffering from trauma. Refugees are a highly mobile population and in undertaking any research with refugees one must be guided by this fact. Obtaining a stable control group would therefore have been a problem and further to that, the researcher would have still had to take them through some psychological interventions as well.

It is strongly recommended that future studies may try to compare NTU psychotherapy with other forms of therapy to ascertain which is more efficacious.

Again, NTU psychotherapy offers promise not just for trauma management, but a host of other psychological problems including depression, anxiety, conduct disorders, phobic disorders and so forth. There is the need to undertake further of such evidence-based research to assertion the wide-reaching potential of NTU psychotherapy.

Evidence-based interventions are becoming more and more important because modern societies are becoming more and more diversified. Castro, Barreira and Steiker (2010) make a strong advocacy for EBIs in the face of a rapidly diversifying country. The same can also be said of Ghana which although having some three broad ethnic groups can be divided into several dialects and ethnic sub-groupings each with its own unique dialect, customs and conventions, etc.

Castro et al (2010) further argue that developing a cultural framework can be quite challenging because of the extremely rapid rate of change in cultural diversity of the population. In Ghana today, due to westernization and the moderating influence of

rapidly changing technology culturally competent therapies will also need to be able to reflect the changing needs of the individuals.

Another major weakness of this study is that it failed to address a very primary concern of the refugee populations which is economic self-sufficiency. Although this study is a psychological study, a truly effective intervention must have an element of economic empowerment. For most of the refugee families their trauma is further exacerbated by their economic problems. Any medium to long term projects aimed at giving support to refugees must combine both psychological support with economic support and empowerment whether it is skills training or land for farming or even capital or technical support.

It is therefore no surprise that during the study there was such a high dropout rate of 45.7% among participants. Refugees are a highly mobile group of people. Their number one priority is getting access to the basics of life. During the study most of them expected to be given some form of financial reward for taking part in the study and when they realized they would receive no such reward they lost interest. Others were also often quite late to sessions and so not much data was gleaned from them to contribute to the study. These challenges are no surprise as other researcher have reported similar challenges with punctuality and attendance to sessions (Baird et al, 2017).

The Implications of NTU Psychotherapy for Psychological Services in Ghana

One of the objectives of the research was to investigate the possibility of using NTU psychotherapy to provide psychological services in Ghana. From the findings it is obvious that NTU psychotherapy is effective in management of trauma.

Several of the techniques employed within NTU psychotherapy should resonate quite well with Ghanaians. For instance prayer (libation) is quite popular. Most Ghanaians are quite spiritual and look up to a higher power for spiritual guidance. The 2010 population census estimated approximately 71.2% of Ghanaians as being Christians, 17.6 % muslim and the rest belonging to other faiths. This reflects a population that is highly spiritual and so prayer as a means of communing with a higher power is quite an effective tool of healing. But it is not the only one

Communality lies at the heart of most traditional Ghanaian communities and it can also be used as a tool for bringing healing both at the individual and group levels. Indeed, during the interventions it was within the group sessions that several of the participants experienced their breakthroughs in dealing with problems; within that environment of sharing and supportiveness.

The core principles of Nguzo Saba (the principles of authentic and harmonious living) are already reflected in the socio cultural beliefs of Ghanaian society. Unity, Self-determination, Collective Work Responsibility, Cooperative Economics, Purpose, Creativity and Faith. These principles are not only curative in the sense that they can be used to heal broken individuals or societies, but they are also restorative and progressive in the sense that they can help in personal and communal elevation. We see some of these values reflected in certain Ghanaian cultural beliefs and adages. Unity, for instance is symbolized by the broom, which is easily broken as a single stick, but is absolutely unbreakable when in a bundle.

It is strongly believed that NTU psychotherapy could be an excellent model for use in Ghana because it sits so well with our African values and way of life

Recommendations

The first major recommendation is that further studies must be undertaken to ensure whether or not NTU psychotherapy works for other psychological problems as well as trauma.

Previous studies have already been undertaken especially in the United States to establish the effectiveness of NTU psychotherapy in a wide variety of psychological problems (Belgrave, Cherry, Cunningham, Walwyn, Letlaka-Roberts & Philips, 1994; Belgrave, Townsend, Cherry & Cunningham, 1997; Belgrave, Brome & Hampton, 2000). However, very few studies have been published outside the US to investigate NTU psychotherapy. It is only proper, then, that an African culturally competent system of intervention must be investigated in an African environment.

Secondly there is a need to investigate the effectiveness of NTU psychotherapy in the use of communal healing programs. Gregory and Jackson (2008) have already recommended that culturally competent programs such as NTU must include elements of collective and individual approaches to learning and problem solving as well.

Thirdly future studies into evidence-based interventions must be inter-disciplinary aimed at empowering the individual psychologically, spiritually and economically.

Conclusion

Donor agencies and host countries have done a fantastic job of supporting the millions of refugees and internally displaced persons globally as well as persons who may be struggling with trauma caused by non-conflict situations. Indeed, the Nobel Peace Prize awarded to the UN is nothing short of well-deserved, but moving forward there is clearly the need for more collaboration in providing refugees with the different facets of support they need. Some need psychological support, others may need medical

support and others may need training, either in skills or trade or basic language proficiency in the language of the host country. Most refugees might need more than just one of these types of support. Donor agencies must therefore adopt the same biopsychosocial-spiritual framework that has proven to be so useful in the health sciences. The same principles may be translated into providing refugees with a more holistic support so that not only are their experiences more useful in the host country, but they can also prove to be more useful agents of positive change in the hopeful event that they return to their home country.

As regards NTU psychotherapy the evidence supports the fact that it is a useful tool not just for managing psychological problems but it can be useful in healing broken families and reconciling (communal) ties that might have been broken. At a certain spiritual level it helps people reconnect with their communities and helps re-affirm an individual's Africanity. In spite of the promise it holds, more research needs to be done at both a quantitative and qualitative level to help make it more and more relevant especially to persons of African origin and beyond that, persons of varying culture.

It is hoped that this study shall mark the onset of a renewed interest in African Cultural Competence and its contribution to the development of psychology and by extension the Biopsychosocial Spiritual Approach to healthcare.

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Appendix B

Belgrave Africentric Worldview Scale (BAWS)

SECTION D: Below is a list of situations describing you perceive the world and your relations with others. Please tick the response that applies to you

SITUATION	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
1. I perform better on oral rather than written tasks.					
2. When greeting someone, I prefer verbal acknowledgements (rather than a nod or hand wave).					
3. I feel that sometimes I do things 'Just because it feels right'.					
4. I listen to my inner voice.					
5. I am likely to rely on my inner voice.					
6. I have to see something to believe it					
7. I can tell when a close friend is in trouble or feels bad.					
8. Attending churches, mosques, or other places of worship are important to me.					
9. I meditate and engage in other acts of faith.					
10. I believe in a spiritual force or power.					
11. When stressed, I put my faith in a higher being.					

12. When I hear music I respond actively to it.					
13. When speaking I am likely to use body language and hand gestures					
SITUATION	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
14. I view death as a spiritual event.					
15. When things don't work out, I try to see the positive side.					
16. People should be judged on who they are rather than material achievements					
17. It is expected that the elderly will be cared for by younger generations					
18. Older members of my family are relied on for advice/guidance.					
19. It is not unusual for me to call close family friends "uncle, aunt, etc.					
20. The ultimate value of a person is in his or her service to others.					
21. My successful achievements are due to the support of significant others.					
22. I usually arrive at meetings, classes, work etc before or at the exact specified time					
23. Remembering the past is as important as preparing for the future					

Belgrave Africentric Belief Scale (Belgrave et al., 1997)

Buss-Durkee Hostility Inventory

Hostility Inventory ✓

by Arnold H. Buss
and Ann Durkee

Tear out the facing page labeled "Answer Sheet." Use this form for recording your answers to the sixty-six statements listed below and on the next page (after the answer sheet is torn out). Decide if each of the statements is true (T) or false (F) as it pertains to you and record your response in the appropriate box on the answer sheet. Note: A duplicate answer form is printed on the back of the answer sheet.

1. Unless somebody asks me in a nice way, I won't do what they want.
2. I don't seem to get what's coming to me.
3. I sometimes spread gossip about people I don't like.
4. Once in a while I cannot control my urge to harm others.
5. I know that people tend to talk about me behind my back.
6. I lose my temper easily but get over it quickly.
7. When I disapprove of my friends' behavior, I let them know it.
8. When someone makes a rule I don't like, I am tempted to break it.
9. Other people always seem to get the breaks.
10. I never get mad enough to throw things.
11. I can think of no good reason for ever hitting anyone.
12. I tend to be on my guard with people who are somewhat more friendly than I expected.
13. I am always patient with others.
14. I often find myself disagreeing with people.
15. When someone is bossy, I do the opposite of what he asks.
16. When I look back on what's happened to me, I can't help feeling mildly resentful.
17. When I am mad, I sometimes slam doors.
18. If somebody hits me first, I let him have it.
19. There are a number of people who seem to dislike me very much.
20. I am irritated a great deal more than people are aware of.
21. I can't help getting into arguments with people when they disagree with me.
22. When people are bossy, I take my time just to show them.
23. Almost every week I see someone I dislike.
24. I never play practical jokes.
25. Whoever insults me or my family is asking for a fight.

Buss, A. H., and Durkee, A. An inventory for assessing the different kinds of hostility. *Journal of Consulting Psychology*, 1957, 21, 4, Table 1, p. 524. Copyright 1957 by the American Psychological Association. Reprinted by permission.

HOSTILITY INVENTORY

ANSWER SHEET

(Tear Out)



OVERALL
TOTAL
SCORE

NE	RE	IN	AS	SU	IR	VE
☐	☐	☐	☐	☐	☐	☐
1. _____	2. _____	3. _____	4. _____	5. _____	6. _____	7. _____
8. _____	9. _____	10. _____	11. _____	12. _____	13. _____	14. _____
15. _____	16. _____	17. _____	18. _____	19. _____	20. _____	21. _____
22. _____	23. _____	24. _____	25. _____	26. _____	27. _____	28. _____
29. _____	30. _____	31. _____	32. _____	33. _____	34. _____	35. _____
	36. _____	37. _____	38. _____	39. _____	40. _____	41. _____
	42. _____	43. _____	44. _____	45. _____	46. _____	47. _____
	48. _____	49. _____	50. _____	51. _____	52. _____	53. _____
		54. _____	55. _____	56. _____	57. _____	58. _____
			59. _____	60. _____	61. _____	62. _____
					63. _____	64. _____
						65. _____
						66. _____

HOSTILITY INVENTORY

ANSWER SHEET

(Tear Out)

OVERALL
TOTAL
SCORE

:

NE

RE

IN

AS

SU

IR

VE

- | | | | | | | |
|-----------|-----------|-----------|-----------|-----------|-----------|-----------|
| 1. _____ | 2. _____ | 3. _____ | 4. _____ | 5. _____ | 6. _____ | 7. _____ |
| 8. _____ | 9. _____ | 10. _____ | 11. _____ | 12. _____ | 13. _____ | 14. _____ |
| 15. _____ | 16. _____ | 17. _____ | 18. _____ | 19. _____ | 20. _____ | 21. _____ |
| 22. _____ | 23. _____ | 24. _____ | 25. _____ | 26. _____ | 27. _____ | 28. _____ |
| 29. _____ | 30. _____ | 31. _____ | 32. _____ | 33. _____ | 34. _____ | 35. _____ |
| | 36. _____ | 37. _____ | 38. _____ | 39. _____ | 40. _____ | 41. _____ |
| | 42. _____ | 43. _____ | 44. _____ | 45. _____ | 46. _____ | 47. _____ |
| | 48. _____ | 49. _____ | 50. _____ | 51. _____ | 52. _____ | 53. _____ |
| | | 54. _____ | 55. _____ | 56. _____ | 57. _____ | 58. _____ |
| | | | 59. _____ | 60. _____ | 61. _____ | 62. _____ |
| | | | | | 63. _____ | 64. _____ |
| | | | | | | 65. _____ |
| | | | | | | 66. _____ |

5. There are a number of people who seem to be jealous of me.
7. It makes my blood boil to have somebody make fun of me.
2. I demand that people respect my rights.
9. Occasionally when I am mad at someone I will give him the "silent treatment."
4. Although I don't show it, I am sometimes eaten up with jealousy.
1. When I am angry, I sometimes sulk.
2. People who continually pester you are asking for a punch in the nose.
3. I sometimes have the feeling that others are laughing at me.
4. If someone doesn't treat me right, I don't let it annoy me.
5. Even when my anger is aroused, I don't use "strong language."
6. I don't know any people that I downright hate.
7. I sometimes pout when I don't get my own way.
8. I seldom strike back, even if someone hits me first.
9. My motto is "Never trust strangers."
10. Sometimes people bother me by just being around.
1. If somebody annoys me, I am apt to tell him what I think of him.
2. If I let people see the way I feel, I'd be considered a hard person to get along with.
3. Since the age of ten, I have never had a temper tantrum.
4. When I really lose my temper, I am capable of slapping someone.
5. I commonly wonder what hidden reason another person may have for doing something nice for me.
6. I often feel like a powder keg ready to explode.
7. When people yell at me, I yell back.
8. At times I feel I get a raw deal out of life.
9. I can remember being so angry that I picked up the nearest thing and broke it.
10. I get into fights about as often as the next person.
1. I used to think that most people told the truth but now I know otherwise.
2. I sometimes carry a chip on my shoulder.
3. When I get mad, I say nasty things.
4. I sometimes show my anger by banging on the table.
5. If I have to resort to physical violence to defend my rights, I will.
6. I have no enemies who really wish to harm me.
7. I can't help being a little rude to people I don't like.
8. I could not put someone in his place, even if he needed it.
9. I have known people who pushed me so far that we came to blows.
10. I seldom feel that people are trying to anger or insult me.
1. I don't let a lot of unimportant things irritate me.
2. I often make threats I don't really mean to carry out.
3. Lately, I have been kind of grouchy.
4. When arguing, I tend to raise my voice.
5. I generally cover up my poor opinion of others.
6. I would rather concede a point than get into an argument about it.

SCORING THE INVENTORY

Compare your answers to those listed on Scoring Key below. Each column on your answer sheet (and Scoring Key) represents a separate subscale of the Hostility Inventory. Mark those answers that *agree* with the ones listed on the Scoring Key. Then add the number of agreements in each column separately and place the number in the boxes at the top of each column. After you have done this for each of the seven columns, add across the boxes at the top of the page and place that number in the box marked "Overall Total Score."

SCORING KEY

NE	RE	IN	AS	SU	IR	VE
1. T	2. T	3. T	4. T	5. T	6. T	7. T
8. T	9. T	10. F	11. F	12. T	13. F	14. T
15. T	16. T	17. T	18. T	19. T	20. T	21. T
22. T	23. T	24. F	25. T	26. T	27. T	28. T
29. T	30. T	31. T	32. T	33. T	34. F	35. F
	36. F	37. T	38. F	39. T	40. T	41. T
	42. T	43. F	44. T	45. T	46. T	47. T
	48. T	49. T	50. T	51. T	52. T	53. T
		54. T	55. T	56. F	57. T	58. F
			59. T	60. F	61. F	62. T
					63. T	64. T
						65. F
						66. F

INTERPRETING YOUR SCORE

Hostility is often the by-product of frustration and the high stress levels that frustration can produce. Most of us are comfortable with different levels of our own hostile feelings, but for some, any hostile feelings at all may be too many to accept. Others may look at the scores we have listed below as high and regard such levels of hostility as necessary to making it through each day.

According to data collected by Drs. Buss and Durkee, most people score below 38 in terms of total hostility, with women scoring slightly lower than men. If your Overall Total Score is well above 38, you are probably already aware of your hostile feelings. Your hostility may make your daily life and various relationships difficult and unpleasant. Without some sincere self-examination, best assisted by professional help, you may find it difficult to lower your level of hostility, frustration, and stress.

Even if you obtained an overall score of less than 38, look over the seven categories and note what constitutes a high score for each of them. One or more of these areas could be a problem for you. Your score for each area is listed at the top of the seven columns on your answer sheet.

NE NEGATIVISM

High Score: 4 and above

Negativism usually is oppositional behavior against authority. It involves refusing to cooperate and can be seen in behavior that can range from passive noncompliance to open rebellion against rules or conventions.

RE RESENTMENT

High Score: 4 and above

Resentment involves being jealous of others, often to a level of hatred. It is often a feeling of anger at the world over real or imagined mistreatment.

NI INDIRECT HOSTILITY

High Score: 6 and above

Indirect hostility involves behavior that directs hostility toward someone in a roundabout way. It can be devious in that, through malicious gossip or practical jokes, the hated person receives the hostility but cannot do much about it. Other indirect behaviors, such as door slamming and temper tantrums, allow a person to discharge general feelings of hostility that may not be directed against anyone in particular.

AS ASSAULT

High Score: 6 and above

Assault involves actual physical violence and the willingness to use physical violence against others. It is usually seen in fights with other people rather than in the destruction of objects.

SU SUSPICION

High Score: 4 and above

Suspicion involves the projection of hostility onto others. It can vary from being distrustful and wary of others to serious beliefs that other people are planning one harm.

IR IRRITABILITY

High Score: 8 and above

Irritability is a readiness to explode at the slightest provocation. It may be seen in behaviors such as quick-temper outbursts, grouching, and rudeness.

VE VERBAL HOSTILITY

High Score: 9 and above

Verbal hostility involves the expression of negative feelings verbally to others, both in what is said and in how it is said. It can be seen in the verbal styles of arguing, shouting, and screaming, and in the verbal content of threats, curses, and overcriticism.



BSI®

Brief Symptom Inventory

Leonard R. Derogatis, PhD

Last Name _____ First _____ MI _____

ID Number _____

Age _____

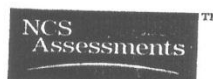
Gender _____

Test Date _____

DIRECTIONS:

1. Print your name, identification number, age, gender, and test date in the area to the left.
2. Use a lead pencil only and make a dark mark when responding to the items on page 3.
3. If you want to change an answer, erase it carefully and then fill in your new choice.
4. Do not make any marks outside the circles.

**DO NOT SEND TO NCS ASSESSMENTS.
USE ONLY FOR HAND SCORING.**



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HUMAN SERVICES ORGANISATION
PSYCHOLOGICAL SERVICES
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Product Number

	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY	
1	0	1	2	3	4	Nervousness or shakiness inside
2	0	1	2	3	4	Faintness or dizziness
3	0	1	2	3	4	The idea that someone else can control your thoughts
4	0	1	2	3	4	Feeling others are to blame for most of your troubles
5	0	1	2	3	4	Trouble remembering things
6	0	1	2	3	4	Feeling easily annoyed or irritated
7	0	1	2	3	4	Pains in heart or chest
8	0	1	2	3	4	Feeling afraid in open spaces or on the streets
9	0	1	2	3	4	Thoughts of ending your life
10	0	1	2	3	4	Feeling that most people cannot be trusted
11	0	1	2	3	4	Poor appetite
12	0	1	2	3	4	Suddenly scared for no reason
13	0	1	2	3	4	Temper outbursts that you could not control
14	0	1	2	3	4	Feeling lonely even when you are with people
15	0	1	2	3	4	Feeling blocked in getting things done
16	0	1	2	3	4	Feeling lonely
17	0	1	2	3	4	Feeling blue
18	0	1	2	3	4	Feeling no interest in things
19	0	1	2	3	4	Feeling fearful
20	0	1	2	3	4	Your feelings being easily hurt
21	0	1	2	3	4	Feeling that people are unfriendly or dislike you
22	0	1	2	3	4	Feeling inferior to others
23	0	1	2	3	4	Nausea or upset stomach
24	0	1	2	3	4	Feeling that you are watched or talked about by others
25	0	1	2	3	4	Trouble falling asleep
26	0	1	2	3	4	Having to check and double-check what you do
27	0	1	2	3	4	Difficulty making decisions
28	0	1	2	3	4	Feeling afraid to travel on buses, subways, or trains
29	0	1	2	3	4	Trouble getting your breath
30	0	1	2	3	4	Hot or cold spells
31	0	1	2	3	4	Having to avoid certain things, places, or activities because they frighten you
32	0	1	2	3	4	Your mind going blank
33	0	1	2	3	4	Numbness or tingling in parts of your body
34	0	1	2	3	4	The idea that you should be punished for your sins
35	0	1	2	3	4	Feeling hopeless about the future
36	0	1	2	3	4	Trouble concentrating
37	0	1	2	3	4	Feeling weak in parts of your body
38	0	1	2	3	4	Feeling tense or keyed up
39	0	1	2	3	4	Thoughts of death or dying
40	0	1	2	3	4	Having urges to beat, injure, or harm someone
41	0	1	2	3	4	Having urges to break or smash things
42	0	1	2	3	4	Feeling very self-conscious with others
43	0	1	2	3	4	Feeling uneasy in crowds, such as shopping or at a movie
44	0	1	2	3	4	Never feeling close to another person
45	0	1	2	3	4	Spells of terror or panic
46	0	1	2	3	4	Getting into frequent arguments
47	0	1	2	3	4	Feeling nervous when you are left alone
48	0	1	2	3	4	Others not giving you proper credit for your achievements
49	0	1	2	3	4	Feeling so restless you couldn't sit still
50	0	1	2	3	4	Feelings of worthlessness
51	0	1	2	3	4	Feeling that people will take advantage of you if you let them
52	0	1	2	3	4	Feelings of guilt
53	0	1	2	3	4	The idea that something is wrong with your mind

PTSD CHECKLIST-CIVILIAN VERSION

PTSD CheckList – Civilian Version (PCL-C)

Client's Name: _____

Instruction to patient: Below is a list of problems and complaints that veterans sometimes have in response to stressful life experiences. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem in the last month.

No.	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?					
2.	Repeated, disturbing dreams of a stressful experience from the past?					
3.	Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?					
4.	Feeling very upset when something reminded you of a stressful experience from the past?					
5.	Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?					
6.	Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?					
7.	Avoid activities or situations because they remind you of a stressful experience from the past?					
8.	Trouble remembering important parts of a stressful experience from the past?					
9.	Loss of interest in things that you used to enjoy?					
10.	Feeling distant or cut off from other people?					
11.	Feeling emotionally numb or being unable to have loving feelings for those close to you?					
12.	Feeling as if your future will somehow be cut short?					
13.	Trouble falling or staying asleep?					
14.	Feeling irritable or having angry outbursts?					
15.	Having difficulty concentrating?					
16.	Being "super alert" or watchful on guard?					
17.	Feeling jumpy or easily startled?					

PCL-M for DSM-IV (11/1/94) Weathers, Litz, Huska, & Keane National Center for PTSD - Behavioral Science Division

This is a Government document in the public domain.

CONSENT FORM

Title: The Effectiveness of NTU Africentric System of Psychotherapy in the Management of Trauma and Loss among Refugee Populations.

Principal Investigator: Derek Kojo Oppong

Co-Principal Investigators: N/A

Address: Department of Psychology, University of Ghana, Legon.

General Information about the research: This research is aimed at studying a system of psychological support called NTU psychotherapy. NTU psychotherapy is a special system of psychological counseling and therapy that is specially designed for people of African origin. It aims at helping people to deal with whatever psychological challenges they may be facing using our own personal belief systems and ways of thinking. It also helps people to restore their position within the society and help them be at peace with themselves and others even as they work towards a better future and go on with the challenges of life.

If you agree to partake in this study you will need to be available for a period of at least three to four months. During this time you will be given four sets of questionnaires to answer. After this you shall undergo personal therapy sessions with the researcher after which you shall then be assessed again. Then you shall undergo group therapy sessions with between ten to fifteen persons in a group after which you shall be finally assessed again.

These counseling sessions will run for a period of not more than four months in all. If you agree to take part as a participant you shall take part in between four to six personal counseling sessions. After this you shall then participate in between four to six group sessions where you and your friends shall meet with the researcher and we shall work

on our issues together. Each session shall run for between forty-five minutes to one hour long.

Please read everything on this form and ask any question bothering your mind before you decide to participate in this study.

Possible Risks and Discomforts:

During the counseling process as a participant it is possible that you may find yourself remembering some very painful and unpleasant experiences that you might have had. All of such hurtful experiences shall be managed during the therapy sessions. Indeed the aim of these sessions is to help you come to terms with these experiences. Several techniques would be used to help you come to terms with these experiences and move on from there. Some of these techniques shall involve discussing the details to help you change how you perceive them, helping you to find strength inside yourself. Other techniques include guided visualization and autogenic relaxation. Guided visualization will help you to access your inner guide and derive strength from yourself. Autogenic relaxation will help you to relax your body and mind.

Possible Benefits:

As a participant who takes part in this study, you would most likely be able to put your past behind you especially those experiences that may have caused psychological problems for you. You would also be able to reintegrate with society and be better positioned as agents for the psychological and social adjustment of your respective societies, because the system of therapy also emphasizes the role of the individual in harmony with his environment

Alternatives to participation:

As a participant you have the right to just answer the questionnaires to measure your levels of post-traumatic stress, hostility and Africentrism. Beyond this the intervention itself is divided into two broad phases; individual therapy sessions with the researcher and group therapy sessions with others. If you feel uncomfortable with one aspect of the study, you may choose not to participate in that aspect of the study. Participants have the right to withdraw from the intervention at any point in the study. If there are certain issues that may crop up during the study that you do not wish to discuss you have the right to say so and the investigator would respect those wishes.

Confidentiality:

Your identity as well as any information you give during the study shall be kept strictly confidential. Names of persons you give shall also be kept confidential. Data will be gathered and maintained using confidential codes so as to protect your identity. Your true identity shall not be made known except to the principal investigator and his assistant (if any) all of whom shall be personally known to you.

Compensation:

participants shall each receive a token of appreciation in the form of a certificate of participation each upon completion of the intervention.

Additional Costs:

As a participant, no additional cost shall be incurred by you as the interventions and assessments shall all be conducted within the vicinity of the refugee camps

Voluntary participation and right to leave the research:

Your agreement to take part in this study should be entirely of your own free volition and without any one prodding you to partake in this study. You also have the right to withdraw from this study at any point in time should you wish to do so and without having to provide any reason.

Termination of participation by the researcher:

You may be withdrawn from the study without your consent for a few reasons:

- You did not meet the criteria for inclusion into the research
- Your presence in the group studies may be proving a continual source of discomfort for other group members
- You may be suffering other health problems (mental or physical) that may put you at risk for the study

Notification of new findings

Throughout the study the researcher will notify you of any significant new findings that may arise. He shall also inform of the findings made when the study is finalized.

Contacts for additional information: should you require any further information on any issue related to the study, you can contact the principal researcher, Derek Oppong on 0243 180 896.

If at any time you feel dissatisfied with the conduct of the researcher or you suffer any accident related injuries you can also contact Prof. S.A. Danquah on 0244 333 196

Your rights as a Participant

This research has been reviewed and approved by the Institutional Review Board of Noguchi Memorial Institute for Medical Research (NMIMR-IRB). If you have any

questions about your rights as a research participant you can contact the IRB Office between the hours of 8am-5pm through the landline 0302916438 or email addresses: nirb@noguchi.mimcom.org or HBaidoo@noguchi.mimcom.org . You may also contact the chairman, Rev. Dr. Ayete-Nyampong through mobile number 0208152360 when necessary.

VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research title (The Effectiveness of NTU Africentric System of Psychotherapy in the Management of Trauma among refugee populations in Ghana) has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

Date

Name and signature or mark of volunteer

If volunteers cannot read the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

Date

Name and signature of witness

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

Date

Name Signature of Person Who Obtained

Consent