



Health psychology in Ghana: A review of the multidisciplinary origins of a young sub-field and its future prospects

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Abstract

This article presents a historical overview of psychology applied to health and health psychology in Ghana. A brief history of health, illness and healthcare in Ghana is introduced. Then, the history of psychology in Ghana is presented, with signposts of the major turns in the field in relation to psychology and other disciplines applied to health and the emergence of health psychology as a sub-field. Selected health psychology studies are reviewed to highlight ideological trends in the field. Finally, future prospects are considered in terms of how the sub-field can transition into an established critical field with unique contributions to make to global health psychology.

Keywords

anthropology, clinical psychology, critical health psychology, Ghana, health policy

Introduction

Health psychology in Ghana is a young sub-field, compared to sub-fields like social psychology and clinical psychology which were developed in the 1960s and 1970s. Its arrival in Ghana was signalled professionally with publications in the early 2000s. However, psychology applied to health has a much longer history alongside a broader field of health research within the medical, health and social sciences in Ghana (de-Graft Aikins, Ofori-Atta and Dzokoto, 2014; Van Der Geest and Krause, 2012 [2013]). In this three-part article, a historical overview is presented of psychology applied to health and health psychology in Ghana, and the future prospects of a Ghanaian health psychology are considered.

Part one presents a brief history of health, illness and healthcare in Ghana and sets the context

for tracking the evolution and scope of psychology applied to health and of health psychology. Part two focuses on a general history of psychology in Ghana, signposting the major turns in the field in relation to health and mental health, including the emergence of health psychology. Health psychology research trends are examined in terms of leanings towards mainstream or critical health psychology, drawing on working definitions of health psychology

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Box 1. Working definitions of health psychology, mainstream health psychology and critical health psychology.

Health psychology

Mattarazzo (1982) defined health psychology as intra-disciplinary sub-field and as an 'aggregate of the specific educational, scientific and professional contributions of the discipline of psychology to the promotion and maintenance of health, the prevention and treatment of illness, the identification of etiologic and diagnostic correlates of health, illness and related dysfunction, and the analysis and improvement of the health care system and health policy formation' (p. 4). Marks et al. (2010) offer this broader definition of health psychology as 'an interdisciplinary field concerned with the application of psychological knowledge and techniques to health, illness and health care' (p. 11).

The definition by Marks et al. (2010), which focuses on interdisciplinarity, is used as the broad working definition in this article. The definition by Mattarazzo (1982) which focuses on intra-disciplinarity is applied to the category of studies labelled 'psychology applied to health in Ghana'. This category refers to the application of sub-fields of psychology – such as social, clinical and community psychology – to research on health, illness, healthcare and associated empirical problems. A distinguishing feature of 'psychology applied to health' in Ghana is that research in this area is conducted: (1) by psychologists who do not explicitly define themselves as health psychologists or (2) by psychologists who have not received training in health psychology.

Mainstream health psychology

Marks (1996) offered a seven-point critique of mainstream psychology which is still valid 20 years on. He argued that mainstream health psychology: (1) offered derivative theories (e.g. social cognition models) decontextualized from the 'real world of health and social care'; (2) had a predominantly clinical focus despite its endorsement of the biopsychosocial model; (3) was individualistic and problematically excluded broader societal political, economic and cultural factors in health analysis and intervention; (4) projected 'value free' 'apolitical' 'scientific' aspirations detached from social policy; (5) failed to develop 'appropriate measures' and methods for diverse contexts; (6) failed to deal with inequalities; and (7) lacked appropriate training models, such as the scientist–practitioner model.

Critical health psychology

Marks (1996) and other critics of mainstream health psychology (cf. Crossley, 2000; Hepworth, 2006) asserted that critical health psychology aimed to address the limitations of mainstream health psychology by: offering a more integrated biopsychosocial model; adopting a multilevel approach that theorized the individual, social, cultural, economic and political contexts of health and illness; applying context-specific measures and methods; addressing problematic expert assumptions, ideologies and systems; and operationalizing a scientist–practitioner model that underscored accountability in research.

(Marks et al., 2010; Mattarazzo, 1982), mainstream health psychology (Marks, 1996) and critical health psychology (Crossley, 2000; Marks, 1996) (see Box 1). In part three, the future prospects of health psychology in Ghana are considered in terms of its ideological focus and its contribution to global health psychology.

Health, illness and healthcare in Ghana: an introduction

Ghana was the first sub-Saharan African country to gain political independence, from the British, in 1957. During the colonial era, spanning 1867 to 1957, the geographical area now

called Ghana was divided into four territories: the Gold Coast and Asante Protectorate covered the southern central/western coast and middle belt of present day Ghana; British Mandated Togoland covered the eastern coast, and the Northern Territories covered the three northern regions. Many of the ethno-linguistic groups making up the current Ghanaian population are reported to have been settled in these territories by the end of the 16th century. Ghana, like much of Africa, has been historically associated with a high burden of infectious diseases. Even so, chronic diseases like cancer of the liver and sickle cell disease were reported by lay communities and in European medical and

travellers' records in the 19th century (Addae, 1996). When the first major hospital, the Gold Coast hospital – now the Korle-Bu Teaching Hospital – was built in Accra in 1924, records included stroke cases. In 1955, a social survey of Accra documented infectious and parasitic diseases, diseases of infancy, respiratory systems, digestive systems, nervous systems, old age, circulatory systems, pregnancy and injuries resulting from violence as the major causes of death (Acquah, 1958). Sixty years on Ghana's public health burden is characterized by this double burden of infectious and chronic diseases. There is a growing prevalence of chronic physical, mental health and neurodegenerative conditions such as diabetes, hypertension, cancers, depression and dementia. The burden of these chronic non-communicable diseases (NCDs) co-exists with a persistent burden of infectious diseases like malaria, tuberculosis and HIV/AIDS and neglected tropical diseases (NTDs) like Buruli ulcer and shistosomiasis¹ (de-Graft Aikins and Koram, 2017). This double burden of disease has been attributed to multifaceted factors. These include internal factors like population ageing, urbanization, urban wealth, urban and rural poverty and westernized diets and external factors like food market globalization and the political economy of global health financing and policies (Agyei-Mensah and de-Graft Aikins, 2010).

Ghana's formal biomedical system is under-resourced and overstretched and healthcare remains inaccessible and inequitable for many. Due to a long history of engagement with infectious disease, biomedical systems are ideologically oriented towards privileging time-limited treatment and cure over prevention and long-term illness management. As a result, public health education is poor and the prevalence rates of preventable infectious and chronic conditions continue to grow exponentially, as are rates of disability and premature deaths from conditions which are managed better in countries with stronger health systems. Ethno-medical and religious healing systems (including herbalists, faith healing centres and prayer camps) and complementary and alternative medicine (CAM,

including Chinese and Indian therapies) compete with biomedical systems to provide healthcare for Ghanaians (de-Graft Aikins and Koram, 2017). In many parts of the country, ethno-medicine, religious healers and CAM are the first port of call for people with minor or serious health conditions. Their professional emphasis on curing all conditions has been criticized as unethical, and aspects of their treatment repertoires – such as prescribing untested herbal medicines and endorsing fasting – have led to iatrogenic outcomes including disease complications and premature deaths (de-Graft Aikins, 2005; Kretchy et al., 2014; Read et al., 2009). There are problematic tensions between expert and lay understandings of health conditions, illness practices, healthcare and social support. These tensions compound the challenges inherent in a top-down instrumentalist approach to healthcare in the country, which is itself a product of unequal and inequitable relations between national health policymakers and powerful actors in global development and health communities.

There is a long history of health research and the development of health interventions and policy dating to Ghana's colonial era. Earlier research was dominated by medicine and the health sciences, as the focus was on the epidemiology, clinical and public health aspects of diseases. The field has evolved and expanded to include the social sciences (anthropology, sociology, social work, social policy, psychology) and the humanities (linguistics, theatre arts). These shifts have occurred as the socio-cultural, religious, economic and political aspects of health, illness and healthcare in Ghana have come to the fore. The evolution of psychology applied to health and health psychology has been situated within this multidisciplinary context.

Psychology in Ghana: trends from the colonial era to present

The first psychology department in Ghana – and the West African sub-region – was established in 1967 at the University of Ghana (UG), the country's oldest public university. However, the

teaching of psychology at the university began 4 years earlier in 1963 at UG's Department of Sociology with a social psychology course taught by a European expatriate faculty, including the British-trained Austrian social psychologist Gustav Jahoda. Cyril E Fiscian, the first Ghanaian to receive a doctorate in social psychology from the United Kingdom (London School of Economics and Political Science (LSE)) was the first head of UG's Psychology Department. Jahoda facilitated the development of undergraduate courses leading to a BA or BS in psychology, which included social, experimental, developmental, industrial, clinical, educational psychology and methods (including statistics, tests and measurements, and psychometrics). Samuel Danquah, the first Ghanaian clinical psychologist trained in the United Kingdom (at the University of Wales), established a master's programme in clinical psychology/behavioural therapy in 1974.

There was a longer history of field-based psychological (and psychiatric) research dating back at least three decades. In the 1930s, the British psychologist WM Beveridge (1939) published research on perception conducted with young male students of the Presbyterian Training College in Akropong, the Gold Coast's first teacher training college established in 1848. In the 1920s and 1930s, the British anthropologist Meyer Fortes (1981), who trained originally as a psychologist, conducted research on cognitive behaviour among Tallensi communities of the then Northern Territories. Fortes' approach blended psychological and anthropological theories and methods, in a framework akin to cultural psychology today.

The period spanning the colonial years until the 1960s in sub-Saharan Africa was regarded as the era of Euro-American psychologists (Gupta, 1995; Wober, 1975). This was also the case in the Gold Coast/Ghana, where Euro-American psychologists conducted research in cognitive psychology and developmental psychology on themes including racial differences in perception, pictorial depth perception in children, the social and psychological aspects of education and the development of self-concepts among children (de-Graft Aikins et al., 2014a).

The historian of psychology, Graham Richards (1997), notes that there were three ideological camps in Euro-American psychology in the colonial era: the racist, anti-racist and 'somewhere in between'. Some of the cognitive/perceptual studies in Gold Coast/Ghana fell under the racist category; while the work of some anthropologists fell under the anti-racist category.² The goal of these studies – like the intelligence studies that were conducted across Africa at the time – was to highlight cultural and racial differences in cognitive processes, as well as underscore the superiority of Euro-American cognitive processes. Many of these were conceptually and methodologically flawed and/or inconclusive, and received robust critiques from researchers who argued for a cultural and environmental, rather than psychological and genetic, analysis of cognitive behaviour (Cryns, 1962; Fortes, 1981).

The 1930s to 1960s also constituted a period during which psychiatrists and anthropologists conducted research on mental health and mental health institutions³ in the Gold Coast (Field, 1937, 1958, 1960; Forster, 1960; Tooth, 1950; Weinberg, 1964, 1965) Fortes expanded his work to focus on the drivers of psychosis in Tallensi communities (Fortes and Mayer, 1966). Margaret Field (1937, 1959, 1960), a British ethno-psychiatrist, conducted health and mental health ethnographic work among the Ga communities of the southern coast and Asante communities of the middle belt. Notably, Field's (1958) work with women seeking help in Ashanti traditional shrines produced a socio-psychological theory of witchcraft aligned with biographical theories of chronic illness in social psychology and medical sociology (de-Graft Aikins, 2015). Despite a popular narrative within colonial psychiatry and mental health research that severe mental illnesses were rare among African populations, these rural and urban community-based surveys and analysis of institutional data suggested a relatively high prevalence of depression, manic-depression and suicide attempts due to extreme mental distress.

In Gold Coast/Ghana, cross-disciplinary meetings and workshops were held, which

explored synergies between psychology, anthropology and history. Darkwah et al. (2014) in their history of sociology in Ghana describe the cross-disciplinary environment in which UG sociology students were trained:

students went to dinner on alternate Tuesdays at Dr Jahoda's house where they met numerous dignitaries. These students were also exposed to the ideas of key scholars of the time such as Melville Herskovits, Meyer Fortes and Evans Pritchard all of whom came in person to share their ideas with the students. These intimate relationships inspired them to work hard to undertake post-graduate studies and become part of that intellectual environment. (p. 98)

The consensus by chroniclers of psychology's development in post-colonial Africa was that the 1970s would be the era of African psychologists (LeVine, 1970; Wober, 1975). Mallory Wober (1975), in a review of social psychology in colonial Africa, predicted this time would be when:

psychology in Africa [turned] a corner, in that [the discipline would] be increasingly in the hands of new people, its own people, with their own outlooks, needs and direction of enquiry. (pp. ix-x)

In many African countries, including Ghana, the role of African psychologists in the production of psychological research on Africans did not emerge until much later, even where the administration of psychology departments was turned over to qualified Africans. In Ghana, research by Euro-American psychologists continued between the 1960s and 1970s, and this was dominated by research from Gustav Jahoda, who published almost 60 percent of the total output of papers (de-Graft Aikins et al., 2014a). Jahoda's research was wide ranging and, crucially, introduced the first themes of health and qualitative research approaches to health within the broader psychology field in Ghana (cf. Jahoda, 1961). Cyril E Fiscian, the first head of UG's Psychology Department, was also the first editor of *Acta Sociologica*,

Ghana's first sociology journal. Fiscian is reported to have contributed an article on 'crime and illness' in the journal's first volume in 1962 (Darkwah et al., 2014).

The era of Ghanaian psychologists emerged in the 1970s with the work of Samuel Danquah on psychological problems among children and youth (cf. Danquah, 1975, 1979). Throughout the 1980s, Danquah was the sole Ghanaian psychologist publishing on Ghana in a field still dominated by Euro-American psychologists.

The lack of research and publications by Ghanaian psychologists – and indeed academics from other disciplines – during the 1970s and 1980s has been partly attributed to the political and economic upheavals in Ghana. During these 'lost decades' (as African political scientists have termed the period), a succession of military coups and government overthrows followed by the introduction of structural adjustment programmes (SAPs) by the World Bank and International Monetary Fund (IMF) led to political unrest and deepening job insecurity. The brain drain phenomenon emerged as several Ghanaian academics migrated from Ghana to other African countries and to Europe and North America (Agbodeka, 1998; Agyei-Mensah and de-Graft Aikins, 2010; Darkwah et al., 2014). Academics remaining carried multiple burdens of administration, teaching and research, with restricted resources and rewards. The early promise of critical multidisciplinary scholarship in Ghanaian public universities was crushed in an increasingly under-resourced, undervalued and politically precarious academic environment. For example, academic journals at the UG, which were established in the 1960s with great excitement and participation by local and international contributors, ceased publication in the 1970s and 1980s due to lack of finance, staffing and time. The aforementioned *Acta Sociologica*, which was later renamed the *Ghana Journal of Sociology*, went the way of other UG journals, ceasing publication in 1977 after a 15-year run, with two 3-year breaks (1962–1965 and 1971–1974).

Public health, mental health and clinical psychology after 1980

During the 1980s and 1990s, health research projects and interventions in the fields of medicine, health sciences and health policy were informed partly by global psychological theories and concepts. For example, early public health interventions on HIV/AIDS in Ghana were informed by knowledge–attitude–behaviour models derived from social cognition models in psychology, as was the case in other African countries (Kalipeni et al., 2003; Yen and Vaccarino, 2017).

A growing consciousness about psychology within the Ghanaian health professional and policy community coincided with the emergence of a new wave of Ghanaian psychologists, trained in the sub-fields of clinical psychology, neuropsychology and cognitive psychology. Ghana's first and second female clinical psychologists – Araba Sefa-Dedeh, trained in the United States and Angela Ofori-Atta trained in Canada – joined UG's Department of Psychiatry, in 1980 and 1992, respectively. They taught medical students and collaborated with Samuel Danquah in strengthening the graduate programme in clinical psychology at UG's Psychology Department. Sefa-Dedeh and Ofori-Atta were physically based at the Accra Psychiatric Hospital, where they provided clinical assessments, counselling, clinical psychology training and community-based rehabilitation work.⁴ They were consulted by the Ministry of Health (MOH), the Ghana Health Service (GHS) and development partners working on community development, to deliver clinical care and to develop interventions in mental health to underserved communities. In the early 2000s, Ofori-Atta was a co-investigator in the Mental Health and Poverty Project (MHaPP), a multicountry project funded by the UK development agency, Department for International Development (DFID), which aimed to develop evidence-based interventions and policy on the mental health in Ghana, South Africa, Uganda and Zambia (Flisher et al., 2007; Ofori-Atta et al., 2010).

This early collaborative work, and engagement with the MOH, grew into an advocacy movement – spanning a decade and a half – to integrate clinical and social psychology into formal healthcare delivery. A major initiative was the establishment of the Psych Corps Programme in 2012, which seconded psychology graduates to regional hospitals to support institutional and community mental healthcare delivery. At a broader organizational level, the Ghana Psychological Association (GPA) was revived in 2012. GPA had been established in the 1990s to provide leadership to a growing community of psychologists being trained in public universities beyond UG. However, leadership and financial challenges forced GPA into dormancy for over two decades. This period also saw advocacy for the development of policies for disability (Persons with Disability Act 715 launched in 2006), ageing (National Ageing Policy, 2010), mental healthcare (Ghana Mental Health Act 846, 2012) and chronic NCDs (National Policy for the Prevention and Control of Chronic Non-Communicable Diseases, 2012). In 2013, the Health Professions Regulatory Bodies Act 857 was passed. Act 857 included provision for the establishment of a Ghana Psychology Council (GPC) as a body that certified and regulated psychology practitioners and aimed 'to secure in the public interest the highest standards in the training and practice of applied psychology' (p. 54). This Act supported the long-term fight to confer recognition on applied psychology as an allied health field. The development of the aforementioned policies on disability, mental health, ageing and NCDs involved contributions by the clinical psychology community, within a broader community of medical and social scientists, civil society groups and non-governmental organizations (NGOs).

The emergence of health psychology in Ghana

Health psychology emerged in Ghana in the early 2000s. The first set of articles was based on PhD research by the social psychologist Ama de-Graft Aikins (2005) – trained in the UK at the

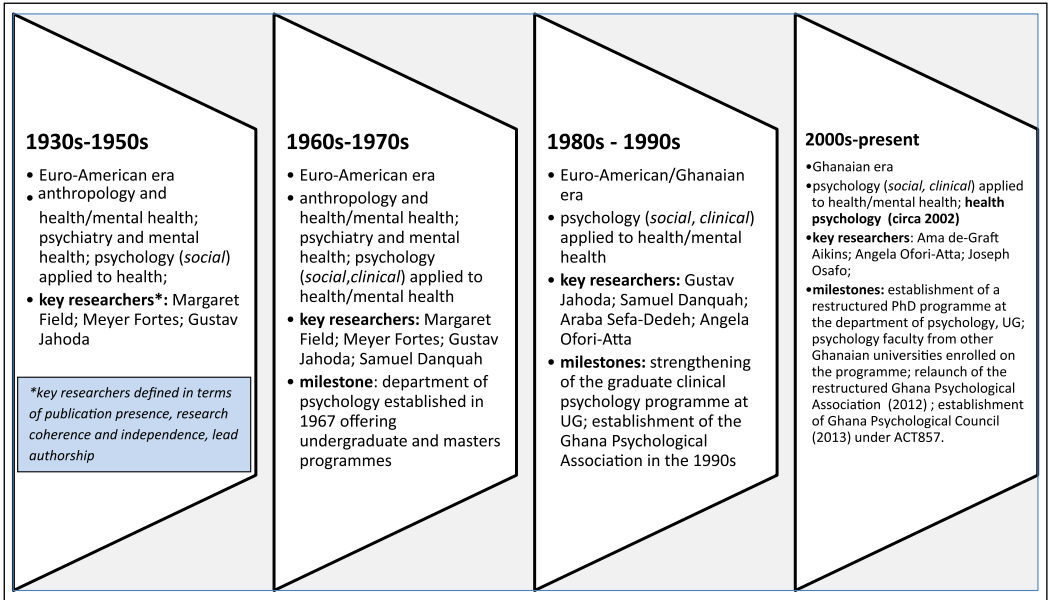


Figure 1. Evolution of health psychology in Ghana.

LSE – on the social representations of diabetes in Ghana. This work applied concepts from the social psychology of health and health psychology and focused on the lived experience of diabetes within the contexts of family, community and pluralistic health systems. Over the next decade and a half, de-Graft Aikins conducted research on mental health (de-Graft Aikins and Ofori-Atta, 2007) and on the community context of diabetes and cardiovascular disease risk, experience and care (de-Graft Aikins et al., 2014a).

The next sets of articles appeared from 2009 onwards and were also based on doctoral research by a cohort of seven researchers based at UG’s Department of Psychology and trained in mental health and wellbeing (Paul Narh Doku), health science (Joseph Osafo) and health psychology (Margaret Amankwah-Poku, Dinah Baah-Odoom, Kwaku Oppong Asante, Enoch Teye-Kwadjo and Joana Salifu Yendork). Three health psychologists were trained in the United Kingdom (Paul Narh Doku, Dinah Baah-Odoom, Margaret Amankwah-Poku) one in Norway (Joseph Osafo), and the remaining three in South African universities (Kwaku Oppong Asante, Enoch Teye-Kwadjo, Joana

Salifu Yendork). Doctoral research themes included social representations of HIV/AIDS (Baah-Odoom), psychological wellbeing of children affected by HIV/AIDS (Doku), psychological wellbeing of orphans (Salifu Yendork) and street children (Oppong Asante), suicide (Osafo), diabetes (Amankwah-Poku) and youth sexual behaviour (Teye-Kwadjo).

Figure 1 presents a summary of the evolution of psychology applied to health and health psychology in Ghana, focusing on the patterns of change with respect to groups of researchers, key researchers and important milestones from the 1930s to present. Table 1 presents a summary of research under the categories of psychology applied to health and health psychology, dating from the 1970s (‘era of the Ghanaian psychologists’) to present. The summary is based on an evolving bibliographic database on psychology research in Ghana, aspects of which have been published elsewhere (de-Graft Aikins et al., 2014a; de-Graft Aikins, 2014).

To examine the ideological focus of health psychology research in Ghana, 25 selected publications produced by seven health psychologists based at UG were analysed. The publications

were based on researchers' doctoral theses and on pre- and post-doctoral research for which they were lead authors or co-authors. The analysis focused on thematic areas, conceptual frameworks, methods and analytical approaches of the reported studies (Supplementary Table 2 presents a summary of the studies). Three types of research approaches emerged.

The first set of reported studies ($N=10$) were informed by critical health psychology principles. The studies blended culturally sensitive (mainly mixed qualitative) research with an explicit concern for the development of practical interventions and policy and attention to the challenges of health systems and health policy implementation in Ghana (e.g. de-Graft Aikins, 2002, 2003, 2005, 2006, de-Graft Aikins et al., 2012, 2015; Osafo et al., 2011; Teye-Kwadjo et al., 2013). Seven studies were drawn from doctoral theses (de-Graft Aikins, 2005; Osafo, 2012) and a master's thesis (Teye-Kwadjo, 2011) that were conceptually informed by critical (health) psychology.

A second set of publications ($N=10$) applied mainstream health psychology approaches. Studies drew on mainstream concepts and models such as the health belief model, self-regulation model and theory of planned behaviour in conceptualizing their research problems (e.g. Kugbey et al., 2017; Teye-Kwadjo et al., 2016, 2017), were explicitly clinically focused and individualistic (Anim et al., 2016), applied quantitative methods to problems requiring mixed methods or phenomenological approaches (e.g. Baah-Odoom and Riley, 2013; Doku, 2009, Doku and Minnis, 2016; Riley and Baah-Odoom, 2010; Teye-Kwadjo et al., 2016, 2017) and replicated studies conducted in 'western communities' without cultural validation of the tools (e.g. Doku, 2009). Seven studies were drawn from doctoral theses that were mainly quantitative (Doku, 2012; Teye-Kwadjo, 2014) or applied mixed quantitative-qualitative methods with a quantitative bias (Baah-Odoom, 2009; Asante, 2015a; Salifu Yendork, 2014).

A third set ($N=5$) occupied a space between mainstream and critical approaches. They were qualitative studies, but were characterized by a

lack of good fit between conceptual frameworks (where clearly defined or inferred), analytical method (e.g. interpretative phenomenological analysis (IPA) superficially applied), interpretation (lacking in theoretical rigour) and practical policy impact (e.g. Asante, 2016; Osafo et al., 2015a, 2015b; Salifu Yendork and Somhlaba, 2015a; 2015b; 2015c; Salifu Yendork et al., 2016). They belonged to the category of qualitative descriptive studies, which Lambert and Lambert (2012) observe are 'the least "theoretical" of all the qualitative approaches to research' despite attempts to project 'epistemological credibility' (p. 255). Two studies drew from aforementioned mixed methods PhD theses (Asante, 2015a; Salifu Yendork, 2014).

Two key insights emerged from the analysis. First, the impact of PhD training on capacity building in Ghanaian health psychology was clear. Of the 120 articles presented in Table 1, 72 (60%) were categorized under health psychology – these were sole and co-authored articles produced by the seven featured psychologists. Research themes covered important health problems in Ghana, although studies were restricted to only four of Ghana's 10 regions (see Supplementary Table 2). Second, the collective research output showed a lack of shared ideological focus. The heterogeneity of research approaches clearly stemmed from different graduate training traditions received by group members in their European and South African institutions. However, the dominance of mainstream studies and the emerging preference for descriptive qualitative study approaches in postdoctoral research projects presented a challenge for developing a critical sub-field in the future.

Health psychology in Ghana: transitioning to an established critical sub-field

Cartwright (1979) described the successful development of post second world war social psychology in the United States, by European expatriate psychologists as follows:

Table 1. Health psychology and psychology applied to health in Ghana, 1970–2017.

| Sub-fields and research themes | No. | References ^a |
|--|-----|--|
| <i>Health psychology</i> | 72 | |
| Child/adolescent health and wellbeing (orphans, homeless and street children) | 17 | Asante (2015b, 2016 ^a); Asante and Meyer-Weitz (2015a ^a , 2015b); Asante et al. (2015) ^a ; Doku (2009 ^a , 2010a ^a , 2010b, 2016a, 2016b); Doku et al. (2015); Oti-Boadi (2009); Salifu Yendork and Somhlaba (2014; 2015a; 2015ba; 2015c; 2016); |
| Chronic illness (experiences, perceptions, representations; diabetes, mental illness, sickle cell disease, HIV/AIDS); disability | 8 | Anim et al. (2016) ^a ; Asante (2012); Asante and Andoh-Arthur (2015); Oti-Boadi and Asante (2017); Kugbey et al. (2017) ^a ; Mensah et al. (2015); Nyarko and Asante (2014); Salifu Yendork et al. (2016) ^a |
| Crimes, misdemeanours (abuse, incest, violence) | 3 | Quarshie et al. (2017); Parimah et al. (2016a, 2016b) |
| Medical pluralism (traditional medicine, faith healing, biomedicine and allied health); help seeking | 5 | Andoh-Arthur et al. (2015); Asamoah et al. (2014); Kretchy et al. (2016); Osafo (2016a); Osafo et al. (2015) |
| Relationships (includes intimate partner violence) | 2 | Asante et al. (2014); Doku and Asante (2015b); |
| Religion, health and wellbeing | 3 | Kpobi et al. (2017); Salifu Yendork and Somhlaba (2016); Salifu Yendork et al. (2017) |
| Sexual and reproductive behaviour and health (includes HIV/AIDS) (adolescents, youth); maternal health | 21 | Ababio et al. (2017); Ananga et al. (2017); Asampong et al. (2013); Asante (2013); Asante and Oti-Boadi (2013); Asante and Doku (2010); Asante et al. (2014a ^a , 2014b; 2016); Baah-Odoom and Riley (2010, 2012, 2013 ^a); de-Graft Aikins (2014) ^a ; Doku et al. (2012); Osafo et al. (2014); Doku and Minnis (2016) ^a ; Riley and Baah-Odoom (2010) ^a ; Teye-Kwadjo et al. (2016, 2017a, 2017b); Wilson et al. (2016) |
| Suicide (ideation, attempts, perceptions) | 13 | Asante and Meyer-Weitz (2017); Asante et al. (2017); Asare-Doku et al. (2017); Osafo (2016b); Osafo and Akotia (2015); Osafo et al. (2011a ^a , 2011b, 2012, 2013, 2015, 2016, 2017a, 2017b) |
| <i>Social and community psychology</i> | 21 | |
| Health/illness knowledge, perceptions and representations | 7 | Abor (2006); Cogan et al. (1996); de-Graft Aikins (2002 ^a , 2010, 2011); de-Graft Aikins et al. (2012) ^a ; Borzekowski et al. (2006) |
| Illness experiences and representations (Diabetes, HIV/AIDS, Sickle-Cell) | 6 | de-Graft Aikins (2003, 2005 ^a , 2006 ^a); de-Graft Aikins et al. (2015) ^a ; Kratzer (2012); Okraku et al. (2009) |
| Mental health/illness (depression, psychosis, suicide) | 5 | Akotia and Anum (2014); de-Graft Aikins and Ofori-Atta (2007); De Menil et al. (2012); Hjelmeland et al. (2008); Knizec et al. (2011) |
| Road traffic safety behaviour (driving, transport laws and interventions) | 3 | Anakwah et al. (2015); Teye-Kwadjo et al. (2013) ^a ; Teye-Kwadjo (2017) |
| <i>Clinical psychology, neuropsychology</i> | 27 | |
| Child/adolescent health and wellbeing; psychological disorders (substance use) | 6 | Danquah (1975a, 1975b, 1975c, 1976, 1979a, 1979b) |

(Continued)

Table 1. (Continued)

| Sub-fields and research themes | No. | References ^a |
|--|-----|---|
| Life stressors and (mental) health; representations; mental health seeking behaviour | 3 | Appiah-Poku et al. (2004); Ofori-Atta and Linden (1995); Ofori-Atta et al. (2010a) |
| Mental health disorders (depression, suicide) | 4 | Eshun (1999, 2000, 2003); Turkson and Dua (1996) |
| Mental Health Systems and Policy | 9 | Akpalu et al. (2010); Awenva et al. (2010); Bhana et al. (2010); Flisher et al. (2007); Kleintjes et al. (2013); Lund et al. (2010); Ofori-Atta et al. (2010b); Omar et al. (2010); Raja et al. (2010); |
| Scale validation and use (depression – postpartum, adult) | 2 | Weobong et al. (2009); Wilson et al. (2017) |
| Other: Malnutrition and social/emotional behaviour; addiction | 3 | Appoh (2004); Appoh and Krekling (2004); Krafona (2014). |
| | 120 | |

^aReviewed papers. All references provided in supplementary reference list.

when the war was over, the field was incomparably different from what had been three or four years before. Prospects were bright, morale was high and social psychologists set about the task of converting into reality their new vision of what social psychology might become. They established new research facilities ... they began submitting research proposals to governmental agencies, foundations and business firms ... they organised doctoral programmes in most of the leading universities and within a few years had trained more social psychologists that there had been in the entire history of the field. And they began to publish large quantities of research. (pp. 84–85)

Peltzer and Bless (1989) made similar observations of the development of psychology in Zambia in the late 1980s when they attributed prospects and challenges to three factors: ‘culture’, ‘organisation’ and ‘manpower and finance’. Culture referred to the shared ideological vision of psychologists and, as Cartwright noted of the US social psychologists, the ‘conversion into reality their new vision of what’ their kind of psychology ‘might become’. Organisation referred to the relationship between psychologists, their ‘university and government, different departments and institutions in the university and government as well as associations, parastatals

and the private sector’ akin to the ‘governmental agencies, foundations and business firms’ of post-war US social psychology. Manpower and finance referred to numbers of trained psychologists and conditions of work and remuneration. In the case of Zambia, in the late 1980s, major challenges undermined these essential factors. The dominant psychology in practice was Eurocentric and inimical to a preferred African-centred emancipatory psychology; the relationships between psychologists, universities, the government and private sector were weak, and the low numbers of trained psychologists were poorly paid and thus forced into careers outside psychology (Peltzer and Bless, 1989). There was no structured system of training psychologists to doctoral level or the enabling intellectual environment for conducting and publishing ‘large quantities of research’.

Accounts of the status and challenges of psychology in Ghana (de-Graft Aikins et al., 2014a) and other countries, such as Cameroon (Nsamenang et al., 2007), Nigeria (Eze, 1991) and South Africa (Yen and Vaccarino, 2017) during the 1980s and 1990s, fit the Peltzer and Bless (1989) model. While cultural, organizational and human resources challenges have been addressed for sub-fields like clinical psychology, these challenges remain for health psychology in Ghana.

Identifying and addressing the challenges for health psychology in Ghana

There is no shared ideological vision of what health psychology in Ghana should be, currently. Research driven by critical health psychology principles is conducted by a minority of psychologists. UG's psychology department, where most of the Ghanaian health psychologists are based, has a mainstream quantitative bias. This stifles efforts to create an enabling environment for mentoring and research support that emphasizes doing and publishing critical health psychology research. While GPA is progressing under stable leadership, it has focused largely on convening annual conferences and thematic meetings and has yet to develop chapters for various active sub-fields including health psychology. GPC registers psychologists from the all sub-fields, but has not created a category for health psychologists; registered health psychologists have been subsumed under the clinical psychology category. The establishment of a restructured PhD programme at the UG in 2013 has led to increased enrolment of graduate students from UG and other Ghanaian universities into psychology PhD programmes. However, these programmes focus on clinical, social and organizational psychology. An 'official origin' of a sub-field, in many countries, often involves the founding of a professional organization or a programme to train the sub-group of psychologists. By this measure, health psychology in Ghana is yet to gain official status.

What is required for Ghanaian health psychology to transition into an established critical sub-field is strong investment in the triad of culture, organization and human resource/finance. This can be done by establishing health psychology chapters under the current GPA and GPC systems (*organization*), and developing graduate health psychology programmes as well as dedicated funding for doctoral and postdoctoral training (*human resource and financing*) and through these organizational and human resource capacity building interventions can support the development shared vision of a community-centred and

culturally appropriate health psychology through networking, mentoring and funded collaborative research (*culture*).

Within Ghana, there are practical models to guide the systematic development of health psychology. The scientist-practitioner clinical psychology model developed by Danquah, Sefa-Dedeh and Ofori-Atta has trained over 200 clinical psychology master's students over the last two decades. The majority of practicing psychologists registered with GPC, including psychologists with doctorates in health psychology, received training from the UG clinical psychology MPhil programme.⁵ Recent research reports that these practising psychologists share a training ideology as scientist-practitioners (de-Graft Aikins et al., submitted). Another model focused on community-based health research and interventions has been developed by de-Graft Aikins. This has involved funding master's and doctoral training for a multidisciplinary group of students – from population studies, social policy studies and social psychology – and has produced nine master's and PhD theses examining different facets of community health development in one urban poor community in Accra (de-Graft Aikins et al., 2014b). The current phase of the capacity building project is focused on social psychology PhD training, with the theses-in-progress informed by the critical psychology models of community health development (Campbell and Jovchelovitch, 2000) and of scholar-activist approaches (Campbell and Murray, 2004). These models have informed successful projects on HIV/AIDS interventions in South Africa (e.g. Campbell, 2003) and urban slum development in Brazil (e.g. Jovchelovitch and Priego-Hernandez, 2013).

Conclusion: reflections on the place of Ghanaian health psychology in global health psychology

'What is African Psychology the psychology of?' asks Augustine Nwoye (2015) in a paper that revisits recurrent themes and tensions in

contemporary debates on the identity and global relevance of psychological research in Africa. Theoretically, the available evidence points to a desire by some African psychologists to produce African-centred or indigenized psychological research (Lazarus et al., 2006; Nwoye, 2015) and for others a ‘worlding’ of African psychology (Painter, 2012). Practically, the answer depends on the specific histories of psychology training in different African countries, a conscientization of the politics of global scientific knowledge production in national academies and whether there is a shared vision of the kind of psychology local psychologists are committed to converting into reality. The continental debates about indigenizing and worlding African psychology are reflected in similar calls for the transformation of psychology in Ghana (de-Graft Aikins, 2015; Mate-Kole, 2013; Asante et al., 2014).

Critical health psychology, critical global health and associated fields (e.g. Campbell and Jovchelovitch, 2000; Biehl and Petryna, 2013; Campbell and Murray, 2004) are aligned with the concepts of indigenizing and worlding. These fields emphasize the importance of understanding the heterogeneity of local knowledge and identities as well as double-edged power relations that shape social lives. They advocate the use of meaningful methods informed by the research questions and societal problems at hand and the application of reflexivity in the interpretation of data, results and interventions. Concepts, methods and interpretive frameworks employed in the critical health field are crucial to the challenges of transforming health, illness and healthcare in Ghana. Ghana’s public health challenges are complex. The roots of illness and responses to illness span medical, psychosocial, socio-cultural, economic and geo-political domains. The pluralistic nature of healthcare delivery requires attention to complex ideologies and regimes of care that may align with or diverge from the needs of individuals seeking care in ways that can be beneficial or harmful. The economics of care in the home and in the community cannot be separated from the

economics and politics of healthcare systems. The persistent gap between policy rhetoric and implementation requires researchers who understand the political economy of public health, including the unequal power relations between local and global policy and funding communities, and apply this understanding to research, interventions and advocacy. There is a clear need for critical health psychology approaches in Ghana that situate health and illness perceptions, experiences, care and outcomes within their complex multilevel contexts. There is also a need for scientist–practitioner and scholar–activist models that engage in research as well as the development of evidence-based practice, interventions and policies tailored to the Ghanaian context. Crucially, there are local and global psychology models that can guide health psychology in Ghana towards a critical locally situated and globally relevant future.

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Notes

1. For a summary on neglected tropical diseases (NTDs), visit http://www.who.int/neglected_diseases/diseases/summary/en/
2. It is important to note here that the Richards typology applied also to anthropologists. Darkwah et al. (2014: 105) detail the problematic work of British anthropologists in the Gold Coast such as Eva Meyerowitz, who published five books on Bono communities based on flawed ethnography. They note that in the 1970s, a politically conscious undergraduate student community demanded that social anthropology in Ghana move beyond ‘towing the tail of Malinowski’ towards progressive, modern and useful discipline that recorded the dynamic evolution of Ghanaian society.
3. Focusing largely on the Accra Psychiatric Hospital, the oldest psychiatric hospital established in 1906. The country now has two additional psychiatric hospitals: Ankaful Hospital established in 1965 in Ankaful; Cape Coast and

- Pantang Hospital established in 1975 in Pantang, Accra.
4. In the late 1990s, the author joined the clinical psychology group established by Ofori-Atta and Sefa-Dedeh, as an unpaid research intern. Activities were wide ranging and included group therapy sessions at the Accra Psychiatric Hospital, patient rehabilitation and community-based research projects. One project involved taking discharged patients home to their families (in the author's private car) and supporting their re-integration. This project, which focused on patients living in Accra and Kumasi (Ghana's second largest city in the Ashanti Region), was short-lived due to lack of funds and of community-based psychiatric nurses. Another project, funded by the Danish Development Agency (DANIDA), focused on developing interventions for foetal alcohol syndrome in the Upper West Region, a (still persistent) public health problem which lay at the intersection of female poverty, regional malnutrition and cultural representations of a popular homebrew (*pito*) – consumed by adults including pregnant women – as a 'food of the gods' (Ofori-Atta et al., 1998).
 5. Visit www.ghanapsychologycouncil.org.gh/ for the registered list.

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References

- Addae S (1996) *History of Western Medicine in Ghana 1880–1960*. Durham, NC: Durham Academic Press.
- Acquah I (1958). *Accra survey*. London: University of London Press.
- Agbodeka F (1998) *A History of University of Ghana: Half a Century of Higher Education (1948–1998)*. Accra, Ghana: Woeli Publishing Services.
- Agyei-Mensah S and de-Graft Aikins A (2010) Epidemiological transition and the double burden of disease in Accra, Ghana. *Journal of Urban Health* 87(5): 879–897.
- Anim MT, Osafo J and Yirdong F (2016) Prevalence of psychological symptoms among adults with sickle cell disease in Korle-Bu Teaching Hospital, Ghana. *BMC Psychology* 4(1): 53.
- Asante KO (2015a) *Health and well-being of homeless youth in Ghana*. PhD Thesis, University of KwaZulu-Natal, Durban, South Africa.
- Asante KO (2015b) Exploring age and gender differences in health risk behaviours and psychological functioning among homeless children and adolescents. *International Journal of Mental Health Promotion* 17(5): 278–292.
- Asante KO (2016) Street children and adolescents in Ghana: A qualitative study of trajectory and behavioural experiences of homelessness. *Global Social Welfare* 3(1): 33–43.
- Asante KO, Boafo IM and Nyamekye M (2014a) Identifying gender differences in Ghanaian university students' sexual practices, attitudes and knowledge regarding HIV. *Journal of Psychology* 5(1): 9–18.
- Asante KO, Meyer-Weitz A and Petersen I (2014b) Substance use and risky sexual behaviours among street connected children and youth in Accra, Ghana. *Substance Abuse Treatment, Prevention, and Policy* 9(1): 45.
- Asante KO, Osafo J and Nyamekye GK (2014c) An exploratory study of factors contributing to divorce among married couples in Accra, Ghana: A qualitative approach. *Journal of Divorce & Remarriage* 55(1): 16–32.
- Baah-Odoom D (2009) *The link between social representations of HIV/AIDS and Sexual Behaviour amongst young people in Ghana and the UK*. PhD Thesis, University of Birmingham, Birmingham.
- Baah-Odoom D and Riley GA (2013) The role HIV-Related Blame and Stigmatization play on risk perception, self-efficacy and sexual behaviour among students in Ghana. *IFE Psychologia* 21(1): 284–303.
- Beveridge WM (1939) Some racial differences in perception. *British Journal of Psychiatry* 30: 57–64.
- Biehl J and Petryna A (2013) Critical global health. In: Biehl J and Petryna A (eds) *When People Come First: Critical Studies in Global Health*. Princeton, NJ: Princeton University Press, pp. 1–20.
- Campbell C (2003) *Letting Them Die: Why HIV/AIDS Prevention Programmes Often Fail*. Oxford: James Currey.
- Campbell C and Murray M (2004) Community health psychology: Promoting analysis and action for social change. *Journal of Health Psychology* 9(2): 187–195.
- Campbell C and Jovchelovitch S (2000) Health, community and development: Towards a

- social psychology of participation. *Journal of Community & Applied Social Psychology* 10: 255–270.
- Cartwright D (1979) Contemporary social psychology in historical perspective. *Social Psychology Quarterly* 42(1): 82–93.
- Crossley M (2000) *Rethinking Health Psychology*. Buckingham: Open University Press.
- Cryns AGJ (1962) African intelligence: A critical survey of cross cultural research in Africa South of the Sahara. *Journal of Social Psychology* 57: 283–301.
- Danquah SA (1975) Behavior modification among children presenting problems in the classroom. *Ghana Journal of Sociology* 11: 29–34.
- Danquah SA (1979) Drug abuse among Ghanaian students. *Journal de Psychopathologie Africaine* 15: 201–211.
- Darkwah A, Tonah S and Assimeng M (2014) The development of sociology and anthropology in Ghana and future trends. In: Agyei-Mensah S, Oduro A and Ayee J (eds) *Changing Perspectives in the Social Sciences in Ghana*. Dordrecht: Springer, pp. 95–112.
- de-Graft Aikins A (2002) Exploring biomedical and ethnomedical representations of diabetes in Ghana and the scope for cross-professional collaboration: A social psychological approach to health policy. *Social Science Information* 41(4): 603–630.
- de-Graft Aikins A (2003) Living with diabetes in rural and urban Ghana: A critical social psychological examination of illness action and scope for intervention. *Journal of Health Psychology* 8(5): 557–572.
- de-Graft Aikins A (2005) Healer-shopping in Africa: New evidence from rural-urban qualitative study of Ghanaian diabetes experiences. *British Medical Journal* 331: 737.
- de-Graft Aikins A (2006) Reframing applied disease stigma research: A multilevel analysis of diabetes stigma in Ghana. *Journal of Community & Applied Social Psychology* 16(6): 426–441.
- de-Graft Aikins A (2014) Social cognition, social representations and social knowledge: Themes in Ghanaian social psychology. In: Mate-Kole C and Akotia C (eds) *Psychology: Readings from Ghana*. Accra: DigiBooks Ghana Ltd., pp. 249–272.
- de-Graft Aikins A, Ofori-Atta A, Anum A, et al. (2014a) Psychology in Ghana: A review of research and practice. In: Agyei-Mensah S, Oduro A and Ayee J (eds) *Changing Perspectives in the Social Sciences in Ghana*. Dordrecht: Springer, pp. 75–93.
- de-Graft Aikins A (2015) Mental illness and destitution in Ghana: A social psychological perspective. In: Emmanuel A, Alan H and Arthur K (eds). *The Culture of Mental Illness and Psychiatric Practice in Africa*. Bloomington: Indiana University Press, pp. 112–143.
- de-Graft Aikins A and Koram K (2017) Health and Healthcare in Ghana, 1957–2017. In: Aryeetey E and Kanbur R (eds) *The Economy of Ghana: Sixty Years after Independence*. Oxford: Oxford University Press, pp. 365–384.
- de-Graft Aikins A and Ofori-Atta A (2007) Homelessness and mental health in Ghana: Everyday experiences of Accra's migrant squatters. *Journal of Health Psychology* 12(5): 761–778.
- de-Graft Aikins A, Anum A, Agyemang C, et al. (2012) Lay representations of chronic diseases in Ghana: Implications for primary prevention. *Ghana Medical Journal* 46(2): 59–68.
- de-Graft Aikins A, Awuah RB, Pera T, et al. (2015) Explanatory models of diabetes in poor urban Ghanaian communities. *Ethnicity & Health*. 20: 391–408.
- de-Graft Aikins A, Ofori-Atta A, Anum A, et al. (2014a) Psychology in Ghana: A review of research and practice. In: Agyei-Mensah S, Oduro A and Ayee J (eds) *Changing Perspectives in the Social Sciences in Ghana*. Dordrecht: Springer, pp. 75–93.
- de-Graft Aikins A, Kushitor M, Koram K, et al. (2014b) Chronic non-communicable diseases and the challenge of universal health coverage: Insights from community-based cardiovascular disease research in urban poor communities in Accra, Ghana. *BMC Public Health* 14(2): S2.
- de-Graft Aikins A, Osei-Tutu A, Agyei F, et al. (submitted) Competence in professional psychology in Ghana: An exploration of practitioners' experiences and perspectives.
- Doku D, Neupane S and Doku PN (2012) Factors associated with reproductive health care utilization among Ghanaian women. *BMC International Health and Human Rights* 12(1): 29.
- Doku PN (2009) Parental HIV/AIDS status and death, and children's psychological wellbeing.

- International Journal of Mental Health Systems* 3(1): 26.
- Doku PN (2012) *The mental health of orphans and vulnerable children within the context of HIV/AIDS in Ghana*. Doctoral Dissertation, University of Glasgow, Glasgow.
- Doku PN and Minnis H (2016) Multi-informant perspective on psychological distress among Ghanaian orphans and vulnerable children within the context of HIV/AIDS. *Psychological Medicine* 46(11): 2329–2336.
- Eze N (1991) Progress and status of psychology in Africa. *Journal of Psychology in Africa* 4: 27–37.
- Field MJ (1937) *Religion and Medicine of the Gambia People*. Oxford: Oxford University Press.
- Field MJ (1958) Mental disorder in rural Ghana. *The Journal of Mental Science* 104: 1043–1051.
- Field MJ (1960) *Search for Security: An Ethno-Psychiatric Study of Rural Ghana*. New York: W. W. Norton & Company.
- Flisher AJ, Lund C, Funk M, et al. (2007) Mental health policy development and implementation in four African countries. *Journal of Health Psychology* 12(3): 505–516.
- Forster EFB (1960) A short psychiatric review from Ghana. In: *Scientific Council for Africa South of the Sahara, Mental Disorders and Mental Health in Africa south of the Sahara*. Bukavu, Nelson: CCTA/CSA-WFMH-WHO Meeting of Specialists on Mental Health, pp. 37–41.
- Fortes M (1981) Tallensi children's drawings. In: Lloyd B and Gay J (eds) *Universals of Human Thought: Some African Evidence*. Cambridge: Cambridge University Press, pp. 46–70.
- Fortes M and Mayer DY (1966) Psychosis and social change among the Tallensi of Northern Ghana. *Cahiers D'etudes Africaines* 61: 5–40.
- Gupta S (1995) Structure of African psychological literature: 1827–1987. *International Information & Library Review* 27: 203–223.
- Hepworth J (2006) The emergence of critical health psychology can it contribute to promoting public health? *Journal of Health Psychology* 11(3): 331–341.
- Jahoda G (1961) Traditional healers and other institutions concerned with mental health in Ghana. *International Journal of Social Psychiatry* 7: 245–268.
- Jovchelovitch S and Priego-Hernandez J (2013) *Underground Sociabilities: Identity, Culture and Resistance in Rio De Janeiro's Favelas*. Brasilia: UNESCO.
- Kalipeni E, Craddock S, Opong JR, et al. (eds) (2004) *HIV & AIDS in Africa: Beyond Epidemiology*. Malden, MA: Blackwell Publishing.
- Kretchy IA, Owusu-Daaku F and Danquah S (2014) Patterns and determinants of the use of complementary and alternative medicine: A cross-sectional study of hypertensive patients in Ghana. *BMC Complementary and Alternative Medicine* 14: 44.
- Kugbey N, Asante KO and Adulai K (2017) Illness perception, diabetes knowledge and self-care practices among type-2 diabetes patients: A cross-sectional study. *BMC Research Notes* 10(1): 381.
- Lambert VA and Lambert CE (2012) Qualitative descriptive research: An acceptable design. *Pacific Rim International Journal of Nursing Research* 16: 4255–4256.
- Lazarus S, Bojuwoye O, Chireshe R, et al. (2006) Community psychology in Africa: Views from across the continent. *Journal of Psychology in Africa* 16(2): 147–160.
- LeVine RA (1970) Psycho-social studies in Africa. *African Studies Review* 13(1): 105–111.
- Marks DF (1996) Health psychology in context. *Journal of Health Psychology* 1(1): 7–21.
- Marks DF, Murray MP, Evans BE, et al. (2010) *Health Psychology: Theory, Research and Practice*. London: SAGE Publications Ltd.
- Mate-Kole CC (2013) Psychology in Ghana revisited. *Journal of Black Psychology* 39(3): 316–320.
- Mattarazzo JD (1982) Behavioral health's challenge to academic, scientific and, professional psychology. *American Psychologist* 37(1): 1–14.
- Nsamenang AB, Fru FN and Browne MA (2007) The roots of community psychology in Cameroon. In: Reich SM, Riemer M, Prilleltensky I, et al. (eds) *International Community Psychology: History and Theories*. New York: Springer, pp. 392–406.
- Nwoye A (2015) What is African psychology a psychology of? *Theory & Psychology* 25(1): 96–116.
- Ofori-Atta AL, de-Graft Aikins A, Sefa-Dedeh A, et al. (1998) *A Survey and Observational Study of Alcohol Drinking Patterns and Impact on Family, Economic and Community Life in the Upper West Region of Ghana*.
- Osafo J (2012) *Attitudes towards suicide: Exploring the cultural meaning(s) of suicide in Ghana*. PhD Thesis, Norwegian University of Science and Technology, Trondheim.

- Osafo J, Agyapong I and Asamoah MK (2015a) Exploring the nature of treatment regimen for mentally ill persons by neo-prophetic ministers in Ghana. *International Journal of Culture and Mental Health* 8(3): 325–339.
- Osafo J, Akotia CS, Andoh-Arthur J, et al. (2015b) Attempted suicide in Ghana: Motivation, stigma, and coping. *Death Studies* 39(5): 274–280.
- Osafo J, Asampong E, Langmagne S, et al. (2014) Perceptions of parents on how religion influences adolescents' sexual behaviours in two Ghanaian communities: Implications for HIV and AIDS prevention. *Journal of Religion & Health* 53(4): 959–971.
- Osafo J, Hjelmeland H, Akotia CS, et al. (2011a) The meanings of suicidal behaviour to psychology students in Ghana: A qualitative approach. *Transcultural Psychiatry* 48(5): 643–659.
- Osafo J, Hjelmeland H, Akotia CS, et al. (2011b) Social injury: An interpretative phenomenological analysis of the attitudes towards suicide of lay persons in Ghana. *International Journal of Qualitative Studies on Health and Well-Being* 6(4): 1–11.
- Osafo J, Knizek BL, Akotia CS, et al. (2012) Attitudes of psychologists and nurses toward suicide and suicide prevention in Ghana: A qualitative study. *International Journal of Nursing Studies* 49(6): 691–700.
- Osafo J, Knizek BL, Akotia CS, et al. (2013) Influence of religious factors on attitudes towards suicidal behaviour in Ghana. *Journal of Religion & Health* 52(2): 488–504.
- Painter D (2012) Towards 'provincializing' and 'worlding' critical psychology. *Annual Review of Critical Psychology* 10: 1–34.
- Peltzer K and Bless C (1989) History and present status of professional psychology in Zambia. *Psychology and Developing Societies* 1: 53–64.
- Read UM, Adiibokah E and Nyame S (2009) Local suffering and the global discourse of mental health and human rights: An ethnographic study of responses to mental illness in rural Ghana. *Globalization and Health* 5: 13.
- Richards G (1997) *'Race', Racism and Psychology: Towards a Reflexive History*. London: Routledge.
- Riley G.R and Baah-Odoom D (2010) Do stigma, blame and stereotyping contribute to unsafe sexual behaviour? A test of claims about the spread of HIV/AIDS arising from social representation theory and the AIDS risk reduction model. *Social Science & Medicine* 71: 600–607.
- Salifu Yendork J (2014) *The psychological functioning and experiences following placement in orphanages: An exploratory study of orphanhood in Accra*. PhD Thesis, Stellenbosch University, Stellenbosch, South Africa.
- Salifu Yendork J and Somhlaba NZ (2015a) Do social support, self-efficacy and resilience influence the experience of stress in Ghanaian orphans? An exploratory study. *Child Care in Practice* 21(2): 140–159.
- Salifu Yendork J and Somhlaba NZ (2015b) 'Exiled life, or home away from home?' Exploring Ghanaian orphan narratives of orphanage placement. *Africa Today* 62(2): 26–42.
- Salifu Yendork J and Somhlaba NZ (2015c) Problems, coping, and efficacy: An exploration of subjective distress in orphans placed in Ghanaian orphanages. *Journal of Loss & Trauma* 20(6): 509–525.
- Salifu Yendork J, Kpobi L and Sarfo EA (2016). 'It's only 'madness' that I know': Analysis of how mental illness is conceptualised by congregants of selected Charismatic churches in Ghana. *Mental Health, Religion & Culture*, 19(9): 984–999.
- Teye-Kwadjo E (2011) *Risk perception, traffic attitudes and behaviour among pedestrians and commercial minibus drivers in Ghana: A case study of Manya Krobo District*. Master's Thesis, Norwegian University of Science and Technology, Trondheim.
- Teye-Kwadjo E (2014) *Testing the theory of planned behaviour in predicting condom use in eastern Ghana: A three-wave longitudinal study*. PhD Thesis, Stellenbosch University, Stellenbosch, South Africa.
- Teye-Kwadjo E, Kagee A and Swart H (2016) Predicting the intention to use condoms and actual condom use behaviour: A three-wave longitudinal study in Ghana. *Applied Psychology: Health and Wellbeing* 9: 81–105.
- Teye-Kwadjo E, Kagee A and Swart H (2017a) Condom use negotiation among high school adolescents in Ghana: The role of gender. *South African Journal of Psychology*. Epub ahead of print 28 September. DOI: 10.1177/0081246317730282.
- Teye-Kwadjo E, Kagee A and Swart H (2017b) Determinants of condom use among heterosexual young men and women in Southeastern Ghana:

- A mediation analysis. *Psychology & Sexuality* 8: 291–305.
- Teye-Kwadjo E, Knizek BL and Rundmo T (2013) Attitudinal and motivational aspects of aberrant driving in a West African country. *Tidsskr Nor Psykologforening* 50: 451–461.
- Tooth G (1950) *Studies in Mental Illness in the Gold Coast: (Issue no 6 of Colonial Research Publications)*. London: H.M. Stationery Office.
- Van Der Geest S and Krause K (2012 [2013]) Introduction: Studying health and health care in Ghana. *Ghana Studies Journal* 15–16: 7–39.
- Weinberg SK (1964) ‘Mental healing’ and social change in West Africa. *Social Problems* 11(3): 257–269.
- Weinberg SK (1965) Cultural aspects of manic-depression in West Africa. *Journal of Health and Human Behavior* 6(4): 247–253.
- Wober M (1975) *Psychology in Africa*. London: International African Institute.
- Yen J and Vaccarino O (2017) ‘Health psychology’ or ‘psychology for health’? A history of psychologists engagement with health in South Africa. *Journal of Health Psychology* 23(3): 408–424.