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Challenging the Eurocentric bias in psychology: A Counselling Psychologist's perspective.

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Portfolio submitted in fulfilment of the requirements of the Professional Doctorate of Counselling Psychology.

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August 2013

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Acknowledgements

I would like to thank the participants that took part in this project and made this research possible. The professionals I visited were welcoming, kind and generous with their time and expertise. This project aimed to give voice to your knowledge and I hope you feel that was achieved.

I would like to thank my hosts in Ghana, my second family at Amamomo who opened up their home and their hearts to me for the last ten years. Thank you is not enough.

I also want to thank my research supervisor, Dr Courtney Raspin, for her patience, support and guidance (and occasional offerings of chocolate).

Last but by no means least, I would like to thank my family and friends whose love and support has been unconditional. Your patience, encouragement and proofreading services kept me going. My colleagues in training, thank you for being there and sharing this journey with me. James, thank you for putting up with me!

I dedicate this work to my parents, whose love and blind faith in me is my biggest blessing.

Declaration

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I confirm that the research contained within this thesis has not been submitted for any other degree, or to any other institution.

A. PREFACE

This portfolio comprises three sections: an empirical research project, a clinical case study and a publishable paper. Each was completed during my training at City University and together demonstrate my competence as a Counselling Psychologist. This portfolio provides evidence of my knowledge and skills, demonstrating critical and independent thought at a doctoral level.

The overarching theme within the portfolio is culture: how it shapes health beliefs, help-seeking behaviour and expression of psychological distress. The cultural values underpinning mainstream psychology are examined, and the implications of a Eurocentric bias are discussed. Both the research and the clinical case study explore psychological work with clients who hold non-Eurocentric health beliefs.

The first section of the portfolio consists of an empirical research project. The study aimed to take a unique perspective to the challenges facing the delivery of mainstream services in multi-cultural Britain by interviewing Ghanaian mental health professionals about their experience of working in a cultural centre of African health beliefs: Ghana. The Ghanaian mental health professionals offered expertise regarding the delivery of Eurocentric interventions with African clients. The participants described specific challenges to psychological work with African clients, and offered solutions and strategies in response to these challenges.

The second section demonstrates my professional practice through the inclusion of a clinical case study. The case demonstrates my developing interest in the way culture impacts experiences of mental illness. The client, an Iranian man, believed he was cursed. The work demonstrates a process of negotiation due to the clash of cultures between therapist and client, and explores strategies that helped minimise the challenges associated with such a clash.

The third section of the portfolio consists of a publishable piece that represents a summary of the empirical research conducted for this portfolio. The *'British Journal of Psychology'* was selected as an appropriate target journal for the paper as it is a mainstream journal that is circulated worldwide. The journal encourages international research and has demonstrated a commitment to supporting the globalisation of psychology by an initiative to allow free or low cost access to the journal in the developing world. The wide readership of the journal makes it an appropriate choice to encourage issues of culture from the periphery to mainstream psychology.

B. EMPIRICAL RESEARCH

'The African always believes that there is always a spiritual side to everything.'

Lessons from Ghanaian colleagues: Working with African clients.

B.1. Abstract

For mainstream services to meet the needs of an increasingly diverse population, a shift from a 'one size fits all' Eurocentric treatment approach is necessary. Inspired by the research efforts in the UK to better understand the discrepancies in service use and experience of Black and ethnic minority service users, the present study aimed to learn from Ghanaian colleagues and to give a voice to their experience and expertise. The project hoped to gain an understanding of Ghanaian mental health professionals' experiences of working in a culture where traditional or spiritual explanations for experiences that are classified as mental illness by Western psychiatric approaches are common; specifically, their knowledge of alternative health beliefs and practices, the challenges associated with working with this client group with Western approaches and the strategies they employed to minimise these challenges. In a cultural centre of traditional African beliefs, the project aimed to explore the process of marrying two drastically different worldviews. Theoretical sampling was used to select participants that could offer rich and relevant data, and qualitative inclusion criteria made experience a priority (community psychiatric nurses, psychiatrists, psychologists and charity workers were included in the sample). The data was thematically analysed according to the procedure of Braun and Clarke (2006). Analysis revealed the Ghanaians' ability to occupy multiple worldviews and explored health beliefs relating to mental illness. The data provides an insight into the challenges and complexities associated with delivering mainstream health care in a culture underpinned by traditional beliefs, and presents data that shines a spotlight on the way Ghanaian mental health professionals work psychologically with this client group. The findings are considered in relation to the British research that documents the challenges facing the UK with regard to improving service engagement, and experience of services, for Africans living in the UK. Clinical implications are discussed.

B.2. Key

BME-	Black and minority ethnic [people/communities]
CDWs-	Community Development Workers
CPN-	Community Psychiatric Nurse
DoH-	Department of Health
DRE-	Delivering Race Equality (The Department of Health's 2005 Scheme)
DSM-	Diagnostic and Statistical Manual of mental disorders
EHTPA-	European Herbal and Traditional Practitioners Association
EPIC-	The Enhanced Pathways Into Care Project
MHA-	Mental Health Act
MHAC-	The Mental Health Act Commission
MHRA-	Medicines and Healthcare products regulatory agency
NFSH-	National Federation of Spiritual Healing (UK) – now called the Healing Trust
NGO-	Non Government Organisation
NHSTA-	National Health Service Training Authority, an association of NHS Trusts, which offers a directory of alternative and complementary medicine
NIMHE-	National Institute for Mental Health in England
NMHDU-	National Mental Health Development Unit
NSF-	The National Service Frameworks
RECAP-	Race Equality Cultural Awareness Programme (a two-day training course in cultural issues developed by DRE)
RECC-	The Race Equality and Cultural Capability (DRE training scheme for mental health workers)
RES-	Race Equality Schemes
RRA-	The Race Relations Act
SCMH-	Sainsbury's Centre for Mental Health (see references for publications cited)
URHP-	Unified Register of Herbal Practitioners
WHO-	World Health Organisation

B.3. Introduction to the thesis

A key theme within the project is 'culture': a term that denotes the ideas, customs, and social behaviour of a particular people or society. However, whilst culture is often treated as something belonging to foreign customs or beliefs, it is important to recognise the cultural values that influence the practice of mainstream treatment approaches. Psychology has traditionally been Eurocentric, deriving from a White, middle-class value system (Katz, 1985; Smith, 1981; Naidoo, 1996). Ethnocentrism is the belief in the inherent superiority of one's own ethnic group or culture (Woolley & Lowenberg, 1997); Eurocentricism reflects the global dominance of western ideas that privilege science, and empiricism. Katz (1985) asserts that White culture serves as the foundation for psychological theory and practice. This is unsurprising, given the cultural and historical context in which psychological theories were developed. However, it is inadequate for the discipline to have a Eurocentric bias for several reasons.

Britain is multi-cultural. 2011 population estimates by Ethnic Group for England and Wales indicate that the majority White British group has stayed constant in size between 2001 and 2009, whilst the population belonging to other groups has risen by around 2.5 million to 9.1 million over that period (see figure B1). These figures translate to about one in six of the population in England and Wales being from an ethnic group other than 'White British', and these figures are on the increase. As figure B1 indicates, 'Black African' is one of the faster growing ethnic groups, with an estimated population of 798.8 thousand in 2009. Black and ethnic minority (BME) individuals make up a large component of our society, and the data suggest these figures will continue to rise. A person's 'ethnicity' indicates a how an individual experiences and self-identifies a state of belonging to a social group that has a common national or cultural tradition. For the purpose of this project, it is important to recognise that the term 'ethnicity' can be limiting, as 'culture' and 'ethnicity' are neither fixed nor static. In the modern, world there are a myriad of processes and influences that create beliefs and worldviews that are personal and must be understood and contextualized without making assumptions. This project uses the term 'BME' to describe those that are non-white-British. This is not to make assumptions of similarities, but with the aim of adding dimensions to psychological theory by confronting what is Eurocentric about mainstream psychology.

Services must address Black and minority ethnic (BME) inequalities, not least because we are legally required to do so. The death of Stephen Lawrence in 1993 resulted in an enquiry that concluded that the Metropolitan Police Service was 'institutionally racist' (Macpherson, 1999). The enquiry had implications for all public services as the Macpherson Report (1999) and the subsequent Race Relations (Amendment) Act (2000) represented a shift in terms of the law and the duty on public bodies as well as individuals to eradicate discrimination in institutional

settings. The death of David Bennett in 1998, an African Caribbean patient who died in hospital, sparked another enquiry into institutional racism, this time within mental health services. A specialist panel was selected to lead an inquiry and made several recommendations for practice.

Ethnicity	Mid 2009 population (Thousands)	Average annual percentage growth
All groups	54809.1	0.6%
White British	45682.1	0.0%
White Irish	574.2	-1.5%
Other White	1936.6	4.3%
Mixed: White and Black Caribbean	310.6	3.3%
Mixed: White and Black African	131.8	6.3%
Mixed: White and Asian	301.6	5.8%
Mixed: Other mixed	242.6	5.5%
Asian: Indian	1434.2	3.9%
Asian: Pakistani	1007.4	4.1%
Asian: Bangladeshi	392.2	4.0%
Other Asian	385.7	5.7%
Black Caribbean	615.2	0.9%
Black African	798.8	6.2%
Other Black	126.1	3.2%
Chinese	451.5	8.6%
Other	422.6	8.0%
Non-White British total	**9127.1**	**4.1%**

Figure B1: Population estimates by ethnicity in England and Wales, Office for National Statistics (2011).

The Race Relations Act (1976, amended in 2000) outlawed discrimination (direct and indirect) and victimisation in all public authority functions. It also placed a general duty on specified public authorities to promote race equality and good race relations. There are also specific duties for listed organisations, including the production of Race Equality Schemes (RES). The

law goes beyond insisting that racism is unacceptable; it also calls for institutions like the NHS to address ethnic inequalities in service use and experience of service.

The Department of Health (DoH) stated its intention to address BME service inequalities. The Department of Health's (2005) 'Delivering Race Equality' (DRE) programme was launched in 2005 as a response to the amendment to the Race Relations Act. It was a five-year programme that aimed to support the development of better mental health services that met the needs of England's increasingly diverse population. The New Horizons document also outlines the government's commitment to tackling ethnic inequalities in access to and experience of mental health services (DoH, 2009).

Another significant reason why mainstream psychological theories need to become less Eurocentric is because the developing world is importing Western approaches. For psychology to be meaningfully exported across the world it needs to be able to claim universality (Maiello, 1999). However, unlike physical illness, there are problems inherent in assuming that categories of mental disorder derived from the study of one ethnic group are relevant or valid to generalise to other groups (Fernando, 1995; Patel & Winston, 1994; Watters, 2011). Wrenn (1962) proposed that to make psychological theory more responsive to the needs of a culturally diverse population requires a willingness to examine the underlying cultural values that act as a foundation for mainstream theory. This paper argues that mainstream theory should learn about alternative worldviews and look for practical solutions to the challenges facing the discipline of psychology. This project focuses on the experience of African mental health professionals in Ghana. The term '*African*' is a huge concept that encompasses a wealth of cultures, ethnicities and identities in Africa, and people of African descent. It is recognised that there are White Africans and Africans with whom ideas of traditional West-African indigenous religions would have little relevance. However, it is this project's aim to add dimensions to the understanding of mainstream psychological theory by exploring the experience of health professionals in one African country. To do this, it is necessary to first review the literature on the relationship between Eurocentric psychology and Africans, and the challenges facing psychology in multicultural Britain. It is also necessary to review the literature relating to the research context, Ghana.

B.4. Literature review: An examination of the relationship between Africans and mainstream psychology

B.4.1. The historical context

European psychology has demonstrated an interest in ethnography and anthropology since its birth. Sue, Arrendo and McDavis (1992) suggest that psychological theory has dealt with race by three approaches: the inferiority model, the genetic deficiency model and the culturally deprived (deficient) model. Indeed, there is a wealth of research that supports this claim. Rush proposed 'Negroes' suffered from an affliction called 'Negritude', which was thought to be a mild form of leprosy (cited in Reiheld, 2010). Rush proposed that as the affliction resulted in dark skin, the only cure for the disorder was to become White. Another theory that served to support White supremacy came from Cartwright, who described 'Drapetomania' in 1851 as a mental illness that caused Black slaves to flee captivity. Cartwright posited that Negroes were inferior biologically and therefore slavery was a necessary intervention and recommended whipping the devil out of them to ensure the slaves obeyed their masters (cited in Szasz, 1971).

Africans have been described as 'deficient' in many ways: deficient in intelligence (Rousseau, 1755; Ferguson, 1916; Carothers, 1951; Prince, 1960; Forster, 1962), deficient in internal control (Freud, 1913; Prince, 1960; Forster, 1962) and deficient in terms of personality (Carothers, 1951; Ritchie, 1943; Smartt, 1956; Gordon, 1934). Carothers and Ritchie wrote about the Africans' lack of gratitude; these ideas were published at the same time as White settlers complained that their native domestic servants were ungrateful and selfish (McCulloch, 1995). Inferior child-rearing techniques (Forster, 1962) and prolonged breastfeeding (Prince, 1960) were blamed for basic flaws in the African personality. Africans have been described as savages (e.g. Freud, 1913), and compared to children (Carothers, 1951) and European psychopaths (Carothers, 1951). In the UK, Terman reported that some ethnicities, including Blacks, were dull, and that the characteristic was racial in etiology (Terman, 1916).

Much research proposed that Africans were too primitive to suffer the same mood disorders associated with the Western world (Rousseau, 1755; Carothers, 1951; Tooth, 1950), implying that was something deficient in the African mind. Mainstream theory at this time implied that the primitive Africans were too simple to be troubled by emotional distress, and that external sanctions were necessary to compensate for the Africans' lack of a well-developed superego (Freud, 1913). As early as 1755, the idea that mental illness was rare amongst 'primitive'

people was promoted based on the knowledge that not many were seen in asylums (Rousseau, 1755). Rousseau coined the concept of a 'noble savage', which suggested that there was something desirable about living simply, resulting in being protected from mental illnesses that only affect the civilised. This very early research ignores differences in health beliefs and help-seeking behaviour and assumed that as the Africans he observed were not seeking help at asylums, they must not suffer what the West defined as psychological ill health.

However, research began to conceptualise the observed differences. Canadian-born Dr. Raymond H. Prince, professor of psychiatry at McGill University, was a pioneer in the fields of transcultural psychiatry and the scientific study of religious experience (Wintrob, 2006). Prince's career in transcultural psychiatry began in September 1957 when he took up the post of 'specialist alienist' at Aro Hospital in Abeokuta, Nigeria, then a British colony (Prince, 2000). In 1967, Prince commented that research conducted in the colonial era (1890-1956) generally found depression and suicide to be rare or absent in the African context; however, research that was conducted in the era of independence reported depressive conditions as more common. Prince proposed that the increase in observed cases of depression may reveal something about the newfound desirability of European ideas (i.e. that to be identified as melancholic/depressed may be to identify yourself as civilised, intellectual, responsible or sensitive). Prince coined this 'the Prestige factor'. Prince suggested that the stark diagnostic differences during and after colonialism could be in part explained by the social climate psychiatrists were operating in; during colonialism, Africans were not deemed responsible and considered too primitive to suffer psychologically in the same way as the civilised West, but when independence was achieved, the social climate was more conducive to Africans being treated as more responsible. Most significantly, Prince commented that concepts of mental illness are culturally specific and that an African with a depressive disorder would not consider themselves to be ill. Prince highlighted the significance of help-seeking behaviour and pathways to treatment, i.e. that those in psychological distress often visit indigenous healing centres, as local explanations of mental illness are associated with ideas of morality, spirituality and witchcraft.

Field's work was the first of its kind to explore differences in health beliefs and subsequent patterns of help-seeking behaviour (Field, 1955, 1960). Field researched the 'ideological background' of witchcraft in the Gold Coast in the 1930s (Field, 1955, 1960). Field posited that Rousseau's idea of the 'nobel savage' was misinterpreting the low levels of depressive illness being observed by clinicians. Field suggested that witches were often mentally disturbed and the people who sought this type of help were often in psychological distress. Field attacked the notion that mental illness was rare amongst primitive people, but instead argued that traditional ideas and beliefs were responsible for differences observed by previous theorists. Field noted that in a culture where the worst possible crime was to be accused of being a witch, women were accusing themselves of this crime. Field suggested that these women were exhibiting self-

blame by identifying themselves as evil, and that this behaviour could be interpreted as depressive. Field also proposed that other European psychiatric concepts were common, such as schizophrenia, paranoia and obsessive compulsive disorders. McCulloch (1995) highlights that the use of European concepts in this way could result in pathologising Ghanaian culture, although Field's work should be celebrated as an early attempt to contextualise the differences that other researchers reported as evidence to support claims of inferiority.

Field's research into cultural differences in health beliefs and help-seeking behaviour is still relevant today, given the reported discrepancies in how BME communities engage with, and experience, mental health services. Arguably, we have come a long way from the crude, insulting descriptions of non-White populations as the 'other'; however, some theorists believe that much of Eurocentric psychology is anti-African (ya Azibo, 1996) and the statistics of over-representation demonstrate that we have not yet achieved equality in terms of who makes use of, and who benefits from, mainstream services.

B.4.2. The current climate: Black service users in multicultural Britain

The negative experiences of psychiatry for Black and other minority groups were first documented in the early 1960s when research pointed to the over-representation of Black people within institutional settings (Kiev, 1965; Hemsi, 1967). Since then, there has been research that consistently indicates that Black and other minority ethnic groups experience psychiatry differently from White people (Sashidharan, DoH, 2003). The research evidence shows that ethnic minority groups have an overwhelmingly negative experience of psychiatry. One of the key challenges to the discipline is making sense of the over representation of Black service users in psychiatric admissions.

B.4.3. Over representation of Black service users

Mental Health Act data reveals that even when standardised for age, data on admission levels show disproportionately high levels of certain diagnoses and detention amongst Black patients, in particular Black-Caribbean and Black-African patients (MHAC, 2008). The Black incidence rate of schizophrenia is higher in the UK than anywhere else in the world (Cochrane & Sashidharan, 1996). Higher than expected rates of schizophrenia amongst African and Caribbean people living in England were reported as early as the 1960s (Kiev, 1965; Hemsi, 1967) and consistently thereafter (Bebbington, Hurry & Tennant, 1981; Dean, Walsh & Downing, 1981; McGovern & Cope, 1987; Cochrane & Bal, 1989). There is an alarmingly higher rate of compulsory admissions for Black compared with White patients (Ineichen et al.,

1984; Moodley & Thornicroft, 1988; Harrison, Holton & Neilson et al., 1989; Dunn & Fahy, 1990; Moodley & Perkins, 1991; Owens, Harrison & Boot, 1991; Birchwood, Cochrane & Macmillan et al., 1992; Crowley & Simmons, 1992; Lloyd & Moodley, 1992; Perkins & Moodley, 1993; Thomas, Stone & Osborn et al., 1993; Davies, Thornicroft & Leese et al., 1996; Koffman, Fulop & Pashley et al., 1997; McCreadie, Leese & Talik-Singh et al., 1997; Parkman et al., 1997; Singh et al., 1998; Takei et al., 1998; Commander et al., 1999; Bhui et al., 2003). Poor use of primary care services, and more frequent use of involuntary admissions, results in the use of high-cost services (SCMH, 2006). The fourth annual 'Count me in' census, published in November 2008, showed that admission rates for BME communities are not falling and that some BME groups are three or more times more likely than average to be admitted. American research suggests similar discrepancies in access to and outcome from public health and human service providers (Snowdon, 2003; van Ryn & Fu, 2003; Snowdon & Cheung, 1990).

B.4.4. Ways of interpreting these statistics: Real differences or a clash of cultures?

Interpretations of the statistics range from attempts to justify real differences in prevalence to suggesting misdiagnosis is responsible for differences in observed prevalence between ethnic groups. The discrepancies highlighted by the statistics pose a challenge to the Western diagnostic system, and a neat biological/genetic explanation for the findings would have been desirable.

B.4.5. Real differences?

Historically, schizophrenia has been thought to be under considerable genetic influence, genetic predisposition amongst the African and Caribbean population was the first hypothesis to be investigated to explain the statistics (Harrison et al., 1988). There is, however, no evidence that the high rates are a consequence of greater genetic risk in certain migrant and minority ethnic populations. Indeed the construct validity of schizophrenia has been challenged by many (e.g.; Boyle, 2002; Bentall, 2004; Fernando, 1995; Bentall, Jackson & Pilgrim, 1988). Morgan et al. highlight the fact that so many diverse groups appear to have higher rates, which suggests that genetic predisposition is an implausible explanation (Morgan et al., 2010).

If genetic predisposition were a substantial factor contributing to high incidence rates of schizophrenia in UK Black Caribbeans, then high rates in their country of origin would also be expected. Comparing frequency of diagnosis is impossible, given differences in access to medical facilities. However, no evidence that the incidence of schizophrenia or other psychoses is similarly elevated in any relevant country has been found. Studies conducted in the 1990s in

Jamaica, Trinidad and Barbados all report similar schizophrenia incidence rates to those found in the native UK population (Hickling et al., 1995; Bhugra et al., 1996; Mahy et al., 1999). Sashidharan (2001) criticised much of the British research that focused on searching for a biological explanation for the observed discrepancies in the prevalence of schizophrenia (Sugarman & Craufurd, 1994; Hutchinson et al., 1996), but it was a logical first step that reflected epistemological and philosophical assumptions of the discipline.

Another explanation for the high rates of psychosis in Black Caribbean individuals in the UK suggested cannabis use was responsible for real differences in the prevalence of severe mental illness (Sharpley, Hutchinson, McKenzie & Murray, 2001). Research supports a link between psychosis and the use of cannabis (Moore et al., 2007; DiForti et al., 2009), although statistics from the British Crime Survey suggest that cannabis use amongst 16-59-year-olds from Black and White British groups is broadly similar (Hoare, 2009). McGuire et al. (1995) did not find any significant difference in the use of cannabis between African-Caribbean and White patients with psychosis, although Callan and Littlewood (1998) found that Black families blamed cannabis use as a cause for a family member's illness more often than White families.

Much research links socioenvironmental factors to the observed high rates of schizophrenia amongst this client group. This hypothesis is appealing as it recognises cultural and social factor variables that were previously underplayed. Hutchinson et al. (1996) found that the morbid risk for schizophrenia was similar for the parents and siblings of White and first-generation African-Caribbean patients, but that the siblings of second-generation African-Caribbean psychotic probands had a morbid risk for schizophrenia that was seven times that of their White counterparts. They concluded that either the second-generation African-Caribbean population in Britain is particularly vulnerable to some environmental risk factors for schizophrenia, or that some environmental factors act selectively on this population in Britain. Research began to focus more on environmental and sociological factors to explain the differences by ethnicity in the prevalence of schizophrenia in the UK (Boydell et al., 2001; Mallett, Leff, Bhugra, Pang & Zhao, 2002; Whitley, Prince, McKenzie & Stewart, 2006). Herrstein and Murray (1994) proposed that African Americans experience psychosocial stress that other groups are not exposed to due to the negative value placed on their skin colour and mental ability (arguably an idea that the discipline of psychology promoted historically).

B.4.6. Clash of cultures?

As the process of psychiatric diagnosis is a relatively subjective one based on clinical judgement, cross-cultural misdiagnosis is another hypothesis offered to explain discrepancies in ethnic representations in psychiatric facilities (Patel & Hegginbotham, 2007; Williams & Earl,

2007). Observed high rates could be a consequence of incorrect diagnosis of either culturally appropriate emotional distress or another form of psychological disorder, i.e. not schizophrenia (McKenzie et al., 2008). Pinto et al. (2008) argue against the hypothesis that misdiagnosis accounts for the statistical difference by stating that the features of schizophrenia in Western countries are broadly similar across ethnic groups; however, research demonstrates that there are culturally specific symptom repertoires (Hutchinson et al., 1999; Demjaha et al., 2006; Ndetei & Vadher, 1985; Toch, Adams & Greene, 1987).

The central issue underlying the problem of racial bias in psychiatric diagnosis is the dominance of a White, Western viewpoint in psychiatry (Sashidharan, 2001). Because of this viewpoint, the kinds of behaviour most likely to be considered normal in DSM classification are those that are acceptable within mainstream society (Fernando, 1998; Caplan, 1995; Russell, 1994). Culturally specific ideas shape a person's experience of distress: modern Western cultures do not assign credibility to hallucinations, and generally regard them as pathological (Al-Issa, 1995; Adebimpe, 1997). However, in many non-Western societies, hallucinatory experiences are not considered bizarre (Al-Issa, 1995):

> *'Symptoms that may mislead clinicians into diagnosing schizophrenia in Black patients include paranoia, abnormal speech, atypical auditory and visual hallucinations, and belief in witchcraft.'* (Adebimpe, 1997, p. 101)

Put simply, Adebimpe's words warn that members of the African and Caribbean community more often have symptoms that British psychiatrists are trained to take as evidence for schizophrenia. These 'symptoms' could have cultural relevance if understood properly. Whether the issue is misdiagnosis, or culturally specific symptom repertoires within a diagnosis or culturally different explanations for the same condition, the research evidence requires further exploration. One noteworthy retrospective study of hospital records suggests that if the culturally atypical features of paranoid and religious flavour are taken into consideration, rates of psychosis are then similar between African-Caribbean and British-born service users (Littlewood & Lipsedge, 1978). These findings are hugely significant as they imply interpretation of the over representation of Blacks in mainstream services should focus on understanding culture clashes between Eurocentric and other worldviews, values and beliefs.

There are a number of studies that suggest Black patients tend to present with more reality distortion (delusions and hallucinations) and affective symptoms and with fewer negative symptoms when compared with White patients (Hutchinson et al., 1999; Demjaha et al., 2006; Ndetei & Vadher, 1985). Research indicates that Black patients report more frequent and more severe hallucinations than White patients (Adebimpe et al., 1981, Adebimpe, 1982; Mukherjee et al., 1983; Lawson et al., 1984; Johns et al., 1998; Ndetei & Vadher, 1985). Sharpley and

Peters (1999) reported an excess of delusional ideation in a small sample of the general African and Caribbean population in Britain when compared with the White population. This does not necessarily indicate real differences in psychosis, if these descriptions can be understood in terms of their cultural relevance.

A US study found an excess of paranoid symptoms in African Americans (Toch et al., 1987). Adebimpe (1997) offers an interpretation of these findings, arguing that due to real negative social feedback, paranoid thinking is learned. 'Paranoia' is a diagnostic term that then pathologises a legitimate experience of poor treatment and discrimination. A number of clinicians and researchers have suggested that the Black experience in America has resulted in a type of cultural paranoia (Maultsby, 1982; Newhill, 1990; Ridley, 1984; Terrell & Terrell, 1981; Whaley, 1998).

There is evidence to suggest there is ethnic bias amongst clinicians; for example, in decisions leading to more admissions of Black patients to secure psychiatric care (Prins, 1993; Fernando et al., 1998; Kaye & Lingiah, 2000). With regard to compulsory admission, young Black men are stereotypically seen as being more threatening and disturbed (Pipe et al., 1991). The report by Sashidharan on behalf of the NHS and Department of Health (*Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England)* in 2003 highlighted that risk assessment was a key issue in the analysis of racist practice. There is also evidence to suggest that GPs' decisions to refer patients with mental health problems to specialist services are influenced by patients' ethnicity (Bhui, 1998; Commander et al., 1999). The statistics that imply clinician bias can be misleading as, arguably, they relate to the differences in help-seeking behaviour that has been documented. Perhaps clinicians correctly assess risk as higher in patients that present later to services in a worse condition.

Differences in help-seeking behaviour and culturally specific explanations of symptoms could offer a different way of formulating the reported differences in service use and experience. Research has demonstrated that culture influences help-seeking behaviour and expressions of distress (Bhui, Bhugr & Goldberg, 2002; Gater et al., 1991; Bhui et al., 2003). Black service users make poor use of primary care services and are more frequently detained involuntarily (Rwegellera, 1980; Commander et al., 1999; Bhui, 2001; Keating et al., 2002; Bhui et al., 2003; Morgan et al., 2005). Black service users are less likely to have mental health problems recognised by their GP (Gillam et al., 1989; Odell et al., 1997; Bhui et al., 2001) and are more likely to have the nature of their presentation wrongly attributed to mental illness (Wilson, 1993). There is evidence that GPs feel less involved in the care of patients with severe mental illness from minority ethnic groups (Bindman et al., 1997).

Black service users are often reluctant to engage with mainstream mental health services and tend to do so in times of crisis or breakdown (Bhui et al., 2003). Police involvement and compulsory admissions for Black and minority ethnic groups are strongly associated with the absence of GP involvement (Cole et al., 1995). These findings suggest that some client groups did not think mainstream medical facilities were the appropriate place to seek help with the symptoms they were experiencing; Western models of 'help' were not sought out, but forced upon them. This culture clash has implications for future help-seeking behaviour and suggests a risk of disengagement. Many patients admitted to secure psychiatric facilities often do so after multiple previous compulsory admissions, which suggests services are failing to intervene effectively. Coid, Kahtan, Gault and Jarman (2000) suggest research should concentrate on recognition of high-risk sub-groups of the mentally ill within all ethnic groups, and the development of new measures to improve compliance with after-care.

In an interesting South African study exploring the help-seeking patterns of 4,315 adult South Africans within a 12-month period, reasons for not seeking treatment were examined (Bruwer, Sorsdahl, Harrison, Stein, Williams & Seedat, 2011). Of the 4,315 adults, 729 (16.9%) met diagnostic criteria for a mental disorder during the 12 months. Only 182 (25%) of these respondents had sought treatment. Attitudinal barriers (belief that they do not require treatment, that treatment would not work, that the problem was not an illness, nor severe, it would go away on its own or that the person could solve their own problems) were found to play a more significant role than structural barriers (access to appropriate services). The majority of participants (93%) described a low perceived need for treatment when explaining why they did not seek mainstream treatment. Interestingly, 20% of the participants that did seek mainstream treatment dropped out. These findings seem to tell us something about how the South African individuals interpreted their symptoms; the fact that the overwhelming majority did not perceive their experiences as requiring mainstream treatment tells us something significant: these individuals did not seek out psychiatric/psychological help because they did not think they needed to. The study found that the strongest barrier to treatment in the South African population involves the knowledge and beliefs about mental illness that aid recognition, management or prevention. It would be interesting to know how the individuals explained their experiences and how many sought help at alternative/traditional/religious centres instead of the mainstream medical facilities, and for a larger scale version of this study to be repeated in the UK.

In considering why Black patients may be reluctant to engage or comply with mainstream services, Rethink, a charity for mental illness, identified several obstacles to BME clients (Rethink website, 2012). They found that different views about mental illness (different culture-specific models of illness) impacted help-seeking behaviour. BME service users experience services that focus on a medical model of illness and neglect the spiritual aspects of a person as

unsatisfactory. Rethink suggest that poor risk assessment (i.e. people from BME communities are much more likely to be assessed as presenting a concern to the public, and as a result, detained under the Mental Health Act) was an obstacle to service engagement of BME patients, as was poor access to alternative treatment to medication and a lack of BME staff (Rethink website, 2012).

The evidence suggests that there are differences in help-seeking behaviour, which result from structural and attitudinal barriers. Morgan et al. (2005) call for future research to explore ethnic variations in pathways to care as the findings are not fully explained by differences in diagnosis, social circumstances and the involvement of others. Morgan et al. (2005) highlight that there is persuasive evidence to challenge earlier research that did not find statistically significant ethnic differences in pathways to treatment (Harrison et al., 1989; Burnett et al., 1999). Understanding differences in pathways to treatment involves exploring the implications of a culture clash between different worldviews and explanations of experiences.

A strong belief in traditional healing ideas can lead to the rejection of mainstream mental health services (Mbiti, 1990). The African worldview subscribes to the idea that mental illness can be caused by witchcraft, a failure to connect spiritually with the ancestors, God and/or with other members of the community, or by the removal of the ancestors' protection (Loveday, 2001; Copsey, 1997). A large study across three European cities in 2005 revealed that a large proportion of the public perceived mental illness in terms of moral or spiritual explanations of mental illness, i.e. that if a person sins they may become ill, or that illness was a form of punishment from God (Angermeyer, Breier, Dietrich, Kenzine & Matschinger, 2005). These beliefs are particularly relevant whilst interpreting help- seeking differences between White British and African populations, and are potentially fundamental in interpreting the over representation of Blacks in involuntary admissions and the poor use of resources such as GPs. It is logical to argue that there is a relationship between a person's explanatory model of their experience and the sources they chose to seek help at (Schnittker et al., 2000).

Onyinah (2002) notes that as West African church members migrated to other countries they shared their faith with others, forming new groups and churches. In London, as well as other multicultural cities, there are many areas where the presence of African church groups can be felt. It is likely that within them, traditional, spiritual or religious healing practices or moral, magical or traditional worldviews exist. Whilst there seems to be a gap in research in terms of quantifying the prevalence of traditional appraisals of mental illness, one study found that in America, traditional ideas and beliefs were maintained within a family and stories were passed down through generations of Black Americans; therefore, the beliefs were not held by first-generation immigrants only (Snow, 1983). Common themes identified related to morality, fear of curses and persons with extraordinary powers, fear of the devil and an angry God, magic and

voodoo (Snow, 1983). A study in South Africa revealed that the primary casual beliefs of 112 students regarding depression and schizophrenia were varied, and these beliefs translated into many different suggested help-seeking behaviours (Samoulihan & Seabi, 2010). Weak will and spiritual forces were offered as explanations for depression (9% and 3% respectively) and schizophrenia (11% and 10%). Samoulihan and Seabi comment that witchcraft was mentioned by some of the participants whilst describing the cause of schizophrenia. The results of a larger scale version of this study would be fascinating as it is not possible to generalise from the South African context; however, it is interesting to note that the sample for this study represented the more educated and socially privileged end of a spectrum; the figures amongst less educated and Westernised individuals are likely to be considerably higher. However, it does offer an interesting insight into the help-seeking behaviour of the participants and calls for similar studies to be done on larger scales and in different countries. The interviewer effect in this type of study is likely to result in these figures being an under representation of the reality; if asked by a member of mainstream mental health services about primary casual beliefs, it is likely that some will modify their answers to what they consider to be acceptable. Larger scale studies should incorporate healers operating outside mainstream mental health services to increase respondent validity.

In 1964, Kiev reported that in the West Indies, people were more likely to interpret unusual experiences of magic or religion as everyday experiences rather than evidence for psychosis (Kiev, 1964). A more recent study exploring perceptions of schizophrenia in multicultural Britain found similar findings, highlighting that Afro-Caribbean individuals were less likely to regard unusual thought content as a sign of mental illness (Pote & Orrell, 2002). Ethnicity was found to be the most significant variable in defining some symptoms of schizophrenia, although differences were not found across all symptoms (Pote & Orrell, 2002).

In the Sainsbury's Centre for Mental Health report entitled *Keeping Faith: The Provision of Community Mental Health Services Within a Multi-faith Context*, Copsey presents qualitative data that supports this hypothesis:

> *'One African pastor told me that of the members of his congregation who come for prayer because of 'hearing voices', some 60% can have these symptoms directly attributed to the influence of demonic forces from the home culture. I asked him how he knew it was a spiritual rather than a mental illness, and he simply said that if it were a spiritual problem, then the voices would disappear when the spell was broken by prayer. If the voices were still there, then he would assume the person needed medical help.'* (Copsey, 1997, p. 16)

Africans living in the West may transpose culturally held beliefs into a Black religiosity, although the complexity of the manifestations of worldviews (mixtures of orthodox religious beliefs and traditional practices and spirit beliefs) should not be underestimated. Certainly, the Sainsbury's Centre for Mental Health research indicates that Africans living in the UK may seek help for psychological distress via their churches (Copsey, 1997), and yet research is lacking that quantifies the prevalence of alternative or spiritual healers that treat mental illness, or the use of such services in multicultural Britain. More than this, research is required to understand the beliefs, theories and treatment approaches operating outside the mainstream services. To consider the best way to improve service user experience and encourage earlier help-seeking amongst BME communities, collaboration with such services is key. In America, there is more evidence to suggest that religious African Americans are likely to turn to religious leaders for psychological support (Mattis & Watson, 2009). Interestingly, Mattis and Watson cite research that suggests that this difference in help-seeking is a protective factor rather than an obstacle to mainstream services, as greater religious attendance was found to positively correlate to willingness to seek mental health care (Morse, Morse, Klebba, Stock, Forehand & Panayotova, 2000, cited in Mattis & Watson, 2009).

B.4.7. Why are BME service users dissatisfied?

There are several likely causes of BME dissatisfaction with mainstream services. As outlined in previous sections, evidence suggests BME service users are likely to spend more time in hospital and enter mainstream mental health services in a more secure way (via police, courts, MHA, etc.) than White patients. This pattern is negatively experienced and associated with poor outcomes, and the research suggests that this reinforces the mistrust of mainstream services (SCMH, 2006). However, there are other sources of dissatisfaction for BME service users, including fear of services and staff, structural barriers to positive experiences, exposure to negative experiences whilst in treatment and the fact that mainstream 'treatments' do not fit with some individuals explanatory models of their experience.

Some members of ethnic groups are afraid of mainstream services (Keating & Robertson, 2004; Keating et al., 2002). Research suggests that the relationship between service and service user is negatively impacted from first contact, resulting in a more negative expectation of treatment to follow. Fountain and Hicks (2010) reported that fear of mental health services was multi-faceted: cultural competence, especially in relation to language, faith and religion, were found to be key variables. Fountain and Hicks (2010) described a study of 42 women, mostly Black African and Black Caribbean, the majority of whom had been inpatients, in which a quarter reported a fear of being mistreated and that this would prevent them from re-engaging with

services. Fountain and Hicks also warn that a large majority of BME users would be prevented from accessing mental health services owing to stigma. Delays in help-seeking create new risks such as police involvement or involuntary inpatient admission, and feed into the pattern of disproportional rates.

As summarised by the Rethink charity, structural barriers are likely to account for some of the dissatisfaction. Language can be a barrier between clinicians and service users; and not being able to communicate effectively is likely to result in a service user experiencing a service negatively. Jervis (1986) found interpreting services are often unavailable, which makes the assessment procedure both unreliable and highly stressful. If a person's first contact with a service (their assessment) is conducted in an unsatisfactory way, it is logical that it will result in negative expectations of the service.

More direct causes of service user dissatisfaction were described by the *Mental Health Act Commission report* (2009). This gave qualitative accounts of patients that were exposed to racist abuse whilst detained under the Mental Health Act; such abuse was described as mostly verbal taunts from other service users from which staff failed to adequately protect individuals.

Nicholls' report, *Strategies for Living*, stated that service users described mixed responses from staff with regard to their religious and spiritual beliefs and that many reported a need to be secretive about their beliefs:

> *'You have to be cautious about what you say because not being mainstream, a little off track, you have to be very careful you're not condemned for what you believe by the professionals.'* (Nicholls, 2002, p. 2)

Nicholls' report describes the interview data of 27 people and cannot be overgeneralised, as even small ethnic communities are neither static nor fixed in their ideas, practices or beliefs. However, qualitative data is essential in understanding the experience of BME populations with the mental health system and this data supports the notion that the dominance of Eurocentric values results in BME communities feeling alienated, suspicious or even pathologised for voicing culturally acceptable ideas.

In Copsey's qualitative study in Newham, he provides further evidence that the most fundamental barrier to experiencing mainstream services more positively relates to a clash of worldviews (Copsey, 1997). Copsey argues that attitudinal barriers are more significant than structural ones. For many BME communities, their belief system contrasts starkly with the approaches of the mental health services which are based on Western worldviews and a medical model of psychiatry:

> *'I spoke with many users of day services. In our discussions it was clear that their beliefs were important to them. However, there was a fear regarding talking about those beliefs because it was thought that if they did so, they would be sectioned, placed on medication, or seen as exhibiting psychotic symptoms. Many mental health workers with whom I spoke saw the whole complexity of religious beliefs as being far too complicated to engage with, and many saw religious beliefs as contributing to mental health problems.'* (Copsey, 1997, p. 10)

Service users described feeling that their faith was not recognised by mental health services and felt frustrated by a lack of access to prayer or religious communities (Copsey, 1997). Copsey stresses the importance of the discipline, reaching out to leaders of different faith communities with the intention of mutual learning, insisting that belief systems surrounding experiences of mental illness must be better understood. Whilst Copsey's work is based on a qualitative study in a specific area, Newham is an example of a very diverse London borough where discrepancies in mainstream service use and experience are apparent. The work valiantly explores an under researched area and makes useful recommendations for future work. The importance of this study cannot be stressed enough. If a service user's worldview differs starkly to the assumptions of mainstream mental health services, it is likely that they have their own ideas about appropriate treatment which may involve religious, spiritual or traditional treatment approaches. These service users do not engage with services but may be unfortunate enough to have services forced upon them via legal procedures when they are more unwell. When this happens, if they do not feel their beliefs or faith is recognised or accommodated for, it is easy to imagine how the end result is an experience that the service user describes as negative. Furnham, Ota, Tatsuro and Koyasu (2000) found participants in their study were unlikely to rate mainstream treatments as helpful if they were completely unrelated to the etiological belief that they had about their mental illness.

Research suggests that BME service users are less likely to have their psychological and social needs addressed adequately whilst in services (Sashidharan, 2003). Outcome of services is worse for BME service users, clearly maintaining negative beliefs about the system. These clients complain of more coercive treatments and adverse experiences (Cochrane & Sashidharan, 1996). It becomes easy to see why mental health services are unattractive to some ethnic groups, especially when their explanatory models of their experience are dismissed, ignored or pathologised by the service.

B.5. Rationale for this study

Research that attempts to explain the statistics that demonstrate cultural and ethnic differences is limited by a lack of focus on BME clients' explanatory model of their experience, help-seeking behaviour and attitudinal barriers preventing early engagement with primary care services. The existence of traditional African beliefs in the UK necessitates research that aims to explore effective ways of supporting these clients. The UK is a modern culture, trying to modify and adapt mental health services for its immigrants, having identified the need. Ghana is a traditional country, embarking on the process of interpreting modern psychology in a way that is useful to its population. This study involves visiting a cultural centre of African beliefs, to learn from Ghanaian colleagues. This offers a unique perspective on the challenges facing the globalisation of psychology and potential strategies for working within a multicultural West.

Whilst other research efforts have involved trips to Africa, research often takes on an ethnographic approach. Research into traditional healing practices offers descriptions of healing practices through Western eyes (Maiello, 1999; Lee, Oh & Mountcastle, 1992; Vontress & Niaker, 1995; Vontress, 1991, 1999), which is useful as these healing practices are often shrouded in secrecy. However, this research is adopting a different approach and is interested in our African colleagues' expertise. The rationale for this project is based on the premise that in an African country that is delivering mainstream/Western mental health services, it will be commonplace for clients to have traditional explanations for their experience (spiritual, religious, traditional explanations), and that Ghanaian colleagues will have expertise regarding how best to work with clients whose health beliefs are non-European (scientific, medical, psychological).

B.5.1. The relevance to Counselling Psychology.

The issue of culture in relation to mental illness is rarely addressed except in the most marginal terms, invariably disconnected from the mainstream (Sashidharan, 2001). However, mental health services are now legally obliged, like many other public institutions, to address criticisms that psychiatric and psychological disciplines are imbued with racism. Whilst much research is needed on this area from many disciplines, Counselling Psychologists are well placed to explore solutions to the challenges associated with clashes of culture between a Eurocentric medical model of mental illness and indigenous explanations of mental illness. Tucker, Ferdinand, Mirsu-Paun, Herman, Delgado-Romero, van den Berg and Jones (2007) describe Counselling Psychology's commitment to 'prevention, multiculturalism and social justice', which are values that could be pivotal in addressing health inequalities. Kasket (2012) highlights that Counselling

Psychology reflects values of pluralism and is willing to expand its horizons to accommodate a plurality of viewpoints: 'Counselling Psychology is the applied psychology that most fully embraces working with these complexities' (Kasket, 2012, p.65).

A significant challenge in developing culturally sensitive services involves examining and challenging the assumptions underlying the cultural and historical specificity of modern psychiatry (Sashidharan, 2001). Counselling Psychologists could be at the forefront of research that encompasses different worldviews as we move towards universally relevant theory and equality. Cross-cultural competence should not be seen as a specialist field but as an integral part of Counselling, and, indeed, all applied Psychology (Kriegler, 1993; Pedersen, 1988). Training in Counselling Psychology should better equip clinicians to work in a culturally sensitive way, reflecting values of pluralism and equality (Naidoo, 1996).

B.6. Literature review: An examination of the research context

B.6.1. General information about Ghana

In 1957, Ghana (formerly known as the Gold Coast) became the first country in sub-Saharan Africa to gain independence, in this case from British colonial rule. Ghana is a West African country made up of 170 districts (Government of Ghana, 2012) and several tribal groups (CIA, 2012; Utley, 2009), resulting in a myriad of cultures and tribes (Utley, 2009). English is the official language, although several other local languages are still spoken widely. There are more detailed tables in the appendix that depict the prevalence of different tribal groups and languages spoken in Ghana (Appendix 16.1).

Ghana is considered a relatively stable and peaceful democracy with good standards of governance, and has a strong and diverse civil society (Ofori-Atta, Read & Lund et al., 2010). In spite of its low-income status, the country has one of the highest literacy rates within West Africa (see tables in Appendix 16.1 for more information). As in much of Africa, there is a strong influence from the West, whilst indigenous ideas and values underpin much of society. Ghanaians often reflect values of collective living; a person sees himself or herself as connected to a community. Mutual help, collective responsibility and honouring community obligations are seen as important (Utley, 2009).

B.6.2. Traditional African religions

Despite efforts of Western missionaries to Christianise Africa, basic faith in Africa relates to ideas of animism and traditionalism (Vontress, 1991). There are many religious systems in Africa (Magesa, 2002; Mbiti, 1990) with diverse concepts and practices (Doumbia & Doumbia, 2004; Krüger, Lubbe & Steyn 2009, p.35), although various indigenous religions share common features (Doumbia & Doumbia, 2004; Krüger et al., 2009; Koss-Chioino, 2005).

European philosophy assumes that the universe is inanimate, whereas African philosophy assumes there is power in all things (Parrinder, 1951). Imasogie (2008) claims that reductionist attempts to summarise and simplify Traditional African Religion often results in incorrect terminology. With that in mind, an attempt is made to present some of the common values described in the literature with the disclaimer that these attempts are merely an introduction to a complex and vast subject which this author is not qualified to do justice to.

The African understanding of religion is an understanding of the connectedness of all things (Beyers, 2010). An underlying philosophy of African Religion holds that religion is reality and

reality is religion, which is where it differs quite drastically from Western worldviews. There is no separation between spheres of reality. Religion can never be perceived as a separate fragment focused on a different 'reality' (Doumbia & Doumbia, 2004; Beyers, 2010).

Turaki (1999) proposes that the main characteristics of African Religion include: belief in a Supreme Being, belief in spirits and divinities, the cult of ancestors and the use of magic, charms and spiritual forces. God takes on the highest position and is considered the creator (Mbiti, 1990; Anderson, 2008); below the Supreme Being are multiple tiers of lesser gods and sprits. The spirits of ancestors, nature spirits and deities feature in African Traditional Religion (Krüger et al., 2009) and are distinct from Gods that are thought to reside in heaven (Sundermeier, 1990). Below lesser Gods and the ancestors is a wide range of additional spiritual beings and forces that are thought to roam the earth (Sundermeier, 1990), for example, local deities associated with geographical features, and animistic spirits of animals or plans sacred to specific clans.

The spirits of the dead have great importance in traditional faiths and receive offerings from their descendants (Anderson, 2008). Offerings include prayers, sacrifices or gifts made to the spirits (Doumbia & Doumbia, 2004). Ancestors are thought to be able to cause harm to those that do not respect them. Possession is thought possible when a demon or spirits enter a body against an individual's will. The body is thought to be filled with energy that can be injured or aided by other forces; hair, nails, spit and even washing water, sleeping mats and other items that come into close contact with the body are considered important and vulnerable to spells of Black magic (Parrinder, 1951). Blood is considered to be one of the most important parts of the body, closely associated with the soul and a vital part of many sacrifices (Parrinder, 1951). Amulets are a popular type of traditional charm worn to ward off trouble, illness and 'disruptive forces' (Doumbia & Doumbia, 2004). Similarly, talismans are thought to bring success and prosperity to the owner.

In Africa, negative life events, including states of illness, especially psychiatric disorders, are often attributed to the activities of external causes such as evil spirits, enemies and the gods, etc. (Aina, 2006); hysterical phenomena are commonly considered to be due to possession by some extraneous force (Parrinder, 1951). External causes are blamed for physical and mental ill health, and these 'external causes' reflect traditional African values (Aina, 2006). Breaching taboos and local customs, disturbances in social relations, hostile ancestral spirit possession, attacks from witches, demonic afflictions, sorcery and afflictions by the gods are all possible explanations for ill health (Edigbo, Oluka, Ezenwa, Obidigbo & Okwaraji, 1995; Aina, 2006).

Traditional healing seeks to explain the cause of an illness or negative life event and then address the problem. Healing can include a range of practices, including dream interpretations,

possession dances, sacrifices, pharmacotherapy and herbalism, exorcism and shock therapy (Singh, 1999). Shock therapy involves shocking the patient by holding them in cold water or by scaring the patient with people dressed up and causing much agitation (Singh, 1999). 'Fetishism' is the belief in 'fetishes', objects that are considered to possess mysterious powers (Mbiti, 1990); a fetish man is able to manipulate these powers.

B.6.3. Religion in Ghana

The earliest contact between Ghana and Christian missionaries was in the late 15th century when Roman Catholic missionaries accompanied the earliest Portuguese traders to the Gold Coast. A succession of missionary societies from Western Europe subsequently lived and worked to impact life in the nation. The missionaries classified African Traditional Religion as heathen, pagan, primitive, unscientific and uncultured, dismissing indigenous worldviews as the superstitious beliefs of uncultured people. Onyinah (2002) suggests that in an effort to evangelise and civilise the people, the missionaries presented the devil as the power behind the Abosom, Asuman and almost all the traditional beliefs and practices. Onyinah also notes that at this time in Ghana, everything from the Europeans was considered godly, whilst everything Akan was seen as devilish. This process resulted in the Ghanaian population being divided in allegiances to tradition and missionary ideas (presented as the new desired position). This resulted in a huge section of the population identifiying themselves as Christian, whilst practising a dual allegiance. Indeed, an attempt to distinguish between culture and religion is a fundamentally Western assumption (Sundermeier, 1999).

Chavunduka, president of the Zimbabwe National Traditional Healers' Association, summarised the historic relationship between Christianity, African Religion and African medicine:

> *'Africans who became Christians were discouraged by the church from taking part in African traditional religious rituals and from consulting traditional healers. This attempt to destroy African religion and medicine has not succeeded. Many African Christians have continued to participate in traditional religious rituals; they have also continued to consult traditional healers. In other words, many African Christians have dual membership: membership in the Christian church and membership in African religion.'* (Chavunduka, 1999, p. 1)

Western notions of Christianity emphasised individuality and man's freedom of choice and will. These values were very different from indigenous values of connectedness. Many Africans who became Christians found it difficult to abandon their religion and medicine completely. Christian conversion was, therefore, shallow; it did not always change the African people's

understanding of life and their relationship to their ancestral spirits and God (Chavunduka, 1999). African independent churches are described as the best example of how Christian beliefs became incorporated with traditional African beliefs to fit the African cultural context, resulting in much less of a spiritual transformation than the missionaries had hoped for (Olabisi Abimbola, 2008). The major ethnic groups in Ghana include the Akan, Ewe, Mole-Dagbane, Guan and Ga-Adangbe, each with its own subgroups of communities. Ethnic groups have their own beliefs, traditions and values, although there are areas of commonality (Ghana High Commission website, 2012).

Akan religion in southern Ghana consists of a Supreme Being (Onyame), lesser deities (Abosom) and supernatural powers that exist with varied potency and quality in beings and objects (Gifford, 2004). The Akan belive in a hierarchy of spirit forces; all the spirits derive their ultimate source and power from the Supreme Being, called Onyankopong, or Onyame (Max, 1989; Onyinah, 2002; Gifford, 2004). Gifford highlights the importance of honouring ancestors and describes how other spirits are thought to dwell in rocks, rivers, trees and various objects. The fundamentally Western assumption that the physical and spiritual realms can be separated differs starkly to this worldview; Gifford emphasises that traditional religion in southern Ghana views the spiritual and physical realm to be bound in one totality: '*nothing is purely matter, since spirit infuses everything and changes occur as the result of one sprit acting upon another*' (Gifford, 2004, p.83).

The Abosom can be viewed as representatives of Onyankopong. Onyinah (2012) states that it is the lesser gods who are in control of the affairs of people on earth. The powers of the abosom are thought to be capable of good and bad. The Akan word for 'witch' is Obayifo, which is suggested to mean 'a person who is of the abode of an evil entity, the Obayi' (Field, 1960). The Akan (Ashanti) people have a complex religious system involving elaborate ceremonies, ancestor worship, ritual, witchcraft and sorcery, and beliefs in many kinds of spirits, divination and shamans. One of the most frequent Ashanti religious ceremonies is to recall the spirits of the departed rulers to ask for their help or protection. These ceremonies, called the Adae, occur every 21 days and participation is expected (The Africa Guide website, 2012). In an Ashanti village there is often a tree or trees whose soul is believed to protect the town, known as gyadua in the local language (Parrinder, 1951). The family I stayed with had a tree in the centre of the home thought to have magical powers to heal and protect.

The Ewe people of southeastern Ghana have over 600 deities. Many village celebrations and ceremonies take place in honour of one or more deities (The Africa Guide website, 2012). The Ewe people believe that each person has his or her own indwelling spirit, to which he or she offers sacrifices (Anderson, 2008). In an extensive study of the Ewe-speaking people of West

Africa, Ellis (1980) documented how deities that are considered to have distinct personalities possessed worshippers at Voodoo shrines.

Dagbon is heavily influenced by Islam. Dagbamba are one of the cultural groups with a very sophisticated oral culture woven around drums and other musical instruments. Prominent festivals they celebrate include the Damba, Bugum (fire festival) and the two Islamic Eid Festivals (GhanaWeb, Ethnic Groups, 2012).

A thorough analysis and description of the many traditions, beliefs and values operating within the many tribes of Ghana is not possible as there is a lack of literature due to the oral tradition of information-sharing and the sheer amount of diversity. However, it is relevant to this project to recognise that there is a wealth of diverse tribal groups, traditions and beliefs in Ghana and that these beliefs, values and traditions can co-exist with religion, modernism and Westernisation.

Whilst the results of the 2000 census suggest the majority (69%) of the country is Christian and only a small 8.5% identify themselves as following a traditional religion (CIA, 2012), these figures are misleading. It is important to note the historical and social context when interpreting the statistics. English is the official language of Ghana, and many Ghanaians consider modernity as a desirable position associated with Westernisation. It is clear from the census results that the majority of Ghanaians identify themselves as Christian. However, the extent to which the population was truly Christianised has come under scrutiny (e.g. the Ghana Evangelism Committee, 1989). For many, traditional ideas have been transposed into their Christian faith. Even for those that do not actively participate in aspects of traditional religion, Christianity in Ghana may take on a very different form to the Western construct of Christianity.

> *'The African so often fails to understand the European insistence upon abandonment of magical practices, and in such a large percentage of cases continues to perform them surreptitiously. For to him there is a "good magic", quite distinct from "Black magic"; the distinction being derived from the belief that good magic reinforces life, whereas Black magic seeks to destroy.'* (Parrinder, 1951, p. 9)

The Pentecostal and Charismatic movements have given a new face to Christianity in Ghana, offering a faith that can be truly Christian and truly African and which appropriately responds to the existential needs of the African (Annorbah-Sarpei, 1990). Charismatic prayer centres offer all night services ('All Nights'), have a strong presence in terms of advertising (posters, radio advertisements, etc.) and have religious figures that have reached celebrity status (Gifford, 2004). My own experience of living within metres of five or six such churches taught me that Charismatic church services operate at high volume; the instruments, choir and preacher seem

to be in competition with each other to see who can generate the most sound and it was common for me to be woken up by screams and shouts from an early morning service that would last all day (and sometimes all night), broken only by enthusiastic singing and clapping from the audience, before the preacher would continue with renewed vigour. These experiences offered an insight into the way Ghanaians' faith represented an integration of ideas and worldviews, incorporating juxtaposing beliefs to create an *African* Christianity.

B.6.4. Mental health services in Ghana

When compared to other African countries, Ghana is relatively well resourced for mental health care (Jacob, Sharan, Mirza et al., 2007; Ofori-Atta & Read et al., 2010). As one of the first countries to gain independence in 1957, it was one of the pioneers of primary health care in the region (Twumasi, 1979). However, it is impossible to explore the journey of psychology in Ghana without acknowledging the legacy of colonialism. Before Ghana gained independence, psychiatry was exported to colonialised countries in the form of asylums. Many theorists highlight that whilst attempting to meet the needs of those suffering from mental illness, colonial psychiatry also served to justify and maintain the social order of colonial regimes (Bhugra & Littlewood, 2001; Keller, 2001; Sadowsky, 1999; McCulloch, 1995; Vaughan, 1991). The first asylum in Ghana (known as the Gold Coast at that time) was opened in 1888. McCulloch (1995) writes:

> *'By 1904 it had 104 inmates, attended by a staff of ten untrained nurses with the assistance of a gatekeeper. The function of the asylum, here as everywhere in this period, was purely custodial, and many of the mentally ill remained in the prison system.'* (McCulloch, 1995, 12)

During the early 1900s, African doctors were paid less than European colleagues and would never have superiority over even the most junior European doctors (Schräm, 1971; Oyebode, 2006). West African natives were considered inferior to European doctors; strong racial prejudice within the West African medical system reflected the status of Eurocentric science. Whether intentional or not, clinical ideology portrayed Africans as incapable of self-rule, thereby justifying the efforts of colonialism (Oyebode, 2006).

Since gaining independence, Ghana initiated attempts to develop mental health care with the establishment of new psychiatric hospitals and later the introduction of psychology, occupational therapy and community psychiatric nursing (Ofori-Atta & Read et al., 2010). That said, as in many low-income countries, mainstream mental health services are under resourced,

frequently lacking appropriate medication (Yaro, Deme-Der, Antwi-Bekoe & Donnir, 2009) and mental health staff (Ofori-Atta & Read et al., 2010). For many of the poorest people in the world, mainstream services may not be a realistic treatment option as traditional healers offer the only treatment that is affordable or accessible to them (Cocks & Moller, 2002; Sodi, 1996; Tabi, 1994). There are three government psychiatric hospitals in Ghana and these facilities are clustered in the southern urban areas (Doku, Ofori-Atta & Akpalu et al., 2008), leaving vast spaces without easy access to hospitals (see figure B3). Ofori-Atta, Read and Lund's situational analysis of mental health services (2010) suggests the three government psychiatric hospitals in Ghana provide 7.04 beds per 100,000 population. This ratio is grossly inadequate (Mensah, 2000). In 2005, the human resources for mental health care were reported to be: 15 psychiatrists, 468 psychiatric nurses, 132 community psychiatric nurses (CPNs) based in the ten regions covering 69 of the 138 districts, 7 psychologists, 10 medical assistants, 6 social workers and 1 occupational therapist (Ofori-Atta, Read et al., 2010). There is approximately one medical doctor per 20,000 in Ghana (Patterson, 2001; Tabi & Frimpong, 2003) and one psychiatrist per 1,470,588 (Doku et al., 2008).

The buildings are basic and the facilities are overcrowded (see figure B2) and resources are inadequate. A recent study into the availability of psychiatric medication found that over 70% of the 108 participants interviewed reported that essential psychotropic drugs were not available (Yaro et al., 2009). Treatment for mental disorders is provided free of charge at the government psychiatric hospitals, although several private services exist too. There are 4 private psychiatric institutions, which provide outpatient clinics and inpatient care; two are located close to Accra and two near the second largest city of Kumasi (Ofori-Atta, Read & Lund, 2010). There are very few rehabilitation and day services for people with mental disorders (Ofori-Atta, Read & Lund, 2010), and resources become even sparser away from the larger cities. Community Psychiatric Nurses (CPNs) represent primary psychiatric services in the rest of the country and liaise with psychiatrists to prescribe and administer medication in the community (Mensah, 2000). Their task is enormous, as is evident by the map (figure B3). Non-government organisations (NGOs), charities and faith-based organisations aim to fill in more of the gap in service provision.



Figure B2. Images of one of the psychiatric hospitals' front entrance, bedroom and toilet (Ghana Nation News, 2010):

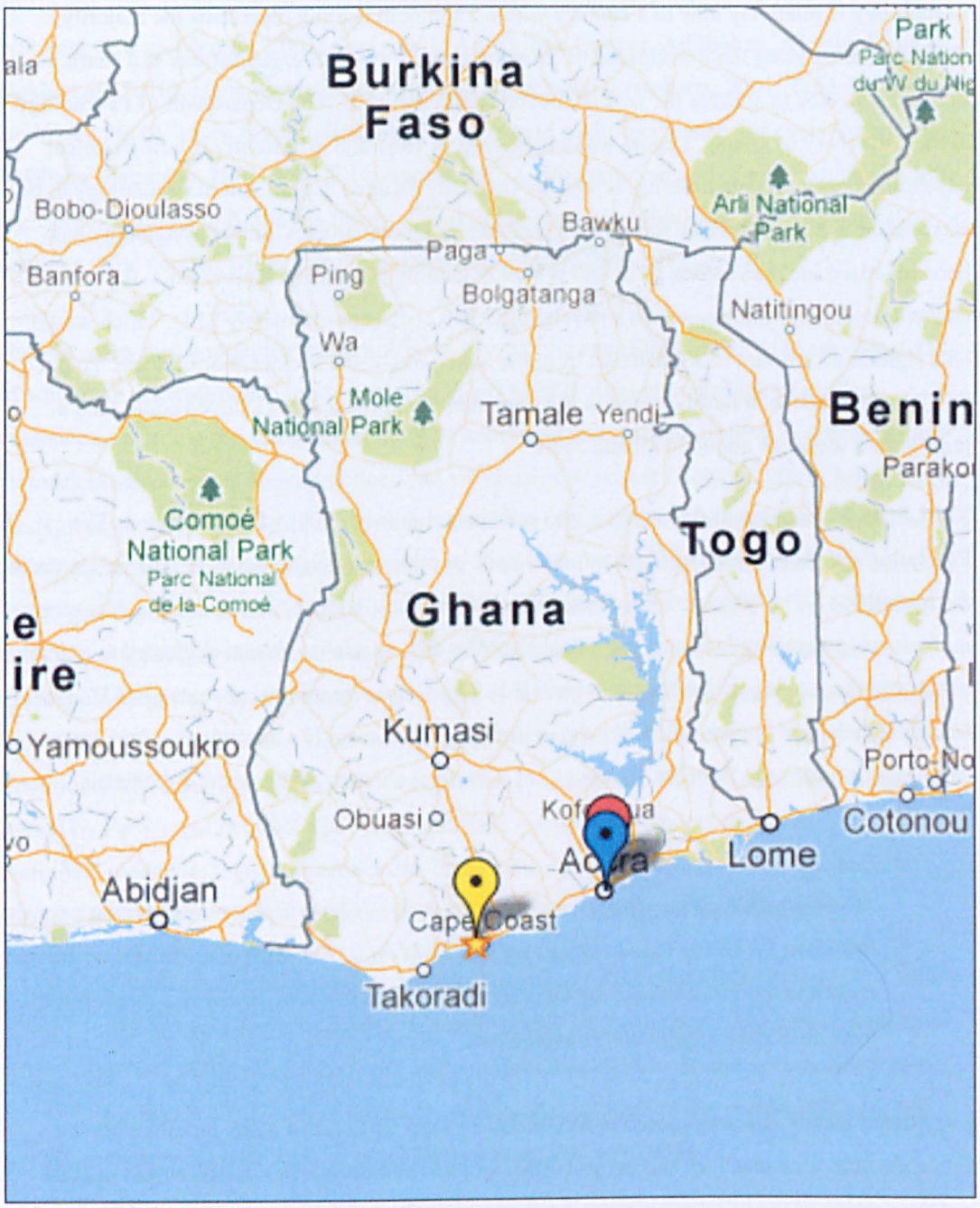


Figure B3. Map of Ghana indicating the location of the three Government psychiatric hospitals

(Copyright © 2013 Google Maps.)

Psychology is relatively new to a country where traditional healing represents the majority, although recent years have witnessed its growing popularity, with organisations and charities being established to address the lack of mental health services. The Department of Psychology at the University of Ghana, Legon, was established in 1967 and is currently offering clinical psychology postgraduate training. It was the first fully-fledged department of psychology to be established in a West African university (Danquah & Opok, 2008). Clinical psychology has been practised in Ghana since 1972 and is slowly gaining popularity. At present, a fee is charged to patients wanting to see a psychologist (40 cedis, approximately £14), which would be a significant amount to a Ghanaian from the lower end of the socioeconomic scale. To put this into perspective, a family living in the poor area of Chokor where I stayed could feed a family for a week for about 50 Ghana cedis.

The Ghana Psychological Association was established in July 2000, which proposed 'The Psychologists' Act', which outlines a formal code of ethics of psychologists in Ghana (Danquah & Opok, 2008). The development of mental health services in Ghana has recently achieved two more developmental milestones: the launching of its first specialist journal dedicated to mental health and the passing of the Mental Health Bill. The *Ghana International Journal of Mental Health* launched in January 2010. On the journal's website there is a description of the launch party, with a statement from Dr. Akwasi Osei, Chief Psychiatrist at the Accra Psychiatric Hospital:

> *'A new day has dawned on us and we must ensure its survival; we shall keep it current and alive for a long time to come; we will build on it. The birth of a Journal on Mental Health is a great privilege for Ghana and Africa as a whole, which will throw more light on Mental Health and related cases.'*

The Mental Health Bill was passed in March 2012 (Yaro, 2012); just a few months after the data collection took place for this project. The bill had been introduced in Parliament in 2004 and the passing of the bill demonstrates another important shift in the provision of mental health services in Ghana. The new bill applies to both public and private facilities, including traditional and spiritual mental health care. These milestones reflect the current climate of psychology and psychiatry in Ghana; an exciting time full of optimism for the future.

B.6.5. Alternative healing in Ghana

Differing starkly from the 'mainstream' services, traditional and alternative healing is accessible to all. There are thought to be approximately 45,000 traditional healers in Ghana (Roberts,

2001) and 70% of the population is reported to consult traditional healers for mental health problems (Ewusi-Mensah, 2001; Osei, 2001; Ae-Ngibse, Cooper, Adiibokah, Akpalu, Lund & Doku et al., 2010), many as a primary help-seeking behaviour (Roberts, 2001; Tabi, Powell & Hodnicki, 2006). There is approximately one registered traditional healer for every 200 people in Ghana (Patterson, 2001; Tabi & Frimpong, 2003), although many more may exist and not be registered. Traditional healing is firmly rooted in indigenous worldviews, and is likely to continue to be popular whilst it holds cultural relevance (Mbiti, 1975).

Healers often start apprentice learning from a very young age (Singh, 1999), the specific details of which are often shrouded in secrecy. The WHO (2002) highlights the lack of clinical evidence concerning the safety and quality of traditional and spiritual healing practices. Much research raises concerns about practices that are abusive or unsafe (Roberts, 2001; Selby, 2008; Ae-Ngibse et al., 2010). In Ghana, there are a number of associations of traditional medicine practitioners, including the Ghana Psychic and Traditional Medicine Practitioners' Association, which was formed in 1961 (WHO, 2001). In 1999, the government brought all the traditional medicine associations together under one umbrella organisation, the Ghana Federation of Traditional Medicine Practitioners' Associations (Mensah, 2000; WHO, 2001). The Traditional Medicine Unit under Ghana's Ministry of Health was created in 1991 (WHO, 2001). The Traditional Medicine Practice Act 595 was drafted by traditional medical practitioners, and passed by Parliament in 2000. The Act established a council to regulate the practice of traditional medicine, register practitioners, license them to practice and to regulate the preparation and sale of herbal medicines. The Act defines traditional medicine as:

> *'Practice based on beliefs and ideas recognised by the community to provide health care by using herbs and other naturally occurring substances"* and herbal medicines as *"any finished labelled medicinal products that contain as active ingredients aerial or underground parts of plants or other plant materials or the combination of them whether in crude state or plant preparation.'* (WHO, 2001)

Given the huge numbers of traditional healers thought to be practising in Ghana, the regulatory body has a huge challenge on their hands. Considerable additional resources would be required to accomplish the mission statement; however, the Act reflects a national health service that acknowledges the importance of identifying and understanding practices that exist outside the medical model.

Ae-Ngibse et al. (2010) interviewed 122 major stakeholders in the mental health system in Ghana to explore the widespread use of traditional healing. The issue of accessible, available and affordable services was recognised as a significant factor in shaping pathways to treatment, given the lack of accessible medical facilities. However, structural barriers to mainstream

mental health services were not thought to be solely responsible for the popularity of traditional and faith healers; respondents felt that traditional healing practices were appealing to Ghanaians as the healers' understanding of mental illness fits with hegemonic cultural explanatory models. The understanding that for many Ghanaians, mental illness was considered a spiritual issue (juju, evil spirits, supernatural powers, etc.), rather than a physical or psychological illness, was key in interpreting help-seeking behaviour. Ae-Ngibse et al. (2010) cite qualitative data of a traditional healer explaining potential causes of mental illness:

> *'At times, it could happen that somebody might have gone with another person's wife and then he will be struck down by juju, or somebody might steal a person's belonging, or it could happen that, as a result of some litigation, somebody may go mad.'* (Ae-Ngibse et al., 2010, p. 561)

The qualitative data cited in the Ae-Ngibse et al. (2010) study offers an insight into the traditional healing practices as described by the healers themselves. Traditional healers reported consulting the gods for guidance on the correct treatment approach and herbal medicine to use. Spiritual healers described prayer and fasting, anointing oils and holy water, and some reported that a confession was an integral first step in effective treatment. The authors present a faith healer's description of this process:

> *'It happens that, someone may be a witch or has done something wrong and as a result, has this problem. In that case, it is necessary for the person to tell the truth, before the right medicine to be given will be known.'* (Ae-Ngibse et al., 2010, p. 561)

Ae-Ngibse et al. (2010) explore other aspects of traditional and faith healing that appeal to Ghanaians. Psychosocial and spiritual support offered by healers were reported as reasons to explain their popularity, and research supports the idea that alternative healers offer psychological and social support that is appealing to its service users (Hewson, 1998; Meissner, 2004; Tanner, 1999; Van der Geest, 1997; Ofori-Atta & Cooper et al., 2010). Positive messages from church services were thought to benefit some mental health conditions, and respondents suggested that in some churches, they offer counselling and guidance, whereas mainstream services were interpreted as sources of medication rather than talking cures (Ae-Ngibse et al., 2010). This description of the respective roles of the church and medicine reflects the duality of Africa health beliefs and a holistic approach to health that includes spiritual or religious components.

Ofori-Atta and Cooper et al. (2010) conducted qualitative research to explore dominant explanatory models of the causes of mental disorders in women in Ghana. The 81 interviews and 7 focus groups revealed respondents thought that common community attitudes tend to

understand mental illness in both genders as 'the work of witches' or 'the doing of witches' or 'women causing damage with witchcraft'. Ofori-Atta and Cooper et al. (2010) present a description of a cleansing camp for women accused of witchcraft:

> *'Sometimes, the community brings them to the camps. Other times, they are chased out by their people that are going to kill them. So they run away to the camp...Now at the camp, certain rites have to be performed to kick off this witchcraft power before they go. They have to weaken the powers of the witchcraft so they can't cause any more problems. Some of them have to stay forever though. There are some we knew when we were kids and they stayed here till they died.'* (Ofori-Atta, Cooper, Akpalu et al., 2010, p. 592)

This quote paints a picture of the seriousness of being accused of witchcraft and the cultural acceptability of such treatment. The healers occupy a position of cultural authority. Their widespread use goes beyond indicating structural barriers to mainstream medical services, rather it highlights that for many African people the most effective therapeutic agents are thought to be those that embody their culture (Vontress, 2005). The conception of an illness, its etiology, and helpseeking behaviour demonstrate the basic cosmology of many African people (Vontress, 2005).

B.7. Methodology

B.7.1. Introduction

This chapter will explain the choices involved in designing this research and why the project employed a qualitative design using semi-structured interviews and thematic analysis. Alternative methodological designs have been critiqued and the strengths and weaknesses of the methodology involved in this research project have been explored. This chapter also includes a description of the procedure of data collection and analysis, and an evaluation of the process. The design and content of the project have been shaped by my own values and identity. Therefore, to introduce this methodology, I will offer a summary of my own cultural identity and my limited personal exposure to traditional healing.

B.7.2. Personal reflexivity

As a White British middle-class woman, I have grown up in a world of financial and social privilege. Living in a society of Western values, I was taught to strive towards reaching markers of achievements in terms of education, status and financial security. My upbringing was vaguely Christian; I was christened in a Church of England church as an infant and attended a village primary school attached to the village church. I was brought up to be familiar with the bible, but religiosity or spirituality did not feature much in terms of my developmental years. I have one sister, and our small family was typical of my parent's social group. I boarded at secondary school and was fortunate enough to meet people from all over the world. From this age I became intrigued by cultural differences in terms of traditions and values. Whilst my family is close, Western values encourage separation and individualisation, and academic and financial markers are entwined with values of success.

Internationally, Eurocentric thinking occupies a position of dominance. International discourse reflects this dominance with words like 'enlightened' 'developed' and 'civilised' used to describe the West and words like 'developing' or 'the third world' used to describe the rest of the world. I had not challenged some of the assumptions underlying this worldview before. In the process of this research, I became increasingly critical of this discourse and the implications of this power imbalance, especially with regard to theories of psychological well-being.

I first visited Ghana in 2001 as a volunteer teacher and have now been twelve times. Trips vary in length, but my relationship with Ghana has been a consistent and valued part of my life. This

can be explained in part by the good friends I have made there. I stay with the same friends in Chokor, whose five children call me Aunty, and I consider them to be part of my extended family. This romantic account of the friendships I have made does not fully explain Ghana's appeal, however. The housing in Chokor is mainly temporary wooden houses, and my home there is no exception. The facilities are modest and contrast starkly with my home in the UK. Cold showers, frequent power cuts and wooden walls that do not keep out mice, cockroaches or other unwanted visitors are the reality. I have been ill several times over the years, quite severely on occasion. Despite these things, there is something about Ghana that is hugely appealing to me. The appeal is hard to articulate, attributable in part to the slower pace of life. I am privy to a community that values being connected, and my relationship with Ghana has benefited from my own desire to take time out from the fast pace of modern city living. Conversations with Ghanaian locals over the years have revealed that some feel that White people are yearning for exposure to authentic values as a symptom of our society's dysfunction.

The explanation offered above is appealing to me, although I suspect some murkier forces are at play, too. Ghana offers me an environment in which I am different. I can be generous and feel useful and appreciated. Perhaps my own desire for this sense of specialness has facilitated the close relationship I have with Ghana. I started an NGO with a friend ten years ago, and have derived enormous pleasure and much pride from the work I have engaged in over the years.

My only direct exposure to traditional African healing practices has been in Ghana over recent years; the more I learned, the more I was intrigued. Ten years ago, during a trip to Ghana, I made friends with a group of Ghanaian youths. The next year I was told by one of the group that 'Mikey' (whose name has been changed to protect his identity) had become ill. I visited Mikey and observed a young man who was withdrawn, seeing visions of spirits that wanted to harm him and who seemed afraid. I watched, feeling horrified as he was tied up with rope and taken to visit the family 'healer'. I asked about his whereabouts and was told by several people that his mother had become rich due to dabbling in Black magic and that the money had come at a price. The story I was told suggested that his mother had moved to America by becoming rich by Black magic, and her actions had come at the sacrifice of her son's health. Members of the extended family had ensured he visited the healer to rectify the situation for fear that others would be next to suffer. The family offered all the money they had to a man claiming he could remedy the situation. The experience was upsetting and the practices seemed cruel to my foreign eyes. I felt that the Western approach was the 'right one' (that Mikey should be taken to the hospital) and that this healer was exploiting vulnerable people.

Four years later, I met another healer; he was a herbalist and had opened up his home to care for people with mental health problems. This experience could not have been more different. I spent weeks living with this family and the tens of patients in his care. His family had passed

down information about the healing qualities of different herbs, which he would make into teas and tonics. A large component of his work involved spending time with each patient, talking with them and asking them to take on small jobs around his house. He was able to explain to me different Ghanaian beliefs about health, and instil in me a less foreign perspective on the practices that I had interpreted as being so cruel. He explained that some used ropes if the patient was likely to run away. This man had a presence about him that I enjoyed being around; he was calm, kind and thoughtful. His speech was considered and slow. His practice seemed closely aligned with Counselling Psychology; the relationship between help-seeker and help-giver appeared respectful and collaborative. He described core conditions, which seemed to mirror my knowledge of Carl Rogers' person-centred counselling (Rogers, 2003; 2007). He worked systemically, incorporating family members into the treatment. Given what I saw as a clear overlap, it is troublesome to realise that for many of my colleagues, their primary exposure to these practices was limited to the horror stories in the media, as mine had been before my experience in Ghana.

Over a decade ago, the death of Victoria Climbié was given huge media coverage; it was reported that she suffered appalling injuries at the hands of her aunt and boyfriend who believed she was possessed by the devil, sparking huge public anger. Victoria died in 2000 in what was described as one of Britain's worst child abuse cases (*The Victoria Climbié Inquiry Report,* 2003). Other cases made the news: more recently, the death of Kristy Bamu, a fifteen-year-old boy who was tortured to death, apparently because his family suspected he was a witch. Appendix 16.2 offers an insight into media coverage on this subject; searches for 'magic' 'witchcraft' and 'traditional healing' were made on several major news websites (*Sky News, BBC News, ITV News, The Daily Mail/Mail online, The Sun, The Times, The Observer, The Guardian).* This selection of media coverage is limited to a superficial search but hopes to indicate the discourse surrounding traditional or magical practices within the UK.

B.7.3. Research objectives

This research aimed to prioritise learning about the interface between Ghanaian culture and mainstream mental health services. More specifically, the research aimed to explore how Ghanaian mental health professionals explained their work with African clients. The research aimed to explore the phenomenon of working psychologically in a mainstream service with a client population whose health beliefs may differ starkly, as well as clarifying the Ghanaian mental health professionals' understanding of the different types of 'traditional and alternative African healers' before exploring the participants' experience of working with Ghanaian clients. The research aimed to *explore* an under researched area as a preliminary investigation that could

generate more in-depth future research. A broad account of the data was desired to create trans-theoretical themes that could generate alternative ways of thinking about how psychology can address the challenges posed by a multicultural Britain. In order to meet these research objectives, I chose a qualitative design, using thematic analysis. The next sections explain my methodological design choices.

B.7.4. Rationale for a qualitative design

Quantitative methods are less conducive to conducting an in-depth exploration of an area about which relatively little is known: they do not lend themselves as readily to explorations into a phenomenon (Henwood & Pidgeon, 1992), which was the purpose of the present study. The advantages of conducting qualitative research include its ability to attend to the complexity of the phenomenon being researched; its ability to facilitate the active engagement of participants; and its primary aim of advancing understanding. This is a relatively under researched phenomenon in the UK, and there is little literature available from international sources. The research question was a broad one and, thus, a qualitative approach utilising semi-structured interviews was deemed the most appropriate fit with the exploratory nature of the research aims (McLeod, 1996; Strauss & Corbin, 1998; Pidgeon & Henwood, 1996).

Choices about research methodology may be informed both by technical and philosophical considerations (Bryman, 1988): often resolved more by pragmatic considerations than by the researcher's ideological or philosophical allegiance (Hammersley, 1996). It was important to prioritise the participants' experience. Similarly, the design reflects time constraints and financial considerations associated with the data collection. Whilst quantitative research could have told me more about the frequency of clients whose health beliefs related to traditional African ideas, I wanted to know about *how* Ghanaian colleagues explained their work with these clients. Qualitative research has been identified as being particularly useful when exploring topics that are characterised by complexity, ambiguity or a lack of prior theory or research (Richardson, 1996; McLeod, 1996), or as a preliminary groundwork for more deductive research (Oppenheim, 1992).

B.7.5. Theoretical framework/ epistemology

My personal position in terms of epistemological stance favours one of constructionism and social constructionism. I am fascinated by the constructs that shape our knowledge and our beliefs and this has shaped my clinical practice. This curiosity of cultural influences has led me

to enjoy learning about different worldviews. I have had rich experiences immersed in other cultures and find local traditions, stories and beliefs fascinating. Our clinical training teaches us to explore our clients' constructs and individual experience, an approach that would be very difficult to put on hold. However, whilst designing this project, there were other factors to consider when considering my relationship to the data.

Thematic analysis is able to incorporate key approaches from conflicting epistemological positions. Guest, MacQueen and Namey (2012, p. 15) suggest thematic analysis 'comprises a bit of everything - grounded theory, positivism, interpretivism and phenomenology - synthesised into one methodological framework'. Guest et al. describe this philosophical integration as a selection of the most 'useful techniques from each theoretical and methodological camp'. Thematic analysis has been described as a 'contextualist' method, sitting between the two poles of essentialism and constructionism (Braun & Clarke, 2006), and is characterised by theories such as critical realism (e.g. Willig, 1999).

The fact that thematic analysis is not closely aligned to one epistemological position was appealing. During this project, there are shifts in terms of how I treat the data. In contrast to my personal position, this research initially adopts a more positivist approach, a position that holds that the goal of knowledge is simply to describe the phenomena that we experience. I present the data at face value, avoiding engaging in epistemological issues about the status of the data (whether or not they actually believe what they are saying, or what their choice of words reveals of their attitudes, etc.). However, as a Counselling Psychologist, I transpose my personal epistemological approach from the other end of the philosophical spectrum; indeed, counselling skills of clarification, elaboration and critical evaluation helped in the process of data collection and analysis. Whilst it felt important to present the data at face value, there are times where I hypothesise about broader meanings, or offer my interpretation of what is being described by the participants, or attempt to contextualise the data that reflects a position of post-positivist critical realism. I recognise that all observation is fallible and has error and that all theory is subject to certain biases. I also recognise the limitations of this design, but felt making a clear distinction between what the participants *said* and what *I felt* about what they said would allow the reader to interact with the data in a more useful way.

I propose that a preliminary description of how Ghanaian mental health professionals describe their clinical practice is useful as a foundation for further research, and is a fresh perspective that could complement other research. The post-positivist believes that researchers are inherently biased by their cultural experiences and worldview. I am aware of the context specificity of the data and potential sources of bias; however, despite these factors, I believe the research objectives were best met by a broad surface level account of the Ghanaian mental health professionals' expertise. Within this approach, I hypothesise about broader implications

of the data and meanings within the discussion, maintaining a simplistic view of the relationship between language and meaning in the results chapters.

The research recognises the limitations of a methodological design that endeavors to present a surface-level description of the data, and justifies the perceived superficial nature of analysis by making explicit the factors that influenced my decisions. The epistemological position of the research design reflects several practical considerations. As a foreigner, the research's etic position resulted in a reluctance to embark on research that would be better done by a Ghanaian national (e.g. discursive analysis). For the purpose of this study, a simplistic view of language is taken; language is considered a tool that enables us to articulate meaning and experience (Widdicombe & Wooffitt, 1995; Potter & Wetherell, 1987; Wilkinson, 2000). There are cultural differences in how language is used, despite the fact that Ghana's official language is English. However, evaluating the interview process involved some critical evaluation of linguistic tools and what they might reveal.

Post-positivist critical realism enables my personal preference for constructivist approaches to transpose a more simplistic view of the data. I believe that we each construct our view of the world based on our perceptions of it, meaning that all knowledge has context specificity. Whilst purist positivists suggest that individual research must achieve objectivity, post-positivists recognise that we are all biased and view the world through our own lens. Braun and Clarke (2006) suggest thematic analysis can be a method that works both to reflect reality and to unpick or unravel the surface of 'reality'. I have presented the data at surface level, organising and describing the data without imposing my own ideas or interpretation of the data, and then contextualised the data, making very clear what ideas are my own versus what ideas were expressed by the participants. Essentially, this research aimed to gather context-specific knowledge, which offers a unique perspective through which other research can be considered. The design reflects the underlying premise of my research, that Ghanaian mental health professionals were specialists in this area, and I wanted to avoid a methodological design that viewed the researcher as an expert (as is often the case in ethnographic methodology or more in-depth analytical tools).

B.7.6. Selection of a qualitative methodology

Thematic analysis was selected as the most appropriate methodology, although several other methods were considered. It is important to make explicit the reasons I had for choosing thematic analysis over other tools. Therefore, before commencing a detailed account of the investigations themselves, I will present an evaluation of possible qualitative methodological designs.

B.7.6.1. Ethnography

Ethnography is the practice of anthropological research based on direct observation of a phenomenon, with the researcher evaluating and reporting on a people's way of life or a specific process. It was a methodology that was considered at length as it lends itself to researchers investigating a phenomenon in a culture other than their own (O'Reilly, 2009). It involves primary data in the form of participant observation, participant participation, interviews, discussions and photographs, as well as drawing on secondary data sources. Ethnography captures behaviour and is able to document unarticulated ideas. An advantage of this approach is that it is able to depict discrepancies between what people *say* they do and what they actually do. Whilst an ethnographic approach would have enabled me to include my own observations and experience of Ghana more freely, there were several reasons why ethnography was not chosen for this research.

Ethnographic research aims to enable observations about a phenomenon, viewing the researcher as an expert following immersion in a foreign culture. I felt this approach was problematic for several reasons. Despite my familiarity with Ghanaian culture, I felt I would not be able to immerse myself entirely without there being serious threats to the validity of how I interpreted what I observed. Margaret Mead is a famous example of an ethnographic research (e.g. *Coming of Age in Samoa*, 1928) that has been criticised for grossly misunderstanding and misrepresenting the Polynesian cultures she studied (Holmes, 1987; Freeman, 1986). On a practical level, I could not invest sufficient time in the process of immersion, and as Mead's study has demonstrated, I believe immersion in a culture cannot offer any guarantee of validity as, essentially, the researcher becomes the authority rather than the subjects themselves.

There were ethical considerations, too, in opting out of an ethnographic design as ethnography has been compared to spying (Madden, 2010), and for its potential to objectify and exploit (Hammersley, 1992). Essentially, an ethnographic design in this research would have involved me asking institutions (probably the three psychiatric hospitals) for permission to observe clinical practice for me to analyse. I did not want to do this for several reasons. I hypothesised that the observer effect of a White British woman would have introduced serious limitations. I

have blond hair and blue eyes and am therefore *easily* identifiable as a westerner, something I knew very well from many trips to Ghana. I wanted to avoid the observer effect of my participants feeling judged. This is particularly pertinent, given that the facilities are delivering Western treatment approaches; I feared I would be considered an expert or seen as powerful. On a practical level, I also hypothesised that it was unlikely that the hospitals would grant consent for ethnographic research, and if they did, I do not believe I would have been able to observe Ghanaian colleagues behaving naturally. The participant experience was of primary importance and it was hypothesised that being asked to be observed for a research project could feel more intrusive and potentially reduce the number of people willing to participate in the research.

The research aimed to raise awareness of the work being done in Ghana and to forge relationships amongst an increasingly global network of psychologists. It felt very important to design a project in which the participants would feel comfortable participating. Negative participant experience could reflect badly on Counselling Psychology as a discipline and sever future alliances.

Also, observing and commenting on what I thought was happening would have offered a different perspective to that described by the Ghanaian mental health professionals in their own words. Participant observations alone were not sufficient to meet the research objectives. Essentially, I do not believe that the data was there to be 'discovered'; by recording my own observations, I would have constructed my own interpretation of what was happening. An observer cannot be neutral or objective or operate outside their own value system and assumptions (Ashcroft, Griffiths & Tiffin, 1998).

Photographs are sometimes used in ethnographic research. There is a cultural sensitivity to being photographed; indeed, some people in Ghana consider photographs to steal a moment of your soul. Taking photographs, especially given my easily identifiable 'foreigner' status, could have caused offence. By opting out of an ethnographic design, secondary data sources, including photos available via secondary sources, could still be included in the data analysis.

B.7.6.2. Discourse analysis

Discourse analysis is an approach to qualitative data that is concerned with deconstructing the content, rhetorical organisation and socially active functions of language (Potter & Wetherell, 1987). This approach was redundant in the present research because of its prime focus on the discursive devices that people use to manage their interests in social interaction and construct their social reality. Such an approach was not considered compatible to the broader level of analysis that would be required. Also, as previously mentioned, a foreigner is not well suited to

such a design as they are not equipped to deconstruct the functions of language. Whilst English is the official language in Ghana, for many, it is a second language and semantics are used slightly differently. For a more in-depth focus of discursive devices, an emic (insider) position is crucial.

B.7.6.3. Content analysis

There are several areas of overlap between content analysis and thematic analysis; the boundaries between the two are often not clearly defined (Viasmoradi, Turunen & Bondas, 2013). Content analysis is an approach to qualitative data that endeavours to describe manifest and latent levels of meaning present in textual data and to reduce these to discrete, mutually exclusive and quantifiable sets of categories that will comprehensively account for what is of interest to the researcher (Weber, 1990). In spite of many similarities between the approaches, including cutting across data and searching for patterns and themes, their main difference lies in the opportunity for quantification of data (Viasmoradi et al., 2013). Content analysis was rejected because its approach to data classification was regarded as being more rigid and reductionist. It was felt that a more flexible, fluid and organic approach to the generation of categories would be more appropriate to the exploratory nature of the study and the complex character of the topic, as I did not have preconceived ideas about what I would find out.

B.7.6.4. Grounded theory

Grounded theory has many similarities to thematic analysis: both approaches seek to support claims with data (Guest, MacQueen & Namey, 2012), and for this reason, it could have been an appropriate methodology. An inductive approach to thematic analysis (as I have opted for) means the themes identified are strongly linked to the data themselves (Patton, 1990), and as such, this form of thematic analysis bears some similarity to grounded theory. Bernand and Ryan (1998) describe a recipe for grounded theory which is remarkably similar to the way thematic analysis can be applied: collecting data, familiarising yourself with the data, identifying possible themes, comparing and contrasting themes, to eventually develop a theoretical model. As with this approach, it was imperative that my interpretations were grounded in the data.

There are different schools of thought within grounded theory approaches. Strauss and Corbin (1990) added to Glaser and Strauss' (1967) original grounded theory literature. Willig (2013) described the 'essential openness' that characterises the approach that is very similar to the way this project employs thematic analysis. There are several examples of research that uses grounded theory to serve a similar function to my own methodological design (e.g. Cohen,

1995, cited in Willig, 2013). Thematic analysis does not preclude theoretical development (Guest et al., 2012); however, for the purpose of my research, it was selected over grounded theory, as my primary objectives were to explore a particular context in relation to my research questions. In retrospect, I believe I could have selected grounded theory due to the overlap between the two approaches. What was appealing about thematic analysis was that I could ground my results in the data, an approach clearly shared by grounded theory. However, I felt a preliminary exploration would lay the foundation for future work that may be more explicitly driven by the generation of a new theory.

B.7.6.5. Interpretative phenomological analysis

Interpretative phenomenological analysis (IPA) is an approach to qualitative data that seeks to gain the 'insider's perspective' regarding the phenomenon of interest (Smith & Osborn, 2003). It places an emphasis on the researcher's own interpretation of the data, rather than trying to separate this out from 'the analysis', and ultimately attempts to produce a coherent narrative account of participants' subjective inner experience of a particular topic or issue. IPA is bound by theory and is aligned to a phenomological epistemology (Smith, Jarman & Osborn, 1999; Smith & Osborn, 2003), which places a primary focus on participant experience (Holloway & Todres, 2003). IPA was rejected in favour of thematic analysis because I did not want to make interpretations beyond the data by imposing my subjective understanding. IPA is less flexible in terms of epistemology, as its focus is on subjective meaning, whereas thematic analysis facilitates multiple epistemological positions. Also, my research objectives did not place emphasis on inner experience. I wanted to elicit a more straightforward account of participants' views and opinions regarding the phenomena of working with clients that attribute their difficulties to traditional African explanations.

B.7.7. Overview of thematic analysis

Within this section, I provide an overview of thematic analysis. I also recognise the criticisms of the approach, and respond to these criticisms in a way that reassures the reader why thematic analysis was selected as the most appropriate tool. This section provides an introduction to the approach and this research design, which is further evaluated and reflected upon with regard to the process in the 'data analysis' and 'evaluation of methodology' sections.

Thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data (Braun & Clarke, 2006). It can be used to produce a lavishly detailed account of a data corpus, which suited the exploratory nature of my research objectives. One of the major advantages of employing thematic analysis for this research was that it was able to generate unanticipated insights in research areas where relatively little is known and is thus a useful tool for producing qualitative analyses suited to informing policy development (Braun & Clarke, 2006).

There are different forms thematic analysis can take: it can be used to summarise key features of a large body of data, and/or offer a thick description of the data set. Thematic analysis can be used as a means of reducing or summarising the data ('factual coding'; usually realist and content analysis) or to index the data ('referential coding'; usually interpretive and constructivist analysis). Broadly speaking, themes serve to identify, label and organise the data. There are two approaches to identifying themes within thematic analysis: inductive or 'bottom up' approaches generate themes that are closely aligned to the data set (Frith & Gleeson, 2004; Patton, 1990), whereas a theoretical thematic analysis would tend to be more influenced by existing theory and is therefore more explicitly analyst-driven. Themes come both from the data, an inductive approach, and from the investigator's prior theoretical understanding of the phenomenon under study, an a priori approach) (Bulmer, 1979; Strauss, 1987; Maxwell, 1996). I opted for inductive analysis, which is a process of coding the data without trying to fit it into a pre-existing coding frame, or the researcher's analytic preconceptions. This decision was impacted by practical considerations (the research being conducted by a foreign researcher) and philosophical considerations (a desire to avoid adopting a position of expert).

A significant advantage of thematic analysis is its flexibility; it is a method that can be viewed as independent of theory and epistemology and can be used amongst a range of theoretical and epistemological approaches (Braun & Clarke, 2006). Thematic analysis can be conducted within both positivist and constructionist paradigms, which was appealing in the initial design considerations. An advantage of thematic analysis was that it allowed me to present the data at surface level (viewing language in simplistic terms and approaching the data from a positivist/post-positivist approach, before moving on to interpret and contextualise the data, adopting a critical realist epistemology). I wanted to be explicit about what the participants actually said, versus what I *thought* about what the participants said in terms of relevant findings to psychology in the UK.

Much research that employs thematic analysis claims that it is a method that gives voice to data. However, I agree with researchers that warn it is naive to imply that themes simply 'emerge' (Ely et al., 1997; Braun & Clarke, 2006). By identifying and selecting research themes of interest, a researcher using thematic analysis cannot claim a passive position (Taylor & Ussher,

2001). As a researcher, I had an active role in describing the data that involved selection, editing and interpretation (Fine, 2002; Braun &Clarke, 2006). It is important to recognise the decisions I made in the treatment of the data as active choices: what questions to ask in interviews, what to identify/chunk, what to omit, what to focus on... etc. This process of active selection was shaped by the research objectives.

Thematic analysis often goes further than descriptive analysis and is able to offer hypotheses to explain various aspects of a research topic (Boyatzis, 1998). For this research project, thematic analysis helped present the reader with a wealth of ideas offered by the participants, in the results section, moving on to interpretation and discussion of these results in conjunction to other research in the discussion section. I propose that thematic analysis was the most appropriate tool to shed light on a topic that is of huge personal interest to me of which very little is known, whilst generating useful ideas for future research and a fresh perspective that contributes to our understanding of the challenges facing a Eurocentric discipline in an increasingly global world.

B.7.8. Ethical approval

City University's committee granted ethical approval. Permission was also granted by senior clinicians in Ghana to conduct research at the teaching hospital and within the psychiatric hospitals. The British Psychological Society Ethical Standards were adhered to (BPS website, Code of Human Research Ethics), and as the research design involved human participants, it was necessary to consider any potential risks to the researcher and participants. The BPS emphasise the need to respect the autonomy and dignity of persons and our social responsibility and state that scientific value should be considered with regard to minimising potential harm.

The research design prioritised positive participant experience. No potential harm was considered a risk for participants. All participants were urged to contact me if they wished to discuss any aspect of the study, or withdraw their participation. The participants also had the research supervisor's contact details. Participants gave their informed consent and their right to privacy was respected. Details were anonymised to protect participant confidentiality. The participants were contacted after participating in the research to feedback on the preliminary analysis, and were given a second opportunity to withdraw their data.

B.7.9. The inclusion criteria, the research population and sampling

Theoretical sampling is an approach to sampling that is explicitly driven by including participants that are considered likely to offer conceptually rich data with the aim of including diverse perspectives. Theoretical sampling violates the ideal of hypothesis-testing in that the direction of new data collection is determined not by a prior hypothesis, but by ongoing interpretation of data and emerging conceptual categories (Suddaby, 2006). The inclusion criteria aimed to encompass professionals that worked within the provision of mental health care who could offer expertise. Ghanaians were eligible to participate in the study if they worked in a mental health service, and described what they do as offering 'psychological help'. Whilst psychologists were sought out, due to the fact I felt their perspective would be of primary relevance, I also wanted to get some input from other mental health professionals.

The parent population of mental health professionals is described in an earlier section (Mental health services in Ghana). Services are under resourced, and so there were also practical considerations in avoiding an inclusion criterion of only psychologists. Despite there being only seven psychologists employed by the government (Ofori-Atta, Read & Lund, 2005), I identified approximately 40 psychologists/therapists working in Ghana, many of whom were funded by international charities (see Appendix 16.3 for full list). Every psychologist and therapist identified was written to, explaining the nature of the study and requesting participation for those that met the inclusion criteria. Of the 38 advertisements that were sent out, nine responded. Three of these responses ended up participating in the study.

From the initial interviews with psychologists, two CPNs, a psychiatrist and a charity worker were suggested as useful sources of data, and subsequent interviews were arranged with these individuals, based on the recommendations of the psychologists I had interviewed. As differences in clinical training was a theme that emerged from the first few interviews, a focus group of trainee clinical psychologists was also arranged.

Ideally, I would have used random sampling to ensure the process of selecting participants did not skew my results. However, due to the limited parent population, time restraints and my desire to capture the expertise of relevant professionals, theoretical sampling seemed an appealing approach.

B.7.10. Participants

Seven interviews and one focus group were conducted. A psychiatrist, two senior community psychiatrist nurses, a regional director of an NGO that specialised in mental health care and four qualified clinical psychologists were interviewed individually; the nurses were interviewed together after the first participant invited the second to join half way through! Twelve trainee clinical psychologists participated in the research as a focus group; these individuals had not been interviewed individually.

In total, twenty participants took part in this study. The participants ranged in terms of age (25-59) and clinical experience (trainee - national policy director). The participants ranged in terms of experience, qualifications and age (ranging from twenty-five to fifty-four). All participants were Ghanaian nationals and lived and worked in Ghana. Both genders were represented, although more females took part in the study (13:6). Two participants had trained overseas (America and Britain).

B.7.11. Apparatus

38 advertisements (Appendix 16.6) were mailed from England to different organisations, psychiatric hospitals and counselling centres. These advertisements were accompanied by covering letters (Appendix 16.5). A further 30 advertisements were handed out in person. All participants had seen the advertisement before participating in the study.

Each participant gave informed consent to participate in the study (Appendix 16.7). A semi-structured interview was developed based on the research objectives.

B.7.12. Interview procedure

The interviews took place over a four-month period. Interviews took place at participants' places of work, usually in their clinic room. It was anticipated that participants would feel more relaxed if interviewed in a familiar environment. Each interview was recorded on two audio recording devices. Meetings lasted between 50 and 90 minutes, with the average interview lasting 70 minutes.

During the interview, I employed basic counselling skills, such as attentive listening, paraphrasing and summarising (Jacobs, 1999). This was particularly important, given linguistic differences. I used reflective and clarifying counselling skills during the interviews, which

served as a way to check/verify information. McDonald (2000) highlights that this process helps the interviewer to ascertain the precision of their understanding of the concepts and themes as they emerge.

Each interviewee was asked three set questions:

1. How do you define the term 'traditional healer'?
2. Have you ever worked with a client that attributed their difficulties to traditional explanations?
3. If so, how did you work with this client?

The rest of the time was free for more reactive questions necessary to clarify and expand on the information given. Dearnley (2005) asserts that the open nature of questions encourages depth and vitality in the participant's discourse and allows new concepts to emerge. The researcher's open questions 'function as triggers that encourage the participant to talk' (Willig, 2001, p. 22). During each interview, the focus was on *how* the individual works with this client group. The interview process evolved as the interviews took place; the interviews became an opportunity to crosscheck or elaborate ideas or themes that presented at earlier interviews.

Interview conditions were not always ideal; occasional interruptions can be heard on the tapes and in one interview, a participant invites a colleague to join half way through the interview. At the end of each interview, participants were asked to reflect on the experience of being interviewed. Some commented that it was an interesting area; one participant commented that there had been some hard questions, and all participants reported finding the experience comfortable. More informal de-brief enabled questions about my research objectives, my length of stay and my experience of Ghana. I spent a few moments reflecting on the process of each interview, jotting down notes about the process. I had lunch with many of the interviewees afterwards. Participants gave their contact details and consented to being contacted to validate the results at a later stage. No participant withdrew his or her data. However, the interview process has been evaluated in a later section, and was not without its challenges.

B.7.13. Data analysis

In choosing thematic analysis, I had to consider a number of factors. One decision to make regarded at what point I should engage in a literature review. Some theorists argue that an early reading can narrow the analytic field and undermine the advantages of thematic analysis, whilst others argue it can enhance the process (Tuckett, 2005). I made a decision to write the introduction to the thesis after the data collection, to reduce my ability to bias coding with preconceived ideas. My inexperience of the topic was reflected in the questions I asked, and is a

position that mirrors the phenomena in the UK. However, a personal interest in the research area, frequent trips to Ghana and designing the research proposal involved me gaining some prior knowledge of African health beliefs. Also, knowledge and observations from the research procedure were incorporated into later questions.

Another decision I had to make related to what counted as a theme. A theme captures something important in the data and the research objectives shape the process of theme selection. The type of analysis desired influenced theme selection. I wanted to provide a rich thematic description of the entire data set so that the reader gets a sense of the predominant or important themes. Therefore, I wanted to produce themes that reflected *everything* I found out. However, the size of a theme, and the selection criteria of a theme, were still active decisions (Braun & Clarke, 2006). Another decision related to the 'level' at which themes were to be identified: at a semantic or explicit level, or at a latent or interpretative level (Boyatzis, 1998; Braun & Clarke, 2006). Initially, coding adopted a semantic approach, focusing on the surface level of the data. As Braun and Clarke suggest, this was then followed by a progression from description to interpretation and attempts to contextualise the data and explore its implications.

I avoided rigid rules in terms of what I would count as a theme. I initially coded anything that seemed to represent an idea that was relevant to my research objectives (the majority of the data), and then moved into a phase of organising the chunks of data into themes and subthemes. Ideas that were expressed by many of the participants were included, as were key ideas that were articulated by one participant or just a few participants.

Another consideration I had to make related to *how* I would conduct thematic analysis. An absence of clear guidelines around thematic analysis means that there is an 'anything goes' critique of the approach (Antaki et al., 2002). Many theorists identify a lack of agreement about what thematic analysis entails (Attride-Stirling, 2001; Boyatzis, 1998; Tuckett, 2005). Attride-Stirling (2001) warns that often insufficient detail is given to reporting the process and detail of analysis. This research aimed to be transparent about how the data was collected and what was done with the data to avoid the pitfall of assuming themes 'emerge' from the data, which underplays the active role of the researcher. Figure B4 outlines this research project's methodological process, as informed by Braun and Clarke's (2006) stage guidelines.

Phase one of analysis involved familiarising myself with the data; this process began whilst conducting the first research interviews. Experiences at the hospitals and unplanned encounters also informed these early ideas. Whilst I was not conducting ethnographic research, the reactive nature of the interviews enabled me to ask about things I had observed or heard about. Each data item (each individual piece of data collected) was transcribed in its entirety.

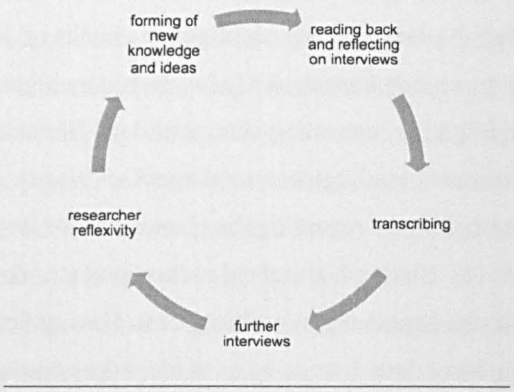
Ethical approval/ research proposal/ initial literature review	Research proposal involved reading around the subject	Phase 1
First interviews First transcription/ active reflection Visit hospitals/healers etc. More interviews More transcription/ active reflection Focus group Transcribe data corpus		
Code data corpus		Phase 2
Code a second time. Define themes.		3-5
Validate preliminary findings with participants. Analyse and interpret themes-.	Involves going beyond describing data (discussion chapter)	6

Figure B4. Stages involved in research using a thematic analysis approach (Braun & Clarke, 2006)

Transcription of verbal data is a good way of familiarising yourself with the data (Riessman, 1993; Bird, 2005); whilst transcribing, I often made notes about process, themes or content, which created a valuable resource for subsequent analysis. Verbatim transcription needed to be true to the original data as grammar can change meanings (Poland, 2002). Interruptions and noises were noted; coughs, etc. were included in the transcripts. The accuracy was examined by listening again to tapes. The next task in this first phase required reading the data in an active way, becoming immersed in the data. Reading, re-reading and jotting down ideas and themes

was a time-consuming process. Active reading was informed by the research objectives; the researcher selectively attends to themes pertinent to the research design (Braun & Clarke, 2006). Whilst all material was transcribed and attended to, it would be naive to think that my researcher objectives did not shape this process.

Phase two involved coding the data, initially highlighting chunks of data in which an idea was articulated or something interesting happened. Coding began by highlighting transcripts with coloured marker pens highlighting interesting chunks of data. Braun and Clarke cite Boyatzis in defining a 'chunk' as 'the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon' (Boyatzis, 1998, p. 63; cited in Braun & Clarke, 2006, p. 18). Having highlighted each segment of data, I developed codes, keywords reflecting what was happening in each segment. Having familiarised myself with the data, and highlighted chunks of data, I wrote a list of ideas (keywords that I felt summarised pertinent themes).

Coding was done manually and was an active stage of the analysis. Initially, I created codes for as many different potential themes/patterns as possible. This process felt difficult to contain as I coded extracts of data inclusively and individual extracts of data were coded for as many different themes as they fit. Codes incorporated similarities and differences across the data set. I developed a coding manual as I coded each text segment, noting labels, definitions and good examples of each category (Appendix 16.4). Having coded all the data for the first time, I coded fresh transcripts a second time to enable me to compare both processes. I refined the codes at this stage and repeated the process.

Phase three of thematic analysis involved searching for themes, with all the data having been initially coded and collated. My focus moved to broader themes, not codes. A 'theme' captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set (Braun & Clarke, 2006). The codes were organised and grouped into themes and subthemes. Repetition was one of the easiest ways to identify themes (Bogdan & Taylor, 1975; Guba, 1978), as the data was considered valid and pertinent if the majority of participants articulated the idea. However, the process was more complex than simply looking at the prevalence of ideas. My judgment was necessary when deciding how to organise the data into themes.

The fourth phase of analysis involved reviewing themes. Themes were refined: some were renamed, some themes were merged, and some were considered less salient to the research objective. Braun and Clarke (2006) suggest this phase has two levels: the first involved reading the clusters for each theme and refining each theme; and the second involved reviewing all the data collected for the project (data corpus) in conjunction to the themes. I underestimated how

lengthy a process this would be, and I struggled to manage the wealth of transcriptions, lists of codes and notes about themes. I decided that I needed a physical way of managing this process. I eventually devised a system whereby I cut each 'chunk' out of their original transcription, and stuck the data extract on a flash card (colour coded so I could identify its source). On the back of each flashcard I wrote a key word or words that summarised the chunk and the overarching theme/themes. I had hundreds of cards, but this process enabled me to group chunks together, and refine and define themes, physically moving chunks of data around to organise the data logically. This phase involved playing with the data to start to map it out in a way that made sense and involved much re-jigging and reflection. Initial themes attempted to capture all of the data and the relationship between codes, themes and levels. Some codes did not fit a theme and were filed under 'miscellaneous'; in this process, 7 chunks of data were discarded as a map of main themes and subthemes was created. With the wealth of data and the broad research questions, this felt like a balancing act between representing the entire data, without losing too much detail, depth or complexity, which is necessarily lost, to some degree, by focusing on all of the pertinent themes (Braun & Clarke, 2006).

Phase five involved defining and naming themes, identifying the essence of what each theme is about and refining the data. A detailed analysis was written of each theme to help pinpoint the story that theme tells, and to identify how it fits into the overall research story. At this stage, subthemes (themes within a theme) were identified.

The final stage in thematic analysis, phase six, consists of producing the report and the full analysis of themes. Foster and Parker (1995) suggest one way to acknowledge the creative and active role of the analyst is to use the first person when writing. The write up included data extracts to portray the content of the themes and to argue that the analysis is convincing and valid. This phase involves moving beyond a description of the data corpus. The aim of this stage is to interpret the data in a way that is meaningful to the discipline of Counselling Psychology. The process of analysis involved a progression from description to interpretation, contextualisation and reflecting on the wider implications of the data within the discussion chapter.

B.7.14. Main themes found in the data

The data was organised into four categories, each consisting of sub-themes (see figure B5). The first theme involved data that related to the parallel belief systems that the participants described. Understanding an ability to occupy multiple positions in terms of worldviews and

beliefs was fundamental to understanding the data. Parallel belief systems were described in terms of the participants' own beliefs, the healers' approach and the Ghanaian patients.

The second theme documents data relating to the relationship between disciplines and approaches, including sources of tension, areas of commonality and collaboration and data that documents how Ghanaian mental health professionals negotiate boundaries between approaches. The third theme includes data that describes the Ghanaian patients' help-seeking behaviour, and how the psychological and psychiatric services have tried to respond to barriers in an attempt to enhance pathways to their services. The final theme relates to the specifics of working psychologically in the Ghanaian context. This theme includes subthemes relating to client expectations, challenges associated with formulating client presentations, specialist knowledge of Ghanaian mental health professionals, incorporating spirituality and action-orientated strategies that were described to increase the effectiveness of psychological therapy.

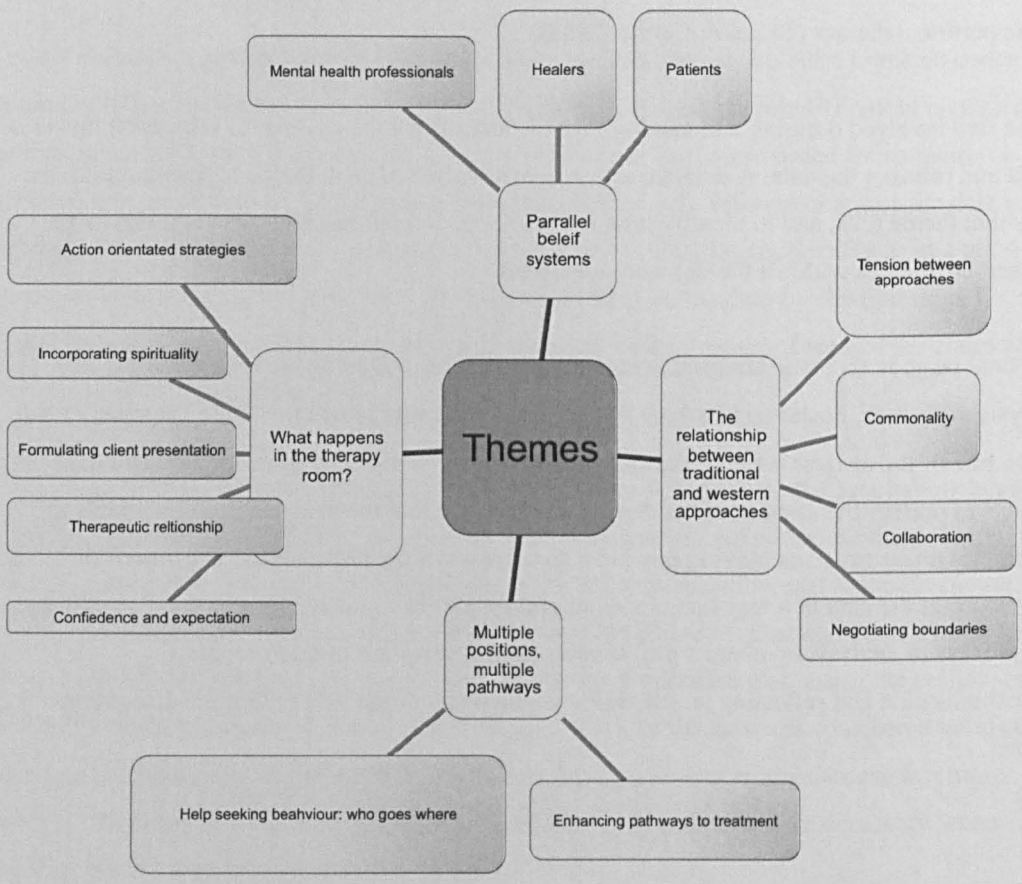


Figure B5: Map of themes and subthemes identified in data

B.7.15. Reliability

In research, the term reliability means 'repeatability' or 'consistency'. A measure is considered reliable if it would give us the same result over and over again (Trochim & Donnelly, 2007). A criticism of thematic analysis is that, like many qualitative tools, it is difficult to ascertain how valid the findings are. The main threats to the reliability and validity of thematic analysis are projection, biased sampling and a researcher's mood and style (Boyatzis, 1998). In this research, some linguistic variability was apparent between the two cultures, and my focus was on understanding what the participant meant by carefully reformulating some questions or clarifying some content. It was important to ensure that an appropriate system of codes was developed, and to minimise the potential for me to project my own ideas into the analysis. Consultation with a Ghanaian national, where necessary, helped ensure I understood the meaning of aspects of the interview data before I attempted to develop a coding system, and by rigorously coding and re-coding, I believe this threat was minimised.

Due to the nature of a doctoral research project, the data was coded and themes identified in the data by just one person. This process allowed for consistency in the method but failed to provide multiple perspectives from a variety of people with differing expertise and may pose a threat to the reliability of the results. However, measures to reduce this threat were undertaken, including careful interview skills, consulting with a Ghanaian when I felt unsure during the post-interview reflections and asking participants to feedback on my preliminary findings. Their feedback consistently supported my analysis, and enabled some degree of collaboration in this process.

Theoretical sampling could be another potential source of bias, and the advantages and disadvantages of such an approach were discussed in an earlier section. Whilst I acknowledge that the lack of random sampling may pose a threat to the reliability of the study, I believe the participants all expressed similar enough ideas, despite differences in their approach, for me to believe that I was gathering data that would be consistent if the study was repeated.

B.7.16. Validity

The term 'validity' refers to the best available approximation to the truth of a given proposition, inference or conclusion (Trochim & Donnelly, 2007). Whilst qualitative research seems to come under particular scrutiny, Guest, MacQueen and Namey (2012) argue that this is unfair as no research is without bias and this is not a challenge that is exclusive to qualitative research. A potential threat to the validity of qualitative data is that the analyst is able to pick and choose aspects of the data that support their ideas. By including the original transcriptions in the

appendix (Appendices16.10 - 16.17), and by presenting an accurate reflection of the entire data (including inconsistencies or contractions), I hope the reader is reassured that my results are valid. Thematic analysis is grounded in the data, and if analysis is done rigorously, the validity of the findings is more threatened by the process of data collection than during the write up. Credible thematic analysis should offer a report that has face validity (Guest et al., 2012), and it is the readers, and in this case, the participants, who decide if the study offers a convincing presentation of the raw data. For this reason, transparency of how I collected the data, what I did with the data and how I interpreted the data is key. All the information that can inform the reader's judgment of research validity is included in the appendix for this reason.

During the data collection phase, the questions were phrased carefully so as not to force participants to a particular conclusion. Guest el al. (2012) correctly point out that all research questions will introduce some degree of bias, but this threat was monitored. Clinical skills of open-ended questions helped minimise directing responses. Basic counselling skills provided useful ways of ensuring my interpretations of what was being said was accurate via immediate feedback and clarification during the interviews. This was also done in a more focused and concerted way by asking for feedback from the participants. 'Respondent validation' refers to the process of asking participants to feedback on the developing analysis to confirm or enhance emerging themes. The basic principle is that 'if participants agree with the researcher's account, then greater confidence can be attached to it' (Pidgeon, 1996). I designed a project that would ask the participants to be involved in my analysis, asking for feedback of my preliminary analysis. This process is discussed in a later section.

Another advantage to the methodological design was that by including some participants of multidisciplinary approaches, I was able to collect multiple perspectives. The focus group of clinical psychologist trainees enabled me to take a less active role in the data collection. The focus group generated some rich discussion and debate. Also, by combining methods and sources (albeit to a limited degree) I was able to introduce some element of triangulation, although without time or financial restrictions I would have incorporated more methodological approaches and data sources to offer increased validity to my findings.

B.7.17. Generalisability

This research aimed to approach the challenges facing psychology in the UK from the perspective of Ghanaian experts, and as such, the generalisability of this research has serious limitations. The research did not aim to offer definite advice or solutions to challenges facing the profession in the UK. The lack of African experts involved in research in this area has been

a significant weakness; this research aimed to approach the problem from a different angle, shining the spotlight on our Ghanaian colleagues who have the advantage of an insider's perspective. The research aimed to offer information that informs further research, not to provide models or theories that were easily generalisable. However, within the research objectives, a point of saturation or similarity was achieved. I believe that if similar research took place, similar findings would be reached, and thus the project is generalisable to the Ghanaian context.

B.7.18. Conclusion

The objective was to provide a surface-level analysis of the data, which could inform a rich interpretation. The data corpus was collected for the purpose of the research project and the questions asked during interviews were geared towards understanding a specific phenomenon. An inductive approach aimed to be led by the content of the data whilst trying to minimise the effects of imposing analysts' hypotheses. This approach was more compatible with the research objectives; to present a summary of the data (results chapter) and interpret the significance of some of the patterns and their broader meanings with regard to the UK by contextualising the findings in terms of other research (discussion chapter).

B.8. Analysis

B.8.1. Introduction

This chapter presents an overview of the data collection, data collected and the emergent themes identified in the process of analysis. My personal reflections introduce the chapter, as the design of the study involved a personal confrontation of ideas that differed from the dominant Eurocentric position. This experience shaped the process of data collection and analysis. The experience of data and collection and analysis is shared and explored in this chapter, before presenting the main themes in detail over the following chapters.

B.8.2. Reflections

Embarking on research in a country that is foreign offered a unique experience in terms of personal and professional development. I was offered the opportunity to reflect on assumptions based on my own cultural background and was aware of shifts in my own attitudes to practices that appeared far removed from my own professional training. On a personal level, this experience was invaluable; however, my outsider status to the participants and to the culture could be considered a fundamental weakness in this project. Whilst my foreignness often made me feel alienated in terms of difference, it can be argued that this difference mirrors the challenges facing psychology in the UK and was the project's greatest strength rather than weakness. My naivety allowed me to ask the perhaps obvious questions. The fact that the participants in this study were mental health professionals enabled a sense of sameness, which I feel was important. If the project had aimed to become immersed in a world of tradition and spirituality, my difference to the sample would have been a much greater obstacle.

As a westerner, I had been shaped by global discourses of power and status of knowledge. My life experiences have taught me that science and empirical research equalled truth. When Ghanaian colleagues spoke of occupying multiple positions I felt frustrated initially. I was projecting my own confusion about how you could balance an allegiance to mainstream psychology with ideas more in keeping with indigenous cultural or traditional roots. Eurocentric thinking is based on Western notions of the self and reflects a hierarchal, individualistic society. An exploration of the wider context and the implications of being identifiable as a member of the developed world was necessary as it impacted the process of this research, e.g. how I approached participants, who I approached and how they responded.

I experienced shifts in my personal position with regard to how I felt about my culture and my allegiance to science. Some aspects of what I saw in Ghana felt crude and inferior. I felt the system I worked in was superior, as was the status of my knowledge. This reaction is understandable in terms of the social constructs I was bringing with me as a foreigner. However, as the social and historical context of my worldview became more apparent, I feel I shifted position. I began to feel uncomfortable with the status of mainstream psychology and the way it was being exported. This shift has had a positive impact on my development as a Counselling Psychologist and has benefited my clinical practice.

B.8.3. Evaluation of the interview process

Whilst reflecting on the interview process, it is important to recognise that the initial semi-structured interview questions were vague and represented an attempt to explore an under researched phenomenon. I did not have a clear agenda and was able to react to what the participants said. I was trying to capture something that happened intuitively with the Ghanaian participants. The questions asked during the data collection reflected my aims of the research, and were shaped by my own cultural identity and naivety regarding the subject. Similarly, complex forces shaped the answers to the questions I asked. My obvious difference to the sample had an impact on the interview process in terms of the preconceptions participants held about me. One participant tried to convince me to marry her son! My White skin meant that to many Ghanaians, I represented wealth and social privilege.

The researcher/participant relationship is considered to be at the heart of qualitative research (Marshall & Rossman, 2006). There are moments within the interviews that demonstrates the researcher's shifts between emic and etic perspectives: in some moments an 'us' is used to describes us both as psychologists/mental health professionals (the identity that I had in common with many of the participants); however, in other moments 'us' clearly describes 'being African' and I am clearly an outsider. There are examples of this shift in the data: aspects of Ghanaian culture are often referred to as 'ours', e.g. *'it is our belief in Africa...' participant 5.* There was a particularly stark example of this during an interview where the participant made specific reference to a shared faith; my hesitation triggered her to speak in a local dialect in which I could only detect the Gha word for 'White man'. The participant laughed before commenting that *Africans* had a strong Christian faith.

The Ghanaian respondents seemed more confident identifying themselves as an 'us' [meaning African] when discussing religion and faith, and 'them' when describing traditional or alternative healing. Perhaps this relates to the culture clash between their allegiance to Western

approaches and their own cultural values. Another possibility is that this shift in language is a result of the White, English psychologist asking them the questions.

The respondents' language reflected the shifts between positions that the interviewees described. The use of 'us' and 'they' seemed to highlight the internal struggle when worldviews clashed. Interestingly, many respondents described a firm allegiance to modern ideas and reported that whilst they did not believe in traditional ideas, they knew that they were true.

> *'Yes, Ghanaians are very eclectic in that way you know... In a sense that they can, erm we can accept different views of illness.' Participant 1*

Another obstacle for the interview process was created by our cultural difference. Many interviewees talked about the fact that patients might be reluctant to talk about their traditional beliefs with doctors. A potential limitation of this research was that the same phenomena might be mirrored in the interviews. I disclosed in some interviews that I had visited Ghana for several years (when asked directly) and even revealed that I stayed in Chokor (an area that is very poor). I wanted to actively challenge preconceptions about what my role was. I stressed that I wanted to learn. I would encourage moments of more personal disclosure with one-word prompts such as 'interesting'. I would smile and try to maintain friendly non-verbal cues to facilitate a safe space. Listening back to tapes, perhaps there are moments where them telling me that '*their patients wouldn't tell them*' is a way of saying to me '*and I would not tell you*'. I feel this limitation is minimised by the fact I was asking them about their professional practice for the most part. Also, the focus group generated a much freer debate, which supports the validity of the individual interviews.

I felt particularly foreign when asked directly about my faith. In my shifts between etic and emic positions, it was during conversations about God or religion that as a European, I felt alienated and firmly positioned in the etic position by the participants, who seemed to view the West as a culture with little place for religion.

> ***'Yeesss! God created us. Where will you have come from?! If Adam hadn't come... or you don't believe that? You don't believe that?' Participant 5 (R1)***

> ***'We are very different from the Western world, we Africans, we Africans are very spiritual, feel, erm I believe this, if you look around you find a whole lot of church buildings around. If you go to England you can hardly find one church.' Participant 4***

Had this been my first trip to Ghana, I think the methodological design would have been crippled by my sense of being an outsider. A respondent who was perhaps commenting on the interview process also echoed this sentiment:

> *'I ... I'm at ... I ... I understand the point you're coming from, but I think that one of the things having interacted with, um, Black Africans who've moved back ... back and forth is their belief that the Caucasians don't understand African issues.' Participant 2*

It is plausible that some of the participants felt frustrated by the naivety of my questions; however, these naive questions reflect the research objectives. Whilst the researcher was foreign, and easily identifiable as such, the familiarity with the country and the culture helped to build a rapport with participants. The methodological design did not aim for me to become immersed in the culture in a way that claimed an inside perspective, but a familiarity of the cultural differences was required to establish a rapport with my participants. I believe that for the most part, this was achieved. There were moments when I felt our differences may have impacted what the interviewees felt comfortable telling me, which will be explored in the next chapter, but for the most part, I feel that the research objectives were met by the methodological design. I feel that the positive framing to my research questions was significant in fostering a good rapport; I was transparent about the fact that in the UK context, we have difficulties meeting the needs of some of our African service users and I was there to learn from them.

Between most researchers and participants there are potential limitations imposed by the inherent power imbalance (Pidgeon & Henwood, 1996; Smith, 1996). In Ghana, the historical, political and social context makes the need to minimise a power imbalance more salient. The researcher's difference to the sample creates an outside-in perspective when interpreting the Ghanaian material. This would be a significant limitation if the aim were to consolidate knowledge for the Ghanaian practitioners. However, as the aim of this study is to approach the dilemma facing Counselling Psychology in the UK from a different perspective, the naivety of the Western-trained researcher does not undermine the validity of the findings.

B.8.4. Validating results

A summary of the preliminary themes from the data corpus was sent to all the participants with a covering letter (Appendix 16.8) and a copy of their transcribed interview. Participant material was anonymised, but extracts from the raw data were included to help participants understand each theme. Each participant was asked to feedback any comments or reactions to the emerging themes.

Of the 20 participants, 9 responded to the email. All respondents made encouraging comments about how they felt the summary represented the situation they described, although feedback was superficial. Two made minor technical adjustments. The process of participant validation attracted very similar replies from all who responded.

Whilst asking for participant feedback, I included a question about the interview process and asked if participants had felt comfortable talking to me. The fact that no participant commented on the interview process, other than superficial comments about the researcher being 'friendly' or that the interview was 'good', raises issues. It is plausible that the inherent power imbalance negatively impacted the participant experience or resulted in the respondents feeling uncomfortable feeding back any negative comments. It is also plausible that due to time constraints and different cultural norms, the participants chose to focus on the content of the data rather than how they felt about the data or the interview process. Expressed emotion and self-reflection are perhaps more encouraged amongst trainees in the UK.

B.8.5. Relationships between themes

As a surface-level account of the whole data set was desired, the themes represent the majority of the data and were organised in a way that aided accessibility. The data could have been organised differently; indeed, several different strategies were trialled and refined before the coding manual and themes were defined. Many chunks of data were coded for more than one theme and areas of overlap between categories indicate that within all the data there were similarities as well as disagreement. Indeed, perhaps the overlap between themes reflects the researcher's process of trying to clarify and define strategies that the Ghanaian samples performed quite intuitively.

There were some differences between and within themes. For example, data that suggested the client should be encouraged to disclose their health beliefs which should be treated respectfully seems to clash with the suggestion that sometimes the therapeutic relationship should be more directive. However, these differences are understandable in context and can co-exist. Contradictions and disagreement within the data reflect the fundamental findings that Ghanaians can occupy multiple positions and that healing practices reflect a spectrum of integrated approaches, some of which have more commonality with Western approaches than others.

B.8.6. Conclusion

The results of this study indicate that for Ghanaian mental health professionals, working psychologically with Ghanaian clients involved many complexities associated with the interface of indigenous, spiritual and modern treatment approaches. The next four chapters relate to the four main themes. The first explores the fundamental notion that Ghanaian health professionals, healers and patients alike can occupy multiple positions in terms of worldview. The second theme explores the relationship between disciplines and approaches (Western/psychological and alternative/traditional/spiritual), including sources of tension, areas of commonality and collaboration and data that document how Ghanaian mental health professionals negotiate boundaries between approaches. The third theme includes data that describes the Ghanaian patients' help-seeking behaviour, and how the psychological and psychiatric services have tried to respond to barriers in an attempt to enhance pathways to their services. The final theme relates to the specifics of working psychologically in the Ghanaian context. This theme includes subthemes relating to client expectations, challenges associated with formulating client presentations using western tools, specialist knowledge of Ghanaian mental health professionals, incorporating spirituality and action-orientated strategies that were described to increase the effectiveness of psychological therapy.

B.9. Theme One: Parallel belief systems

Understanding that Ghanaians can congruently occupy multiple positions in terms of worldviews, and integrate and consolidate these approaches, is of fundamental importance in understanding the data. The participants introduced the idea that fact and faith can co-exist with apparent ease, a notion that represented an advantage of the Ghanaian mental health professionals and highlighted a significant component of their ability to understand their patients. This theme explores the duality and plurality of Ghanaian worldviews and health beliefs. The theme is divided into smaller themes relating to: the beliefs of the participants themselves (mental health professionals), the descriptions of healer belief systems and data relating to descriptions of Ghanaian patient belief systems.

B.9.1. 'I believe in tradition and I believe in medicine...'

Mental health professionals' belief systems

One of the most striking findings from the data related to the way in which Ghanaian mental health professionals were able to occupy multiple positions in terms of their worldview. I found this idea very difficult to understand; my own cultural background was an obstacle to understanding how Ghanaians were able to marry such philosophically different worldviews. The Eurocentric tradition of evaluating knowledge in a scientific and hierarchal way resulted in me struggling to grasp the ease in which Ghanaian mental health professionals integrated their culture and clinical training. The participants were not dismissive or rejecting of the health beliefs associated with traditional African ideas, and demonstrated an appreciation of alternative approaches. Most commonly, there was a description of not *believing* in these ideas whilst recognising them as *true*.

> *'I know. You see, this is Africa and I don't believe in witches and I don't believe in curse. But I know it exists. There are cases where (... ...) erm it does happen, well I don't believe in it but I know - as a Christian and as, with my level of education I don't believe it is possible. But I know it exists. So if it is a true, it is true that the person has been really cursed, the rituals can solve the problem. Fine. But I wouldn't be able to erm to know when this is spiritual because I don't have that skill okay but I believe that I know that it does exist. Yes.' Participant 6*

The data revealed the cultural values that underpin much of Ghanaian society and the significance of religion. The interviewees were happy disclosing their religion. All the participants identified themselves as Christian and volunteered the information. Their faith seemed to affect how they worked with this client group and shaped their interpretation of what their clients told them.

> *'Okay so basically this person thinks God is hearing his prayers, which to some extent could be very true okay.' Participant 4*

> *'We all believe in God and God is powerful so yes, treat God but make sure you take the medication and come for therapy.' Participant 6*

> *'When I don't know where to go with my patients I will pray.' Participant 1*

Those that identified an allegiance to modern psychological theory seemed to represent a superficial allegiance, which may be rooted in the social desirability of this position, or the impact of being interviewed by a White British psychologist. This duality was evidenced by claims that participants did not believe in these ideas themselves, which was sometimes attributed to their studies of Western approaches, but they knew them to be true. Not believing in something but accepting it as true felt like a contradiction when viewed from my cultural background.

Christianity has a desirable position in Ghana as it demonstrates embracing Western ideas; participants were less forthcoming describing their own experiences or beliefs in more traditional ideas, although some did. The respondents' language seemed to indicate a parallel belief system: the use of 'us' and 'they' seemed to highlight the internal struggle when worldviews clashed.

> *Yes, Ghanaians are very eclectic in that way you know... In a sense that they can, erm we can accept different views of illness.' Participant 1*

Interestingly, within the context of the focus group, participants seemed more willing to disclose personal experiences of traditional African ideas. I had been cautious about asking colleagues about their personal belief system, but the debate within the focus group revealed the parallel belief system held by many of the clinical trainees. The self-disclosure on the part of the trainees could reflect an environment that was frustrating to the trainees, as the researcher was considered to be too foreign to understand these ideas. The process could also have been shaped by the fact that the clinical trainees' lack of experience meant they felt a less strong allegiance to Western ideas, or were modifying their answers less to appear professional.

'For instance yesterday I went to my church. One of the members is ill, we are going to organise a meeting very soon, it is believed that one of the members needs help. It is believed so, it is also believed that we are able to help this woman with our prayers to God..' Focus group

'Err, it is this because my part, where I come from we normally believe that when something out of the ordinary happens... then we believe something strange is involved in causing that.' Focus group

The different ideas within the group resulted in some debate, which was more emotive than the individual interviews. Perhaps their emotionality resulted in sharing more personal information to support their argument. When asked about the process during the validation of the results, no member of the focus group commented on this.

Within many of the individual interviews, the term 'enlightened' was used to describe patients with an allegiance to Eurocentric ideas. However, the participants articulated their own parallel belief system. My own experience of my friend's poor treatment, and horror stories on the news in both Ghana and the UK, had led to me suspect that the Ghanaian mental health professionals would paint a negative picture of alternative healers. There were contradictions in the data in terms of how mental health professionals viewed healers, as many conveyed serious risks associated with aspects of alternative healing practices. However, the data revealed that the participants did not view healing practices negatively: there were positives, too. None of the respondents were dismissive of the efficacy of herbal treatments, although some were able to describe the challenges associated with the treatment approach.

'I don't have the scientific proof, but there are some scientists or health professionals that say, oh yes some of them are able to find some herbs that really have some chemical components that treat some of these. So yes to some extent, those herbs may work.' Participant 3

The Ghanaian mental health professionals I interviewed had a respect for this branch of alternative healing; none were dismissive of the potential efficacy of herbal medicine. One participant explained they believed modern medicine had taken inspiration from herbal approaches:

'Rauwolfia is er, an old plant, it's actually one of the, one of the first anti-psychotics to be used in Britain.' Participant 1

Respondents demonstrated an understanding of how herbalists work, contextualising the poor treatment I had heard about, such as patients being chained. The descriptions were much less

emotive in this context and the parallels between modern and herbal approaches seemed striking. Similarly, spiritual and traditional healers were praised for some of their work.

> *'Erm, that's important, erm because we do have some fantastic traditional healers, and erm...' Participant 1*

> *'What they do is good, because they are the first place people can go... let me put it this way- if I am sick, and you come to visit me, even if you just touch me, I feel relief because somebody cares...' Participant 5 (R1)*

An understanding of Ghanaians' ability to occupy multiple positions, and integrate this knowledge, is fundamental to understanding the advantages that the Ghanaian mental health professionals have for work with this client group. This concept helps lay the foundation for understanding the population's health beliefs. The participants represented a privileged position in terms of education and social status (factors described by the participants as being correlated with a stronger belief in modern/Western ideas). They were trained in mainstream (Western) ideas, and demonstrated an allegiance to their training, in many respects. However, it is critical to understand that these participants were also shaped by beliefs that underpin much of their culture. They seemed comfortable recognising the skills and expertise associated with healing approaches. The only analogy I could use to formulate this dichotomy relates to the process of integration associated within Counselling Psychology. My own training involved learning about different approaches to psychological therapy, across schools that have tension between each other (e.g. psychodynamic and CBT). I am able to integrate information from very different schools of thought in a similar way to that described by the Ghanaian participants, although marrying two completely different worldviews seemed, to me, to raise a lot more challenges.

It was important to understand the historical context of what they were describing. In a world in which Eurocentric ideas are dominant, participants explained that many Ghanaians strive to be identified as modern. Respondents reported that whilst traditional ideas are still widespread amongst the population, people are often reluctant to identify themselves as traditionalists as a result of Christianity. It seemed traditional ideas transpose religions as they are firmly rooted in the culture, although traditional healing is often shrouded in secrecy:

> *'And don't forget that some years back, or in as a result of religion, Christianity and the rest the traditional healers have been more or less demonised. That they are evil, erm they are hidden and they have nothing good to offer. So they have either protested quietly or recoiled erm into the background.' Participant 3*

By contextualising the belief systems associated with the different worldviews, it becomes easier to see how Ghanaians are able to occupy multiple positions. The following subtheme

depicts the Ghanaian mental health professionals' descriptions of healers' worldviews and belief systems.

B.9.2. 'Yes churches refer their patient, I mean their congregants...'

Descriptions of healers' belief systems

Descriptions of traditional and alternative healing practices suggested the healers also held parallel beliefs. Some healers were described as purists to their approach, viewing Western treatments with suspicion and resentment (which is understandable in terms of their historical relationship). However, many healers were described as integrating different healing approaches. Indeed, the term 'traditionalism' was revised, as in modern Ghana, ideas from Christianity and science have transposed indigenous beliefs, in many cases. Therefore, the term 'alternative' better captures the work of healers operating outside mainstream approaches. My first task was to ensure I understood the terms my participants were using and the distinctions between the different types of healers (figure B6).

In figure B6, I have separated the definitions into distinct categories of types of healers (purist descriptions); however, the information from the data suggests that healers integrate different approaches, and that the process of integration varies. A traditional healer may emphasise herbalism whilst offering traditional healing, and a Christian faith healer may also employ strategies associated with more traditional African ideas (ideas that predate Christianity in Africa). It was evident in the data extracts that the accounts of healing practices are rarely purist.

Traditional religion predates Christianity in Ghana and remains an integral component of Ghanaian culture. It was explained to me that however spirituality or religiosity is manifested, traditional ideas were likely to be transposed, to some degree. Respondents described how various religions manifested in Ghana; they stressed religion was culturally influenced and differed from the form religions may take in different cultures such as the UK.

> *'Um, some of them may prefer the Christian belief and mind you our understanding of Christianity is quite, um, culturally influenced. Um, a lot of Africans transpose our cultural belief system into Christianity and it might be different from the way you in Britain ...' Participant 2*

Whilst the effort to categorise types of healers implies its distinct approach, descriptions alluded to much overlap between religion and tradition. Respondents described how faith healers practised and accounts generally featured something that sounded magical or supernatural.

> *'"I went to this pastor, he laid hands on me or sprinkled some holy water on me and therefore, um, the person got healed." That person will get a lot of recommendation.' Participant 2*

In addition to understanding that healers often integrate different alternative approaches, it was explained that healers sometimes integrate modern medical approaches. There were descriptions of a minority of healers that insisted upon a collaborative relationship with medical services.

Figure B6: Working definitions of the different types of alternative healers (extracts from data).

Alternative healer	Example from the data
Herbalists	*'Somebody who is well versed in using herbs to treat maladies or to treat ailments...' Participant 3* *'The herbalist are those who use purely herbal treatments to treat.' Participant 6* *'There is also herbalists. They use natural herbs, tonics and some concoctions. To heal people...' Focus group*
Faith healers	*'Those who are purely religious in nature. So I think those who use their spiritual knowledge and gift as they call it to heal people.' Participant 6* *'We also have faith healers. Those ones usually talk about, um, the more charismatic kind of churches. The newer crop of churches.' Participant 7* *'There is also the Church. Well we have a strong belief in the Church so that even if the person does seek medical help we believe that the Church, we go to the Church and you pray or the Pastor prays for you or you confess. Your spirit is, is absolved of that sin or whatever is causing this order and when it has taken place within the spirit.' Focus group.* *'People who use erm their Christian religion, the Pentecostal Holy Spirit powers to heal people again afflicted psychologically or otherwise to address their, their concerns of lack of material erm needs or marital and family erm, erm arrangements or successes and the rest, you know. Or even academic achievements and so on, or generally success by being prayed for by this person who is a powerful Christian spiritualist, you know. Then you also have similar erm Sikh people from within the Muslim sect who are either well versed with the Koran, and, and are believed to have some powers by their, their knowledge of the Koranic verses they can incant to exorcise people and, and, or whatever ailment they are afflicted with...' Participant 3*
Prayer camps	*'Prayer camps where these patients are sent and then they'll go also so ... ordeal and rituals to as it were exorcise them of the, um, of the bad spirits or to break bonds of or chains of, um ... to deliver them from their bondage as I may say it from sin or from other, um, offences they might have caused that is bringing a curse upon them.' Participant 2*
Traditional healers/fetish priests	*'Somebody who has some psychological and spiritual erm know how or he can have powers to (...) to help (...) address certain anxieties and, and frustrations somebody may have, that can have any effect on him.' Participant 3* *'No, I'm told we shouldn't even be calling fetish priests, but those who have their Gods, the smaller Gods, we call them smaller Gods, those who, um, sort of worship the deities and perform rites and stuff to them. Those, those are the ones that come to mind. That would be traditional healers.' Participant 7* *'So the person could be asked to maybe replace the items he stole or if the person has hurt someone or caused an insult he has to be brought to appease the Gods so that the priest acts as a link between the patient who is suffering from this or that or what he has done, and the spirits. So the person is asked to perform certain acts. The spirits who are harming or causing the disorder, are then appeased after that, they did that the person would be well again. So that is what a traditional healer is.' Focus group*

Many of the participants described a collaborative relationship between mainstream and alternative healing approaches. Some participants had direct experience of receiving referrals from healers, herbalists and pastors.

> *'And if you go, there are some prayer centres that work with district nurses.' Participant 1*

> *'Because there are some faith healers who make sure you have seen a psychologist and a psychiatrist as well as. So I would prefer you go to such a place than just anyone. So you try to combine all of them.' Participant 6*

However, some data contradicted accounts of collaboration.

> *'There are also traditional healers who will vehemently tell you: "Western medicine - forget it! They are criminal, they are hiding under education to rob people and the rest".' (laughing) Participant 3*

The multiple worldviews that many Ghanaians seem able to occupy makes simplistic, reductionist analysis difficult, and this complexity and integration of ideas is fundamental to understanding psychological work in the Ghanaian context. Alternative healers offer a spectrum of approaches, some with areas of commonality with mainstream approaches, some differing starkly. The variety of different healing practices, and the different approaches these healers have to integration, suggest Ghanaian patients have many different options in terms of treatment. The next subtheme reveals the participants' descriptions of their service users' worldviews and health beliefs.

B.9.3. 'Ghanaians are very eclectic in that way you know... In a sense that they can, erm we can accept different views of illness.'

Descriptions of patients' health beliefs

Ghanaian patients' health beliefs also represent multiple worldviews. Throughout the data, spiritual, religious or traditional explanations for psychological suffering were described as the norm; the participants described these health beliefs.

> *'And so he told me about this interesting case where erm there was a guy, a young boy whose father had died and his uncle had inherited his father's property. Now the traditional belief is that when you do, you have to take that person's responsibilities,*

but he'd inherited his brother's wealth and was not looking after the widow or the children and so forth and suddenly he began to hallucinate, to hear voices, thought he saw ghosts, so they brought him to the priest, they brought the uncle to the priest. And, so when he heard, after he heard all of that, he called the family in, "I think he has something to say to you" (laughter) so the guy confessed that he hadn't been looking after his nephews and nieces and the widow, he was going to change his ways and you know, then that kind of settled and healed and then...' Participant 1

In contradiction to the descriptions of the prevalence of African explanations of mental illness was the idea that the global dominance of Eurocentric thinking had resulted in doctors being viewed with authority. The status of educated individuals, especially doctors, was described. Participants described how they thought their patients viewed them as representatives of the modern world.

'Um, on the other hand, there is this thing that we believe, some people believe, er, a foreigner can do things better than Ghanaians. So they may take what you're saying, um, even though it's not quite, doesn't quite fit in with their, their beliefs, they may at least try.' Participant 7

Another way the parallel belief system of Ghanaian patients was described related to descriptions of help-seeking behaviour. The participants explained that if a patient identifies himself or herself as aligned to one particular faith or worldview, it does not always translate to a specific route to treatment. Pathways to treatment reflected a trial-and-error approach. This process was thought to be shaped by attitudinal and structural factors, although, interestingly, recommendations of friends or family were described as one of the most influential factors of help-seeking behaviour.

'Sometimes you find that even though the person is Christian, professing to be Christian, they have been to some of those other places...' Participant 7

'And the funny thing is that you don't have to be ... you know, even within the Christian sects the quite different doctrinal teachings, right, you don't ... you have a Catholic who goes to a Protestant pastor because it has been recommended that this pastor is ... is ... is, um, favoured by God, is very powerful and when he touches your forehead you will be healed. They will not go to the Catholic priest or to the bishop, they will go there.' Participant 2

The respondents described a small subgroup of patients that they felt would seek help at the hospital as a first port of call. However, participants were unanimous in explaining that Ghanaians represent an ability to occupy multiple positions in terms of how they interpreted

experiences of mental illness, and subsequent help-seeking behaviour. Explanations of psychological suffering offered by healers were thought to be causal, enabling healers to offer direct advice regarding how to undo the causes of suffering, which participants felt was appealing to Ghanaians.

B.10. Theme two: The relationship between Western approaches and alternative healing approaches

The second theme included data that related to 'the relationship between systems' (Western/psychological/psychiatric and traditional/spiritual/alternative). This theme is divided into subthemes relating to: tension between approaches, areas of commonality, collaboration between approaches and negotiating boundaries.

B.10.1. 'There is mutual suspicion from both sides...'

Tension between approaches

In contrast to the accounts of collaboration and commonality, the data revealed some tension between the different worldviews. The data extract below was taken from an interview with a charity worker, who represents a third space between the two approaches (neither medical nor traditional). The participant offers a useful description of the tension between the two approaches: resistance is primarily attributed to the Western approaches.

> *'I think that there, I am not speaking for traditional healers, but even though there is mutual suspicion from both sides, I think the resistance is from Western medicine. I think so. They feel superior, they feel they are more scientific and they are more rigorous. They feel they are cleaner, erm they feel they have learnt it formally, and, and only they can prove it. Traditional healers cannot do that you know. And so erm, it is also an element as I said, this whole thing is a status, status issue sorry, I wear a White coat, you always in tatted clothes, you can't even read and write.' Participant 3*

As suggested by the above extract, all of the respondents articulated sources of tension between approaches. Whilst the respondents generally demonstrated a respect for *some* alternative health beliefs, a placebo effect was offered as an explanation for the efficacy of some of the healing practices, as were accounts of trickery. These descriptions were more in keeping with my culturally rooted suspicions.

> *'You do have charlatans, or you do have people who think the families are a problem. And they break the ties with family completely, so that they have, they, they think that if you have a belief that it's the family that's leading to your patient's illness, then the thing to do is to separate your family from... Then you, then the healer becomes the family and they, they can then extort.' Participant 1*

The tension between different treatment approaches can, in part, be contextualised by the historical relationship between the different worldviews. Many felt that the process of demonising indigenous beliefs, whilst importing Christianity, resulted in healing practices often being shrouded in secrecy.

> *'So there are issues about it being difficult to see the practices. It is probably because of how they can protect their practice. And it seems to be across the board... all professionals have certain secrets that they will never, just watch a computer erm scientist who comes to work on your laptop or whatever. He will never let you see what he is doing. Or if he sees a problem, he will do something to distract your attention and fix it so that you can always get back to call him. So erm, then it is a level to with we can push them to reveal.' (Laughing) Participant 3*

Practices that are shrouded in secrecy are difficult to regulate, which creates tension when viewed from a Eurocentric culture of evidence-based practice and random control trials. This tension can also be understood in terms of fear and concern for their patients as all of the participants were able to articulate some serious risks associated with some forms of alternative healing. A philosophical clash seemed to stem from the fact that many spiritual or traditional healers view the patient as being less than human whilst possessed by spirits, which the mainstream professionals did not agree with.

> *'Because there are some practices of course that are not good or violate the person's human rights, for example flogging. Flogging the patient. Now why are they doing that? They are doing that on the understanding that they are beating out the spirits that has invaded the body, right? The other thing is starvation, which they call, um, fasting. They basically starve the patient. Now we try to tell them the man is ... or the woman is sick. How effectively is this person going to fast and pray when they are sick? OK?' Participant 2*

The participants seemed able to distinguish between safe and unsafe healers, although the risks associated with delayed presentation at medical facilities related to all alternative healing approaches. Ghanaian mental health professionals expressed concern regarding several practices, including: the use of physical restraints (chains, tree trunks, etc.), the use of flogging and beating, fasting, scarification, burns, sleep deprivation, blood flow restriction, dehydration/starvation and the use of Western medication without proper training or monitoring. Restricted bathing, dirty living conditions and infections resulting from poor hygiene were also described.

'There was a client who before he was brought here he was at the prayer camp. And according to him they beat them all the time, they don't give them food, they have to fast.' Participant 6

Participants also reported that they had heard of cases where vulnerable people were forced to work, had been sexually assaulted or had died in the care of alternative healers.

'For example things like erm having, there are instances where people who have gone for healing services with traditional healers especially women, later report that they have been either raped or who have had sexual affairs with people. Or people have been told to go and work, have been used on farms of traditional healers as labour, cheap labour and the rest. They have often come up. Or some remedies to treat people go wrong and the person dies. And traditional healers have been arrested for, for that. So some of them also have had that kind of fear.' Participant 3

Another source of tension was that participants had heard of healers that were employing mainstream medication without proper training. Whilst participants seemed comfortable with the fact that CPNs collaborate with healers to administer medication, offering healers some insight into Western pharmacological approaches was not without its challenges. Western approaches could be viewed as endorsing healing approaches if a patient considers them to be working jointly. Similarly, if the introduction of Western medication into the healer's practice results in healers offering a more effective treatment, patients are more likely to have their belief in the healer reinforced, which results in that healer being recommended to shape others' help-seeking behaviour. Mental health professionals viewed healers using Western medication without consultation with a medical expert as dangerous.

'Now the danger is also that under the current practice a lot of the traditional healers are employing orthodox medication alongside all that they do without any knowledge of how to use these drugs just based on the fact that this person had this ailment, went to the psychiatric hospital and was prescribed this medicine, so another person comes and they ... they go out there and try and ... I don't know how they manage to get the drugs, of course they can get it from ... unapproved sources and then they administer it to ... to the patients, right?' Participant 2

The participants' accounts of physical harm potentially associated with alternative healing practices demonstrated their insight into the practices of various healers operating within their country. The awareness of potential risks enables clinicians to start a dialogue about alternative places of healing and to assess the risk. If clients disclose that they are attending a place of healing that the clinician fears is harmful, they are able to explore the benefits and disadvantages of the different approaches with the client.

BasicNeeds produced a photo book of images of the experiences of individuals with mental illness (*BasicNeeds Photo Book*, 2011, photographed by Nyani Quarmyne). Within the book are images that depict aspects of risky and unsafe conditions at alternative places of healing (figures B7-10) which illustrate the participants' descriptions. BasicNeeds gave permission for these images to be reprinted.

Risk of psychological harm was another emerging theme from the interviews, raised in conjunction with the fear that families would be disrupted or that vulnerable people could be abused. Risk of financial exploitation was also described.

> *'They believe in it and the rituals. They collect everything they are told to do. "Bring goats, bring sheep, bring corn, bring corn, bring yam." And rather they collect everything of yours and make you poorer!' Participant 5*

The data suggested that the participants distinguished between healers with a genuine gift or talent for healing, and those 'charlatans' that were motivated by financial gain. This classification demonstrates the participants' duality of beliefs.

> *'They care only about getting the money, or you to believe in them or something like that. The fetish people believe that if they do a wrong intentionally, it will come back to haunt them. So you know, they, they are bound by more strict morals than some of these faith healers these days. You would expect the other way around, actually, but...unfortunately that's not the case nowadays.' Participant 6*



Figure B7: Photograph of tree trunks used to restrict a patient's movement. (Left)

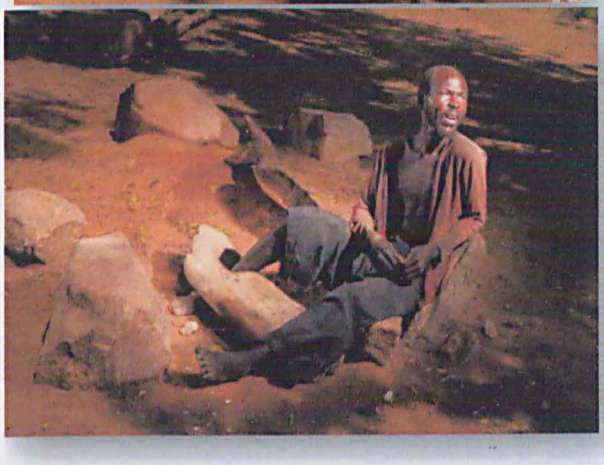
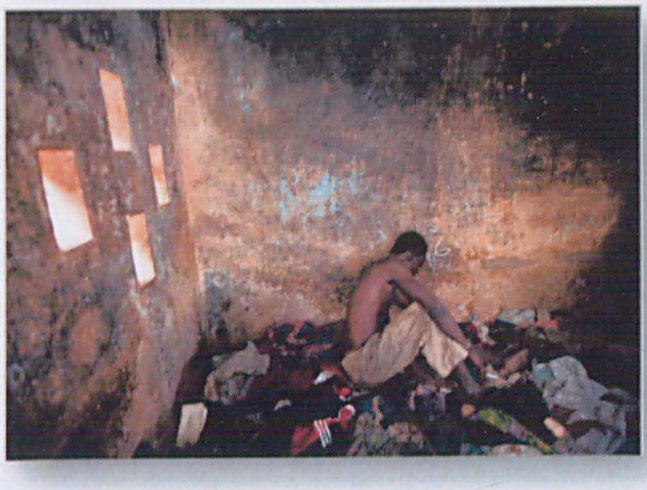


Figure B8: Second photograph of tree trunk used to restrict a patient's movement (left)

Figure B9: Photograph of woman in chains to restrict movement (below right)



Figure B10: Photograph of the conditions at a healing centre (below)



Figures B7-B10. Photographs reprinted from the BasicNeeds photo book, photographed by Nyani Quarmyne (Copyright protected)

Another source of tension between approaches resulted from the wider ramifications of the existence of African health beliefs. The implications of a moral or magical explanation for mental illness were discussed in conjunction to: maintaining blame or stigma, causing psychological distress or justifying poor treatment of a sufferer in the community. Respondents thought that healers reaffirm these health beliefs and, therefore, the psychological implications of such beliefs. Similarly, participants felt healers reinforced delusions or paranoid thinking amongst patients.

> *'The person tells you it's your aunt in the village who is zapping you and then all of a sudden, the, the worry is focused. You know, on getting that person to stop what they are doing... So sometimes it helps because it reduces the anxiety, but then it brings up the whole new set of problems because now all of a sudden they are doing things to either avoid their aunt or to harm their aunt or, you know, things like that. So sometimes, once in a while, it may have helped, but a lot of the time, it causes more harm than good, in my opinion anyway.' (Laughter) Participant 7*

Sources of tension resulted from aspects of difference; the explanatory models are fundamentally different with different beliefs underpinning each approach. The commonality between approaches, and the mental health professionals' ability to occupy multiple positions, did not eradicate sources of tension.

B.10.2. 'I think they employ principles of psychotherapy in a way...'

Commonality between approaches

The data revealed that the participants understood there to be a spectrum of different healing approaches; some areas of overlap between mainstream approaches and alternative healing were described. A fundamental similarity seemed to relate to the fact that they recognised that many of the healers offered a form of primary care. The participants articulated appreciating that many of the healers offered treatment to patients that would otherwise receive no treatment.

> *'What they do is good, because they are the first place people can go... let me put it this way - if I am sick, and you come to visit me, even if you just touch me, I feel relief because somebody cares... somebody cares and somebody is ready to talk to you, somebody is ready to try to help you, even if it means beating... somebody is beating you to remove the devils in you, what do you do? at that time you have nothing else, you just succumbed to whatever they are doing... so that is why we appreciate them -*

for being the first place - for reaching out to these patients that we cannot see...' Participant 5

Whilst the data extract above highlights differences in approach, many of the participants described similarities in treatment approach. Some participants articulated that areas of commonality related mostly to approaches the Western world would define as counselling.

'I think they employ principles of psychotherapy in a way, especially with counselling. In performing rituals and so on they actually end up should I say making the patient feel valuable - or valued and they listen to them and then they offer advice, so in mild to moderate depression, some anxiety disorders they are able to effectively treat them and that is why people still keep going there because there is something they are doing right...' Participant 2

'We don't work the same way or in the same environment but it is about what happens between 2 people...' Focus group

'Sometimes I think the best word for what they do is counselling... The least harmful aspect of what they do... Erm I don't know whether traditional healers understand it as counselling...' Participant 3

Counselling was described as a component of alternative healing practices, although it was acknowledged that it might take on a different form to mainstream psychological counselling. The participants suggested the therapeutic relationship may be more directive at sites of alternative healing compared to psychological services, and that specific interventions, such as the use of charms and rituals, belonged solely to alternative healing approaches. However, there were aspects that were described as being fundamentally similar. The fact that healers offer patients a space to be heard and an experience of someone trying to understand what they are going through was described as a powerful component of the approach. Other areas of commonality were described, for example: involving the family to assess the patient's difficulties, listening to the patient and making them feel valued.

Similarly, areas of overlap were identified between approaches of herbal and Western medicines. Whilst participants recognised that herbal medicines often lacked empirical testing and clear prescription guidelines, fundamentally both Western medicine and indigenous herbalists offer treatment to reduce symptomology, based on knowledge of the way different ingredients interact with the body.

'But they really know what they're doing, er herbs have been handed down from generation to generation or they've been apprenticed to erm, er a bonafide healer you know, we do have them...' Participant 1

The participants' ability to identify areas of commonality between approaches was aided by the fact that mental health professionals were able to congruently occupy multiple positions in terms of worldview. Aspects of Ghanaian culture transposed mental health professionals' allegiance to Western approaches; additionally, the participants accepted that with the current resources, many Ghanaian patients would continue to seek alternative healing as a first port of call. Perhaps it is the areas of commonality between approaches that enables some degree of collaboration.

B.10.3. 'You must work together, you cannot build walls between us'

Collaboration between approaches

Respondents described collaboration between medical and alternative approaches on a number of levels. 'BasicNeeds' is an international non-government organisation that aims to improve the lives of people with mental health conditions in developing countries. BasicNeeds is very active in Ghana and many respondents mentioned its work forging relationships between mainstream and alternative services. Many of the respondents were aware of the work of BasicNeeds and some referenced projects that they had been involved in.

'I have not done that before but I know one of my professors did with BasicNeeds is to go and give them education. Educate those centres the need for the two you know ideas coming together and one depending on the other. Because some of the cases, erm the faith healers cannot solve, so why don't you do your part but make sure other, you know what the client or patient actually needs is done. Such as medication and psychotherapy.' Participant 6

'BasicNeeds helped them build up their buildings, from a small room they opened up to an airy place, sometimes they would have a party eating and dancing, it helped them. We tried to organise some recreation together. It helped...' Participant 5 (R1)

A key lesson from their experience seems to relate to the importance of forging collaborative relationships between mainstream services and healers operating outside these services. Participants described strategies that aimed to identify healers and forge relationships with these

healers. Participants reported that alternative healers experienced these strategies positively and stressed the importance of not judging the healers they collaborated with.

Another driving force in the process of collaboration was attributed to community psychiatric nurses (CPNs). Respondents reported that CPNs work with alternative healers, and due to the distance between much of the population and the three psychiatric facilities in Ghana, are responsible for much of the outreach work on behalf of the hospitals. CPNs were included in this research project as early interviews revealed that they have frequent exposure to traditional healing practices and could offer valuable expertise.

> *'Build a relationship between the community psychiatry nurse and the group of traditional healers within the setting. And then encouraging periodic experience sharing and, and, and introducing Western remedies of mental illnesses to them.' Participant 3*

Participants stated that CPNs in Ghana work flexibly and creatively, often involving family members and the community. CPNs that participated in this study suggested that a significant part of their work involved educating people, communities, schools and churches about Western models of illness and treatment. Similarly, teaching healers and patients and families alike about potential side effects of medication, relapse indicators and protective factors were important strategies. One form of collaboration described related to the use of Western medication by alternative healers:

> *'So what we did in the northern region was that we trained some of the traditional healers who were coming to us for tranquillisers and anti-consultants and they gave us reports. It happened in the northern region, if you could go there you would be very interested...' Participant 5 (CPN)*

The significant structural barriers for patients seeking help at mainstream services, as well as attitudinal ones, necessitate representatives of the hospitals to be in the community. CPNs are a vital way of reaching out to the people the hospital would otherwise not see. They were clear that they did not think what they were doing was teaching them how to act as nurses, but felt it was in the patients' best interest to educate the healers about Western medication, how to administer medicine safely and what side effects, or signs of relapse or deterioration, to look for. The nurses described teaching the healers how to continue administering medication that had been prescribed by mainstream clinicians. The challenges associated with allowing alternative healing approaches to use Western medication relate to the fact that the effectiveness of medication may be a powerful cue to action: participants described cases that had begun to believe more firmly in Western approaches after they had responded to pharmacological treatments. If traditional healers are able to incorporate these medicines into their treatment, it seems likely this will increase the recommendations they get. The lending of Western

approaches could then be viewed as legitimising these practices, as the boundaries blur regarding what is distinct in belonging to the different disciplines.

Conferences organised to encourage information-sharing between disciplines was another indicator of collaboration. One of the clinicians interviewed reported attending a conference aimed at sensitising faith healers to issues around human rights and patient well-being. Many reported that they felt collaboration between different approaches to healing was important.

> *'You can't change that perception. You must work together, you cannot build walls between us. We must find ways of working together. The patient must be our goal. And it is the same goal. We have different ways of doing things. But the same goal means we can work together.' Participant 5 (R2)*

Respondents gauged the attitudes of alternative healers as being willing to collaborate with Western or mainstream facilities. However, there were discrepancies and contradictions in the data. Some felt that healers were keen to get recognition from mainstream approaches. Some respondents suggested that whilst some healers are willing to collaborate, others are very opposed to being associated with mainstream ideas. Similarly, some of the data suggested that tension between the approaches was a significant obstacle to collaboration and that perhaps this tension is maintained by the 'superiority complex' of modern medicine.

> *'Some of them are welcoming, others believe that you don't have a place you know. You don't know what they do and you have no knowledge. So if you, it depends on the centre and their ideas and, I think their motives. If you get those who believe that you know science and religion can work together like this. You get centres like that, you get others who think that is only towards the spiritual aspect, so, and they are not welcoming. But those that believe in the two are more welcoming.' Participant 6*

All of the clinicians I interviewed suggested that they acknowledge and accept that Ghana is a country with a strong emphasis on spiritual and religious beliefs and that this was something unlikely to change.

B.10.4. 'But as a clinician I am not a reverend, a minister or something...'

Negotiating boundaries between approaches

An interesting challenge reported by the respondents was about how to negotiate the relationship between the different disciplines. There was a fear described that clinicians have a

way of avoiding work with a client who is treatment-resistant by attributing the illness to a spiritual cause. The ethical issues involved in negotiating how to bring spirituality into the room without stepping outside of our own discipline was considered a challenge by many of the clinicians I interviewed.

Ethical considerations were described by some respondents relating to incorporating spirituality into psychological and psychiatric services; whilst a clinician and a patient might share the same faith, being mindful of working within your own area of expertise was emphasised. Some respondents mentioned that they had heard stories of doctors recommending a prayer camp or faith healer; referring treatment-resistant clients on to alternative healers was described as bad practice.

> *'I had a few cases of people telling me they went to doctor upon doctor and nothing was happening, the doctor told them from the looks of things it's a spiritual thing, so they should forget about the medicine and go look for spiritual assistance.' Participant 7*

Whether the motivation is a way of avoiding difficult work or the result of a congruent belief in both worldviews, the participants in this study suggested that it was important to negotiate boundaries between approaches.

> *'I think a doctor that recommends traditional treatment has forgotten his job...' Participant 2*

All the participants interviewed felt it was unethical to charge a client for a service that a priest or faith healer was better qualified to do, and that avoiding falling into that trap was sometimes difficult.

> *'But as a clinician I am not a reverend, a minister or something, so my concentration is not really on the belief system but I try to explain the person's issues psychologically to them okay? And sometimes they have to go back to their pastors to work with them. For example a person comes to you and he says erm he thinks the problem he is going through is because he thinks a sin committed. I don't have that skills to deal with that. It is the pastor or their spiritual leader who has that skills, so I am going to do my part as a clinician and he has to go back to that spiritual leader to work on that aspect. Personally I wouldn't want to deal with that.' Participant 4*

> *'You know, you can't do everything and you have to know where your limits are.' Participant 1*

The participants reflected that with some difficult patients, there is a danger of it being appealing to suggest they seek traditional or alternative healing, as it can be a way of avoiding difficult work or clients that were difficult to work with.

Another boundary that needed to be carefully negotiated relates to the clash of cultures that can be experienced within the therapy room. Strategies that were described as useful in bridging the gap between a patient that believes firmly in a worldview that clashes with a clinician who has an allegiance to Western models is explored in the next theme; however, negotiating the boundaries between approaches involved carefully handling of the patient's belief system. The challenges associated with the balancing act between trying to avoid alienating or disregarding a patient's belief system and avoiding reaffirming beliefs that would shape future help-seeking behaviours were discussed. Rejecting the client's belief system could result in disengagement and subsequent help-seeking being at alternative sites of healing, although reinforcing a client's belief system could also result in legitimising a belief system that would also support help-seeking being at alternative sites of healing.

B.11. Theme three: Multiple positions, multiple pathways

Due to the plurality of Ghanaians' health beliefs, data relating to 'pathways to treatment' was a significant theme. The data revealed several strategies in response to attitudinal and structural obstacles to treatment. This section is divided into two sections: data relating to help-seeking behaviour and data relating to how services try to minimise the reported challenges.

B.11.1. 'You'll be sure that the majority of the patients you'll be seeing do not choose you as a doctor as a first option.'

Help-seeking behaviour: Who goes where?

In Ghana, the interface between the different treatment approaches results in several challenges to the delivery of mainstream psychological and psychiatric treatments. Attitudinal barriers are a key component of these challenges, as are structural barriers. As described in an earlier chapter, resources in Ghana are relatively sparse and mainstream facilities are clustered in the southern region. The participants reported structural barriers like geographical distance to psychiatric facilities and financial considerations as explanations for some of the help sought at sites of alterative healing.

> *'Because there are just three psychiatric hospitals in Ghana all situated along the costal belt of Ghana. With the rest of the hinterland left on its own. And there were very few people who would have the opportunity or the means to come down to get assessment.' Participant 3*

Whilst structural barriers account for physical obstacles to treatment, attitudinal barriers were significant too. The clinicians were unanimous in reporting that attitudinal barriers (alternative health beliefs) resulted in many patients presenting at mainstream services as a last resort. The respondents described stigma associated with suffering from a mental illness. Alternative health beliefs were thought to reinforce and maintain stigma surrounding mental illness, and the secrecy that shrouds alternative healing practices is appealing to those fearing the stigma associated with being a patient at the psychiatric hospital.

> *'Once you're mentally ill, you're mentally ill, irrespective of your diagnosis. It doesn't really make a difference in the community. Um, if you've suffered a depression and you've been seen, treated or receiving treatment from the psychiatric*

hospital or you've been brought to the psychiatric hospital, as far as they are concerned in the community you are a mental patient. It's ... it's ... it doesn't matter whether it was anxiety or hypochondriasis or ... yes, schizophrenia. They don't care. All they ... they ... they, um, they know is that you were behaving oddly, um, or had a strange behaviour or your behaviour changed and you were being punished by the psychiatric hospital.' Participant 2

With a moral explanation of illness there is an implicit implication of blame, i.e. a vengeful god punishes sinners. Interestingly, the above extract suggested that local knowledge maintained an idea that the psychiatric hospital 'punishes' its patients.

Many of the interviewees described difficulties engaging patients in psychological and psychiatric services due to differences in health beliefs. Most of the interviewees spoke of the importance of spirituality in Africa, which was reflected by their accounts of clients seeking help with spiritual, traditional or alternative healers as a first port of call. Addressing the spiritual side to an illness or problem was reported to be of great importance to the Ghanaian patient and alternative healing was described as common alongside, preceding or post mainstream treatment. The respondents reported that clients delayed presenting to psychological and psychiatric services because they first sought alternative healing. Respondents suggested that a patient's family or community often served to reinforce an alternative explanation of the mental illness and thereby maintain existing help-seeking patterns.

'No some come from the traditional healers, when it is getting worse. Sometimes on the verge of dying then they send the person to the hospital. So in most case they believe in that, they have to first take the sick to the ritual healing before any physical healing.' Focus group

'And you'll be sure that the majority of the patients you'll be seeing do not choose you as a doctor as a first option. You are, um, actually the last trial...' Participant 2

My understanding of the participants' responses is that the Ghanaian patient embarks on a trial-and-error approach to treatment: instead of having a firm allegiance to one approach (religious, traditional or Western), the Ghanaian patient was more likely to try what they felt could work. Some respondents described clients trying other people's medication based on a recommendation. The data suggests advice from friends and relatives has a significant impact on where an individual will seek treatment.

Other challenges associated with the interface between systems and health beliefs related to risk of disengagement, non-compliance and future help-seeking being at alternative sites of healing if a patient experiences a relapse. Non-compliance with medication was attributed to a lack of

confidence in the explanations of their symptoms by the medical model. Therapy was reported to be ineffective if the patient did not have confidence in what the therapist said and was likely to result in disengagement. Patients can seek multiple sources of treatment and shift between models depending on their results and to whom they attribute the treatment outcomes. Respondents suggested that relapse rates were high because positive treatment outcomes are attributed to alternative healers, which serves to reinforce an idea and dictate future help-seeking patterns.

> *'And happens in, in psychiatric illness what we have realised is, the rate of relapse is very high, so if someone goes away with the belief that the hospital made them better, they will come back. But if they go away and see a traditional healer too, they have the belief that the healer was the one to help them, and they go back there. They go to find out why they got unwell, to be mad is not something people accept. People around you will treat you differently. The healer will tell them something to explain why it has happened. They are eager to do what they say to keep it away... then they feel confident and they stop taking the drugs and they get ill again. They come back. But they go to the healer first... they should come to us first. They relapse and come back. It's a vicious circle.' Participant 5 (R2)*

The data suggested that Ghanaian colleagues experienced difficulties working effectively with their service users due to the clash of cultures between mainstream services and indigenous beliefs. Clients that do not experience a service positively, or do not have confidence in the mainstream explanations of symptoms, will disengage. Similarly, even if they get well, as it is unlikely that the patient will solely engage in mainstream services, an effective treatment outcome does not necessarily predict future help-seeking behaviour, as it depends on whom the client attributes the outcome to. Many participants described seeing patients that engaged in alternative healing practices as well as psychiatric/psychological treatment, and that they attributed treatment outcomes to the alternative healer or the power of God.

> *'They won't attribute it to you... They attribute it to the power of God.' Participant 2*

In the context of Ghana, healers have the advantage of offering treatments that fit with cultural explanations of psychological suffering or mental illness. However, if friends or family have direct experience of positive treatment outcomes from any approach, participants felt this kind of recommendation would be a powerful cue to action.

B.11.2. *'Eventually people will start seeing the benefits of orthodox treatment...'*

Systemic strategies to address attitudinal barriers to engagement: Enhancing pathways to treatment

More in keeping with principles of Community Psychology were strategies relating to addressing public health concerns and longer term strategies aimed at educating the population about Western models of psychological suffering and mental illness. These strategies can be seen as a response to the challenges associated with the help-seeking behaviours described in the last section. Longer term national strategies were described that attempt to encourage clients to engage with medical and psychological services earlier. These strategies include: laws that aim to regulate alternative healing practices, community outreach and education programmes and a Mental Health Bill.

As stigma, especially in rural areas, can lead to mistreatment of a sufferer of mental illness, community work that educates families, teachers, priests and faith healers helps to actively challenge some of the misconceptions about mental illness (for example, that it is contagious or due to the fact the person has sinned). Whilst local beliefs will not be changed over a short period of time, this strategy seemed essential in building relationships between the community and mainstream services. Respondents also informed me that education programmes are targeting rural areas to encourage an understanding of psychological and medical explanations of mental illness. Respondents described community education programmes that were often facilitated by community nurses or organisations like BasicNeeds.

> *'Slowly slowly. We go to villages, churches, schools.... educating the young ones is good. We tell them whatever. And they see from what we do. But we cannot change their minds... not to entirely forget about traditional ideas- no!' Participant 5 (R1)*

Working in the community is vital if attitudinal barriers are to be addressed. The culture clash between Western and local indigenous worldviews can be reduced by gently exposing the population to positive experiences of psychiatric and psychological services. When this data was collected there was no equivalent to the Mental Health Act, and patients were entitled to seek treatment wherever they saw fit. Respondents described hoping that a Mental Health Bill would be passed soon, and it was a few months later in March 2012. During the interviews, I learned that families had a big stake in a patient's treatment and could admit them to the hospital for treatment due to the lack of clear laws.

The data revealed discrepancies in terms of at what point clinicians felt they should intervene, whilst considering the implications of the proposed Bill. As with all psychologists, Ghanaian respondents' professional identities reflect individual values. Some felt the new law would

result in more people being detained in hospital involuntarily, and some explained they felt it was most ethical to let a client seek treatment wherever they saw fit.

> *'You do your job as you should do, well, and then still the person wants to go to prayer camp, it's, it's their choice.' Participant 6*

> *'It is becoming more common, because when the bill gets passed they won't be able to keep people with mental illness for more than three days.' Participant 1*

It will be interesting to observe how much impact the Mental Health Bill will have as it makes it illegal for an alternative healer to hold a person with mental illness for a prolonged period of time. Perhaps the Bill will facilitate stronger links between healers and medical services as healers are, at least in theory, required to refer patients on to medical services.

Another government strategy to address the risk of harm was described by the participants. In an attempt to regulate traditional/alternative healers, the Traditional Healers' Act was passed in 2000 (WHO, 2001) and requires that healers obtain a licence to practice. One participant raised the idea that licences could be viewed as government endorsement. This licence was described as being easy to obtain and the body that regulates healers was not adequately resourced.

> *'So anything that will recognise them is very, very important in boost their confidence, you know. So that is why they would gladly flash out their licences to say, "look I have a licence".' Participant 3*

Participants suggested that there was no way of knowing which healers were safe for clients to use. Respondents suggested that the historical context of the relationship between tradition, Christianity and modern medicine meant that traditional healers and traditional beliefs had been devalued and had become more shrouded in secrecy. Respondents suggested that traditional healers feel they perform a service for which they receive no thanks or recognition. Respondents reported a shift over time from attempts to distance the discipline from the approach of traditional healers to a current climate that was more open to collaboration and information-sharing.

> *'You see, but if we could only be able to, so if we had a way of knowing who are the good ... The good, er, traditional healers...' Participant 1*

Respondents suggested that the effectiveness of the Traditional Healers' Act was limited due to inadequate resources. However, they felt that strategies that aimed to recognise and support traditional healers operating safely would be gratefully received.

B.12. Theme four: Eurocentric interventions in the Ghanaian context – what happens in the therapy room?

The fourth theme explores the specifics of working psychologically in the Ghanaian context. The previous chapters reveal some of the complexities and challenges associated with working psychologically with this client group, and this chapter consists of data that relates to the process. Data that related to *how* Ghanaian psychologists interpret and utilise Eurocentric theory and practise in the Ghanaian context was coded for, as well as specific challenges to psychological work in a cultural centre of African health beliefs. Subthemes consist of: data relating to patient expectations for treatment and how this impacts the therapeutic relationship, challenges associated with formulating client presentations, Ghanaian mental health professionals' specialist knowledge regarding working with these clients, how mental health professionals incorporate spirituality into their therapy and action-orientated strategies that aim to maximise the effectiveness of psychological work in the Ghanaian context.

B.12.1. 'So they are not even thinking that it will work in the first place.'

Confidence in and expectations for treatment

The participants reported that many of their patients did not have much confidence in the treatment being offered by the hospital, as it did not fit with their beliefs regarding the cause of the illness. A client's lack of conviction in psychological and psychiatric models of treatment was a recurring theme, and was reported to be an obstacle in the delivery of mainstream treatments.

> *'And if they don't buy into what we are offering to them and their sole belief is in their, their religious belief then you won't achieve anything good.' Participant 6*

Advice from an alternative healer regarding mainstream approaches was thought to impact a patient's perception of the efficacy of mainstream approaches; this advice could impact the attribution of effectiveness as well. Respondents reported that some healers recommend psychiatric treatment, whilst some vehemently warn against it.

> *'A lot of them are very sceptical! (Laughter). They call it the White man's treatment, or system, and say this is our African way, the local, the Black man's way, you know, so you should do it like this, or....' Participant 7*

Another emerging theme relating to the issue of patient confidence was that many of the participants interviewed thought that some people who could benefit from seeing a psychologist

are not aware of the service they offer or what a psychologist does. Attitudinal barriers were described as a major obstacle to patient engagement and confidence in the approach.

'Therefore he doesn't look your way so why would he come?' Participant 4

Part of the appeal of alternative healers was attributed to the concrete, directive advice they give, offering an *explanation* for a person's suffering and strategies to *remove or undo* the cause in some way. In contrast to this approach, psychologists are trained towards fostering a collaborative relationship, gently guiding patients towards self-discovery. Participants explained they thought this approach was experienced as unsatisfactory by many Ghanaian patients and resulted in low expectations for treatment. Participants explained that as many Ghanaians are not very socialised to the idea of therapy, they expect a similar relationship to the ones they have with their pastor or healer. Similarly, as psychologists are seen as members of the 'medical' camp, which is a position of high social status, expert advice is expected. Experiences of nurses and doctors that diagnose and treat reinforce an expectation for concrete advice.

As a person's worldview and culture is a fundamental part of how they view the world, the challenges associated with engaging a client in a treatment approach that differs from their own explanatory model of their experience involves a careful negotiation. For many Ghanaians, a more directive therapeutic relationship feels more comfortable.

> *'A lot of the time that's what happens, when they've been to their pastor or their sorcerer or their priest, they've been told they need to do this and that and that, even the medic, medical field, they've been given medication – "Take this medication on this day and that day and that day," or something, so they're used to being told, "You do this and that and that and that," and then they come to the psychologist and you're like, "Okay, what do you think needs to be done?" or, "Where do you think we can go from here?", things like that, then they know, they don't believe you as much.' Participant 7*

The participants suggested collaborative explorations were not well received by patients. The participants described responding to the expectations that their clients had for direct advice, by employing testimonials of other patients with similar complaints they had treated successfully, or by being more directive in early sessions. To overcome a client's lack of faith in treatment being offered, clinicians described adopting an authoritative position:

> *'Now if you can, um, relate to the patient, "Look, this person you see sitting out there you came to meet in the queue, um, was maybe worse off than you or had the same kind of ... or similar symptoms, but today look at him or her, he's fine, because he*

applied himself or herself to our medications." Then you get the person, "OK, let me try it and see."' Participant 2

The above data extract was taken from an interview with a psychiatrist. However, other respondents described strategies aimed at encouraging a client to feel confident in their approach. Relaxation training was an example of an intervention that could be used early on to increase client confidence. In any context, psychologists embark on a process of socialising a client to their theoretical approach.

The data revealed there were ways in which the therapeutic relationship can differ with clients that have alternative health beliefs. Several respondents described needing to work hard to gain the patient's trust. One respondent explained that entwined with the cultural values of connectedness was a need for some reciprocal conversation. The participants described pre-therapy to develop trust.

The issue of when to disclose a clinician's own belief system was also discussed as it was thought to impact the client's expectations for therapy. Another component of the notion of self-disclosure was how to handle direct questions about the practitioner's belief in traditional ideas. This data seemed to describe therapeutic relationships that were congruent, transparent and respectful.

'Now they ask me whether I believe in witchcraft. It's always a difficult point to say, "Well I don't believe in witchcraft," in which case a patient will not have trust in me or I will say, "Well I'm a Christian, the Bible talks about witchcraft, yes, but, um, they may be existent, but what I know is that whether there is witchcraft or not, people like you have presented with these symptoms to me severally and the so-called spirits have left them. They responded to my treatment."' Participant 2

Some respondents described being asked directly about whether they believed the health beliefs of their clients. Disclosing the clinician's belief in God seemed to help bridge the gap between the different worldviews. Disclosing being a Christian, where appropriate, is less problematic in a country where Christianity is dominant, and as Christianity seems to encompass a spectrum of ideas and practices in Ghana, some more heavily intertwined with traditional ideas, focusing on the positives associated with faith in God facilitates a common ground between clinician and patient.

B.12.2. 'Mmm. No they are not delusions, they are really, real because these are beliefs.'

Formulating client presentations

Due to the authority many Ghanaian patients attribute to medical doctors, the participants felt that a challenge for their work involved encouraging a patient to disclose information. The participants reported that clients modify what they disclose based on how they gauge the attitudes of the person asking them. Respondents emphasised the need for a therapist to understand the individual's, and their family's, understanding of the client's difficulties and that secrecy surrounding many of the alternative healing practices made accurate formulations more difficult. Respondents suggested that patients were often not forthcoming about alternative healing practices and that some may deliberately conceal their beliefs.

> *'People don't like to tell me about these beliefs (laughter) yeah because they think erm I won't understand or I'll laugh at it or something...' Participant 1*

The data suggests that the perceived attitude of the mental health professional would have more importance in determining what the patient discloses than the patient's own worldview. Not having information about the person's explanatory model of their experience was described as an obstacle to formulating a client's presentation.

Another obstacle to formulating a client's presentation related to defining what constituted mental illness. Respondents described how delusions are maintained or reinforced by the family or community, or how ideas that sound like delusions may be socially acceptable in the client's local context. For example, one participant described a client who may have met the diagnostic criteria for psychosis, but after the clinician realised that the client's friends and family also held the bizarre ideas, the clinician described formulating the client's presentation differently.

> *'To some extent we could say, we could see it as psychosis, we could see it that way, but at the same time, it was a person with low self worth and there was some evidence to support his fear... how do I even put this, er, because we don't have all the information on what's really going on in the school, what we, all we had to work with was what the boy presented with and the little bit of information I was able to get from some of the others in the school, even though it wasn't as detailed. I didn't think he was psychotic... Um, I did believe – because there was no other incident like that, no other history of any psychotic incidents.' Participant 7*

The participants were not unanimous in their descriptions of how they formulate clients' health beliefs.

'You see the, the problem for me is we buy into the concept that erm if you believe somebody has hexed you then that's just a part of the culture, it's not, well a certain, at a certain point you will have to make a determination that you are paranoid, you know. And I think we, we, we take the, the perhaps a romanticism of African beliefs too far. So I, we haven't written enough about it to alert clinicians to say, "Okay when, when you see somebody that's come with this belief treat them as you would the person that is paranoid..."' Participant 1

One explanation of this discrepancy in the data is that Western classifications did not always fit. The problems inherent in assuming that categories of mental disorder derived from the study of one ethnic group are relevant or valid to generalise to other groups were presented in the introduction to this project (Fernando, 1995; Patel & Winston, 1994; Watters, 2011), an idea that may have some relevance as Ghana imports Western models of psychology. Respondents were not united in terms of what constituted mental illness, and at what point they believed mainstream medicine should intervene. This point was salient as Ghana has recently passed a Mental Health Bill which imposes limits on the length of time a non-mainstream healer can treat someone before referring him or her to a hospital.

B.12.3. 'Yes, we grow up with these things being said and hear about them and things like that.'

Specialist knowledge/shared culture

Clinicians described several therapeutic strategies for working with this client group; an understanding of traditional African healing practices and beliefs and aspects of a shared culture seemed a major advantage to their work. The participants in this project were able to explain many local ideas in a way that straddled both worldviews. It was interesting that respondents switched between describing these ideas as 'ours' and 'theirs'. However closely they wished to align themselves with these ideas whilst being interviewed by a White British woman, a familiarity with indigenous ideas was apparent. The participants revealed that operating within a shared culture aided their work with clients. Significant aspects of Ghanaian culture related to the importance of family, community and the importance of spirituality.

'Yes, we grow up with these things being said and hear about them and things like that.' Participant 7

'We also understand that Africans value community and their family, maybe we do more of that kind of stuff too... you know you have to fit your work to your patient...' Focus group

'The ... the African philosophy, um, emphasises on empathy, emphasises on the perception that I'm one of you.' Participant 2

A shared culture between clinician and patient enabled interventions from mainstream psychology to be sensitively modified to meet the needs of the Ghanaian population. As well as operating within a shared culture, Ghanaian psychologists had the significant advantage of being taught about traditional healing practices as part of their clinical training. Respondents reported that they were encouraged to visit prayer camps and healing centres, and that their training involved lectures on these approaches. African psychology is also taught alongside Western ideas.

'Western theories of personality and then we teach them er an African theory of personality based on the Akan belief system, you know and there is very much a spiritual component to how your personality develops. It has the blood which we get from your mother and the, the spiritual which you get from your father, and the two together combine erm in, in some way to help you build your character, but at the same time you're born with this Okra - your spirit, you have your own spirit that you come with, and then your character develops from a mixture of socialisation and the spiritual, you know day name and you know that's why we have day names, er and all of that and it's quite a nice mix in there.' Participant 1

'We learn about traditionalism and we learn African ideas... it is taken to our training...' Focus group

'...And we are being encouraged to do is to try and visit those centres to find out what they do, yes.' Participant 6

The fact that clinical training recognises the importance of understanding alternative health beliefs is arguably necessitated by the prevalence of traditional healers and alternative beliefs in Ghana; and it represents a significant advantage to successfully working with clients with alternative health beliefs. Specialist training equips clinicians to conduct risk assessments, and have dialogues about health beliefs that will shape a person's experience of mental illness and their confidence and expectations for treatment.

B.12.4. 'But I think that is what is not being addressed from the mainstream Western medical, spirituality.'

Incorporating spirituality in psychological therapy

Many of the participants described trying to incorporate spirituality into their therapy. Many felt that spirituality was not properly addressed by psychology, and that it was difficult to work with African clients without taking a more holistic approach to treatment.

> *'Erm and the spirituality I don't know whether you can divulge what is it from the psychology camp or the psychosocial, I don't know, I don't have the answer. But I think that is what is not being addressed from the mainstream Western medical, spirituality. Yes the spirituality that he understands.' Participant 3*

> *'I don't think we have the capacity for spiritual work, no. I don't think Western psychology does... maybe we do a bit more...' Focus group*

The participants described many strategies to incorporate spirituality. Using the bible or other religious texts, especially scriptures that speak of forgiveness and second chances, was reported to be used in treatment sessions by many of the respondents when clients feared their illness resulted from sins they had committed. The participants' ability to occupy multiple positions when integrating their own faith and culture into the treatment is evident.

> *'And I try to use the bible as a Christian, because the knowledge erm faith healers, wherever they get their spirit from, their power is coming from God. And the knowledge I have as a psychologist, I believe is also coming from God. So if you believe that God, I mean give both knowledge why don't you use both? And two methods is always better than one, that is my idea.' Participant 6*

Engagement in a church was described as a behavioural tool that could be used to help treat mental illness. As with all cognitive behavioural therapists, the clinicians described behavioural activation assignments that reflected the resources available to the client, and the values that impact the client's motivation to engage with homework tasks. Respondents explained that regular attendance at a church involved socialising, singing and dancing, all of which have benefits to mental health.

> *'The person may go to church, see people, sing, do all sort of things, that relieves him of his stress at that particular moment. So if he is doing this regularly every Sunday he comes home refreshed, dancing some form of exercise and he forgets about his*

troubles for a while. At least for a week he goes back and renews that okay?' Participant 4

Working within a patient's belief system was described as a balancing act between reaffirming the belief and challenging a belief in a way that would alienate the client. Again, the principle of reframing is relevant to any context or country. However, perhaps this process is more salient in the Ghanaian context as *what* the Ghanaian psychologists are trying to reframe is more fundamental.

'And if he is coming to you and you want to condemn what he truly believes in. Remember that beliefs are strong and you, it is probably inculcated since his childhood, so you can't take a minute or an hour and take it out on the person...' Participant 4

'Yeah, yeah. It's just as difficult as you're dealing with, well maybe even more, a bit more difficult because of the spiritual part, you know you can, you have to find ingenious ways of testing it out.' Participant 1

Participants described encouraging a client to develop a good relationship with God. Building a stronger spirit was thought to help those that believed someone had cursed them, without challenging or reaffirming the belief directly. Respondents described focusing on the positive aspects of the patient's belief.

'If you have a client saying for instance he believes people, someone in his family is attacking him spiritually, trying to harm him or preventing him something, feeding or something, changing that belief sometimes is difficult, so in a case like that sometimes what you could do is help them to work within that belief. Now they would do that by say, by for instance saying, "Well, fine, somebody you, somebody is trying to do this to you, but what can you do for yourself, to, to guard yourself against the person's attack working?" So if it means going to church more often, you encourage them to do that. If it means meditating more often, you work with them to do that. You know, things like that within that belief, so that they don't feel quite so helpless.' Participant 7

Some respondents described telling clients that they felt that God had granted them the ability to practice within mainstream healthcare facilities. Again, the significance of the duality of the psychologist's own belief system is emphasised here. The respondents felt that identifying themselves as a Christian helped develop a therapeutic rapport. Some respondents described asking a patient if they minded if the clinician prayed for them; my understanding of this gesture was that it reflects a shared belief system, which can help build trust. Disclosing the

therapist's own faith was reported to be useful with some clients, although some respondents felt this was not good practice unless asked directly by the client.

> *'"Well you know there is a real, there's a physical illness" and so they're like, "Yes but God has taken it away". But then you need to be part of that, you need to have part of that worldview to be able to say, "Yes he can take it away". But he doesn't always choose to take it away, you know. Erm, so I'm not challenging your faith but I'm, I'm letting you know that he ultimately decided whether he will do it or not. But if he hasn't done it then he asks you to rely on the likes of us to help, and so he's provided, he's made that avenue also possible for you, you know, but if you don't enter into that worlds views and you push that away then the patient is not going to hear you either.' Participant 1*

Harnessing the positive aspect of a belief serves to build a rapport with a client that might otherwise disengage. Avoiding reinforcing the part of the belief that might be causing the client distress was reported to be achieved by finding the common ground between the traditional idea and Christianity.

B.12.5. *'...You have to demystify things. You have to teach people it's not a curse.'*

Practical strategies to maximise effectiveness of therapeutic interventions

The psychologists interviewed for this research described trying to modify Western techniques to suit their clients. Many favoured CBT for the time-limited nature of their therapy, but reported that they modify it to fit the cultural context.

> *'Cognitive behaviour therapy. But erm, its almost difficult, almost impossible to practice in its purest forms, you know... here.' Participant 1*

> *'Erm it is mostly cognitive behavioural. And with erm sometimes religious, you know, aspects.' Participant 6*

Many respondents described doing CBT slightly differently to the purist form they had been taught, often involving self-disclosure about the therapist's own beliefs. Respondents suggested that psychoeducation was a significant component of their clinical work.

Education was carried out on many levels: on an individual level with the client in the therapy room, with family members, and sometimes in conjunction with faith healers, pastors or traditional healers. Ghanaian colleagues spoke of needing to educate their clients about psychological and biological models of illness.

> *'...You have to demystify things. You have to teach people its not a curse, it's not by the devil, it's a condition... that is why it happened.' R1 interview 5*

> *'...It's an education, some of psychoeducation okay, but this is, this is not er. By the time they have left us they understand it's not a spiritual illness, that it gets better and it can come back.' Participant 1*

An emphasis on involving family members and other individuals in the treatment plan seemed to reflect Ghanaian cultural values of family and community. Effective therapy was described by maximising the involvement of important stakeholders in the treatment plan. Respondents suggested that psycho-education also involved family work, encouraging family members to buy into the model of treatment. This approach incorporates the patient's support network as stakeholders in the treatment. Respondents noted that people are brought to hospital by their relations who are considered to be directly responsible for the care of this person, and whose advice will have a significant influence on the patient's health beliefs.

> *'And one also good thing is if you are able to get someone in the client's family to buy into what you are offering them. It is easier for them to also help in the process. So I use that a lot, I always try to involve...' Participant 6*

> *'What you need for the patient is to provide your patient and their relatives, um, I'm sure the African community comes with a significant other – one or two of them or three (laughs) of them – you need to appreciate which angle they are coming from.' Participant 2*

A person's level of education was thought to impact the effectiveness of psycho-education. Similarly, it was explained that as education is associated with social status, the most educated family member's advice is likely to carry considerable weight.

> *'One other thing I think, um, needs to be understood is that if I am in a family home and I'm the only one who is going to school, going to secondary school or high school to, um, college and I tell my illiterate patients ... illiterate in terms that they are not formally educated. I tell them that, "Well this thing that you've been doing is wrong, let's try it another way." They would more believe in what I'm telling them than what they know.' Participant 2*

Information about a client's belief can be obtained from significant figures in their life to help the clinician assess how widely held is this belief. Clinicians noted that family members and members of the community can sometimes reaffirm a client's belief, which can undermine the effectiveness of mainstream treatment.

> *'Yes she also believed that the son was cursed by somebody, someone actually put something. So I start by psycho-educating the mother. And I believe that in the mother I am a stranger in the person's life, so the mother whom the clients believe, is able to understand my point of view and is able to transfer the knowledge to their son, it is going to work better than me just telling you that I don't think what they are saying is true.' Participant 6*

Respondents explained that education also took place with individuals from the community. One of the challenges described in an earlier chapter related to the idea of sticking to the remit of your job description and not being persuaded to take on the role of a spiritual or religious healer because your client attributes their difficulties to those ideas. A way around this challenge was suggested: respondents reported that clinicians could liaise with pastors or healers and try to involve them in the treatment as they already held the client's confidence.

> *'I started trying to help get him to challenge these beliefs, but he didn't trust me as much as he trusted his spiritual leader...' Participant 7*

> *'The pastor was willing to work with us, that was the thing, so I had to get him to remember that even though he might see it as lying, he should think about the boy's welfare, and that if he does believe that, and if there's something that can happen, they do believe that the Holy Spirit can give you this kind of strength, so he should...' Participant 7*

Involving significant members of the community was used as a strategy to reinforce what the professional was saying to the patient, and to increase patient confidence in the treatment plan. This strategy also serves a longer-term function of educating people about Western models of mental illness and healing approaches.

B.13. Discussion:

B.13.1. Introduction

The purpose of this chapter is to compare and contrast the findings of this project to research from the West and the rest of the world in an attempt to interpret and contextualise the data. The aim of this research was not to generate information that would be directly transferable to the UK context; however, the similarities in terms of the obstacles facing service delivery in both contexts indicate parallels. Whilst some of the obstacles impacting the delivery of mainstream/medical treatment are similar in Ghana and the UK, fundamentally, it seems as though the relationship between mainstream/medical and alternative/traditional/spiritual approaches is different. The data offers an interesting perspective on the challenges facing mainstream mental health services in multicultural Britain.

B.13.2. Similarities: Obstacles to treatment

The challenges described by the Ghanaian participants mirrored the challenges facing mainstream service delivery in the UK. The literature in the West identifies several similar challenges, including: differences in help-seeking and client engagement (e.g. Rwegellera, 1980; Commander et al., 1999; Bhui, 2001; Keating et al., 2002; Bhui et al., 2003; Morgan et al., 2005), difficulties gaining client trust and encouraging clients to disclose their beliefs (e.g. Nicholls, 2002), problems with cross-cultural diagnoses and formulating BME clients' difficulties (e.g. Littlewood & Lipsedge, 1981; Sashidharan, 1993), and trials associated with maximising the effectiveness of therapy (e.g. Sue, Fujini, Hu, Takeuchi & Zane, 1991) and managing higher than expected disengagement/relapse rates (Bhugra, 2001). A key challenge facing mental health services in the UK and Ghana is how to encourage African service users to buy into mainstream treatment approaches.

In the UK, research has indicated differences in terms of service use and over representation of ethnic minorities in secure settings for decades (e.g. Rwegellera, 1980; Commander et al., 1999; Bhui, 2001; Keating et al., 2002; Bhui et al., 2003; Morgan et al., 2005). These differences were explored more fully in the introduction to this project. Having documented how these potential service users do *not* make use of psychological services as readily, it seems strange that research is lacking that reveals where these clients *do seek help*. Research is necessary to indicate the prevalence, popularity and practices of healers operating outside mainstream service. There is currently very little literature on the use of traditional healers by ethnic minorities; and their use

by psychiatric patients has been little studied. If ethnic minorities interpret their symptoms according to worldviews that differ from Eurocentric ideas of illness, it follows suit that they would differ from the White majority in terms of how they use psychiatric services. The fact that research suggests that Africans are over represented in terms of forced admission to psychiatric services serves to support the hypothesis that a potentially significant variable is that of difference in help-seeking behaviour and interpretation of symptoms. In his study in Newham, Copsey (1997) made a similar conclusion:

> *'The belief system underpinning nearly half of Newham is grounded in non-Western culture. This culture has a long history of integration between the mind, body and spirit. Spiritual values are an essential part of life. There is no dichotomy between the secular and the spiritual. Life is sacred. The transcendent is part of life. Such a belief system permeates the whole of life. This is very hard for those with a Western worldview to understand. The history of both psychiatry and most psychotherapy is based on a worldview that has excluded the transcendent. If this fact were to be taken seriously, then we would attempt to initiate a dialogue between the two belief systems. My research over the last two years shows that no real attempt at dialogue on this crucial issue.'* (1997, p. 14)

Sashidharan states that if the observed ethnic differences in admission rates are not a result of real differences in prevalence, the statistics demonstrating variations in service use indicate institutional racism and are 'fundamentally to do with how European psychiatry discriminates against Black people' (Sashidharan, 2001). The data from this project suggests that a fundamental barrier to more equal rates of engagement could be the result of a clash of health beliefs, differences in help-seeking behaviour and the failure of mainstream services to effectively adapt interventions to be culturally sensitive.

The Ghanaian data revealed that Ghanaian mental health professionals perceived reluctance in some of their clients to disclose their explanatory models of their experience. In Ghana, traditional, spiritual and religious beliefs are rife. Whilst there is a lack of British research, it seems logical to suspect the same process could be observed here. The limited English research available has alluded to the fact that in the UK, service users fear that the professionals involved in their care do not understand their beliefs (e.g. Nicholls, 2002). A fear of disclosing health beliefs of culturally relevant ideas creates a serious obstacle to psychological therapy. This project emphasises the need to contextualise and understand a patient's interpretation of their experience. Over thirty years ago, Katon and Kleinman (1981) stated that a clinician's first task should be to understand a patient's explanatory model of their illness. Clinical training is currently inadequate to equip clinicians to meet this goal. Indeed, achieving this level of cultural

competency is both difficult and complex, and may oversimplify the obstacles between two starkly different worldviews that have little knowledge of each other (Koss, 1987). Clinicians must recognise their strong allegiance to their own treatment approach and culture (Koss, 1987). The Ghanaian data described a process of negotiation between endorsing practices that could be potentially harmful, and alienating clients that believed in these practices. Koss' warning of the complexity involved in finding a way to marry different approaches is valid and worthy of further research (Koss, 1987). The fact that Koss raised this issue in 1987, over a quarter of a century ago, and that it continues to be relevant, can perhaps be interpreted as a reluctance of the discipline to tackle such difficult questions that pose philosophical and ethical challenges to mainstream theory.

Another obstacle relating to a philosophical clash of worldviews and values relates to the difficulties of accurately diagnosing BME service users that present with alternative health beliefs. This research highlights the potential difficulties associated with using classification and psychological theory derived from one culture with patients from another culture. Ghanaian colleagues reported that traditional African explanations of mental illness could be an obstacle when formulating a client's difficulties using Western classification. In the UK, the over representation of African and Caribbean clients could be interpreted in a similar vein. Research evidence relating to the role of misdiagnosis was reviewed in the introduction of this project, and indicates that there are similarities between the experiences of health care professionals working in both the Ghanaian and English context. The research supports the hypothesis that some of the high incidence of schizophrenia amongst African and Caribbean residents in England is due to misdiagnosis by British psychiatrists unfamiliar with foreign beliefs (Littlewood & Lipsedge, 1981; Sashidharan, 1993). Hickling, McKenzie, Mullen and Muray's (1999) pivotal study to explore the role of ethnicity in differences in diagnostic attitudes raises serious questions about the ability to formulate client experiences cross-culturally. In Hickling et al.'s study, a group of patients diagnosed by British psychiatrists was then re-diagnosed by a Jamaican psychiatrist. Of the sample of 66 patients, 24 were White, 29 Black African-Caribbeans and 13 Blacks from other countries of origin. Of 29 African and African-Caribbean patients diagnosed with schizophrenia, the diagnoses of the British and the Jamaican psychiatrists agreed in 16 instances (55%) and disagreed in 13 (45%). The British psychiatrists diagnosed 55% of the Black patients as having schizophrenia and the Jamaican psychiatrist 52%. Whilst the sample size was relatively small, the fact that the diagnoses of the British psychiatrists and the Jamaican psychiatrist agreed in only 55% of cases indicates that the routine clinical diagnosis of schizophrenia is not a reliable one, and highlights the importance that culture plays in the process of assessment, formulations and diagnosis.

Sharpley, Hutchinson, McKenzie and Murray (2001) provided further support to research that

questioned the construct validity of Western diagnostic tools, suggesting that when African and Caribbean patients meet the criteria for schizophrenia, there may be different implications in terms of prognosis when compared to White patients. The significance of this statement cannot be overstated. It is plausible, based on the current research evidence, that British psychiatry pathologises experiences that have cultural relevance and meaning to those with alternative worldviews. Several theorists have argued against the validity of schizophrenia as a scientific concept (Slade & Cooper, 1979; Bentall, Jackson & Pilgrim, 1998; Ullmann & Krasner, 1975; Szasz, 1976), arguing against a unitary model of psychosis and disease-orientated approaches. Kleinman (1978) rejected the physicalistic reductionism of the biomedical model, and emphasised that psychological 'illness' often refers to a person's perceptions and experiences of certain socially disvalued states.

The problems associated with diagnosis when diagnostic tools are either culturally specific or lacking scientific validity could be avoided by the discipline opting for symptom-orientated research and clinical formulations (Bentall, Jackson & Pilgrim, 1988; Bannister, 1968; Persons, 1986; Slade & Cooper, 1979). Sashidharan calls for research to move away from a sterile interest in explaining differences in prevalence, towards challenging and addressing the cultural and historical specificity of psychiatry, in particular the theoretical underpinning of diagnosis and classification (Sashidharan, 2001). As recent research with voice hearers suggests, not all unusual experiences are pathological (Jackson, 2001; Jackson & Fulford, 1997; Romme & Escher, 1993; Romme, Honig, Noorthoorn & Escher, 1992).

Negative experiences of services and higher than expected rates of disengagement are other challenges likely to result from a clash of cultures. Like the Ghanaian data, research suggests that in the UK, client disengagement, poor compliance with medication and aversion to treatment are common amongst ethnic minority groups (Bhugra, 2001). Low adherence to recommended treatment behaviours amongst ethnically and racially diverse patients is, to some degree, due to limited levels of culture-related knowledge, skills, experience and awareness demonstrated by their health care providers (Shapiro, Hollingshead & Morrison, 2002). If service users' health beliefs differ from Eurocentric explanations of their experiences, it is likely they will not have much confidence in mainstream services. Studies suggest that African Americans who are high in cultural mistrust tend to have more negative views and expectations of White clinicians (Grant-Thompson & Atkinson, 1997; Nickerson, Helms & Terrell, 1994; Poston, Craine & Atkinson, 1991; Terrell & Terrell, 1984; Thompson, Worthington & Atkinson, 1994; Watkins & Terrell, 1988; Watkins, Terrell, Miller & Terrell, 1989). This has implications for meaningful psychological therapy and also raises questions about whom any positive outcome is attributed to. If a patient benefits from psychological therapy and/or pharmaceutical interventions but attributes the outcome to another source in keeping with alternative health beliefs, they may still disengage or seek help elsewhere if they relapse.

Another potentially similar challenge (although further research is required within the Western contexts) relates to the risks associated with alternative healing practices. The Ghanaian mental health professionals involved in this study identified several facets of risk associated with alternative healing practices. However, there is very little research in the West regarding alternative healing practices and psychiatric disorders. In 1998, Larkin wrote about preventable child fatalities in the USA associated with faith healing, warning that even if laws were stricter, those with strong religious or spiritual convictions that refuse to access medical care for their children were unlikely to change their actions. In the UK, the media attention given to the high-profile child deaths associated with witchcraft and magical/spiritual African worldviews has sparked an interest in safeguarding issues and culture; however, clinicians trained within a Eurocentric approach learn little in terms of alternative healing approaches and are probably naive to the potential risks associated with such practices. Enough basic knowledge is required of the clinician for them to create an open dialogue about alternative health beliefs and help-seeking behaviour for an adequate assessment of risk to be conducted, and to be able to explore the positive aspects of such practices.

There is still much ignorance surrounding culturally specific health beliefs and healing approaches, and it is necessary for psychology as a discipline to address the gaps in our knowledge. Generalising information from one context to the other is impossible. Just as African Christianity incorporates traditional African ideas, it seems likely that traditional, spiritual and alternative models of healing in the UK differ from their indigenous contexts. Aspects of harmful practice related to lack of resources, e.g. one would suppose the images of patients pinned down by tree trunks are context-specific. However, a belief that whilst possessed or cursed, poor treatment will not harm the person themselves, but the spirits within them, can result in the risk of physical harm being posed:

> *'It is not generally thought in West Africa that the physical substance of a man's body is greatly injured. But it is the essence ('kra, soul, in the Twi language group) which is thought to be harmed or removed.'* (Parrinder, 1951, p. 13)

Similarly, risk of psychological harm and stigma and blame are real if psychological distress or illness is explained in moral, spiritual or religious models. The idea that illness is the result of a sin or wrongdoing, and that God punishes individuals as penance, has serious psychological implications. Magical explanations that presume illness can be caught, or that another has cursed a person, also maintain social isolation for the sufferers.

Special interest in terms of risk prevention has been demonstrated but not within mainstream psychology. Project Violet is a Metropolitan Police initiative dedicated to safeguarding children

from sacrificial or magical practices that can cause harm (Metropolitan Police, 2010). However, the distance between the two worldviews at present is not conducive to information-sharing about models of best practice and safety. If the Ghanaian data offers advice, it is that safeguarding initiatives should be done in conjunction with relationship-building, collaborative service development and information-sharing. Ghanaian respondents in this study encouraged collaboration, whilst warning that negotiating boundaries between disciplines raises some ethical and practical questions.

B.13.3. The obstacles are similar but the *relationship* is different

One of the most striking advantages of the Ghanaian context relates to the ease in which Ghanaian mental health professionals were able to explain the different types of traditional/spiritual/alternative healer aspects of traditional healing practices and service users' explanatory models. They described positive aspects of alternative healing and accepted that alternative healing approaches had a place in Ghana. The Ghanaian mental health professionals occupied multiple positions in terms of their worldview, and could intuitively interpret and modify Eurocentric theory to the Ghanaian context. This congruent process of faith and fact being able to co-exist would be difficult to achieve in the UK. There are several obstacles to negotiate if we are to achieve a better relationship with knowledge that exists outside of our own system. We must address our ignorance surrounding cultural health beliefs and alternative healing approaches.

There is an absence of research that qualitatively or quantitatively explores psychologists' understanding of alternative health beliefs and alternative healing practices. In Ghana, practitioners' understanding of alternative models of illness and healing resulted from operating within a shared culture, *and* was aided by clinical training. In the UK, training on issues relating to culturally competent practice is inadequate and specific training on models of treatment operating outside mainstream ideas are not common (Singh, 1999). The diversity and spectrum of ethnicities and cultures within the UK arguably make this process more challenging than in the Ghanaian context.

Whilst there are many examples indicating an uncomfortable relationship between mainstream psychological theory and alternative worldviews, there are also examples of psychologists that are actively encouraging reaching out to, and learning from, alternative healing approaches (Swinna, 2005; Sollod, 2005, West & Moodley, 2005). Koss-Chionio (2005) proposes that the active ingredient in traditional healing is worthy of more exploration. Koss-Chioino suggests

that emotion-regulation processes are a component of spiritual healing and that by manipulating the environment and uninhibited expressed emotion, patients learn to regulate emotion. Part of the appeal of traditional or spiritual healing is that it offers holistic treatment that incorporates the patient's spirituality, faith and culture; and psychology should integrate knowledge that resonates with the service users it currently discriminates against.

B.13.4. Lessons for the UK

Having presented the areas of overlap in terms of challenges facing psychologists and mainstream services in both the UK and Ghana, and having explored how these systems differ in the way they relate to knowledge that exists outside of mainstream/Western theory, the next section explores the relevance of this project to psychologists operating within multicultural Britain. Some of the data suggests practical suggestions for service modification, many of which provide support to research conducted in the UK.

The lack of a shared reality between western and traditional approaches is a serious challenge to effective cross-cultural therapy (Vontress, 2001, 2005). This project offers valuable information about *how* Ghanaian psychologists interpret and utilise Eurocentric theory and practice in the Ghanaian context. The strategies that the Ghanaian mental health professionals suggested can aid work with this client group include: involving family members in therapeutic interventions, ways of modifying interventions, ways of incorporating spirituality into treatment plans and therapy, and strategies to increase client confidence by educating the client (and the stakeholders in the treatment) about Western treatment approaches and models of illness. The data also revealed ideas for community work, collaboration between approaches, improving clinical training and revising the law.

B.13.4.1. Involve family members

Ghanaian clinicians recognised family members as significant stakeholders in a patient's treatment. They explained that family members impact a patient's help-seeking behaviour and that their fear of mainstream services or lack of knowledge about the role of Western approaches may maintain a patient's reluctance to engage early on with medical facilities. In the UK, research suggests that relatives of Black patients often feel unable to participate in treatment decisions and report little help from services (Sashidaran, 2003; Arksey et al., 2002, DoH, 2002). Carers expressed a desire to remain involved in all aspects of care and they wished

to be listened to, especially when the professional agencies are unaware of the cultural needs of minority groups (Newbigging, 2000). Research indicates that relatives of Black patients are sometimes concerned about the administration of large doses of medication, in particular anti-psychotic medication (National Association for Black Mental Health, 2002). Much research highlights the need to involve family members more in the treatment of a patient, although much of the research is anecdotal; there is a need for further research to explore the experiences of families and carers.

Even in family therapy there seem to be cultural differences in how professionals are experienced. Warren et al. (1973) reported that Black parents felt alienated and misunderstood by their family therapists and saw family therapy as less helpful than White families. Hall and Sandberg (2012) conducted qualitative research that explored how African Americans overcame barriers to engage in family therapy. Whilst their findings highlighted structural barriers (affordability, accessibility and availability), attitudinal barriers were also identified (stigma, mistrust, the desire for privacy and the resistance of a family member to engage in therapy). There were several factors that could help minimise these barriers; the impact of friends and family in shaping the decision to engage in therapy was emphasised. Supportive and non-supportive messages from friends and family were identified (Hall & Sandberg, 2012). The clinical implications of this study emphasise that time spent with the family, explaining treatment approaches and involving them where possible, are likely to be experienced positively by African service users.

Singh (1999) suggested that if a patient brings a relative or friend to counselling, the therapist should allow the patient to invite them into the room and actively involve them in the session. Increasing family members' understanding and confidence in the treatment approach can result in the family members acting as 'allies' that can encourage a patient to engage in services (Singh, 1999). Bhatti and Varghese (1995) explored family therapy in India and reported that the involvement of family members reduced the duration of hospitalisation, increased the family's acceptance of the patient and enhanced family coping.

Further research should be conducted in Britain to understand *how* to involve a patient's support system more effectively, with the aim of improving service user experience and engagement. This preventative strategy could reduce the heavy financial implications of the over representation of Black service users in long-stay involuntary admissions. Systemic and family therapists offer a perspective on this issue that could be useful in informing policy development (e.g. Hall & Sandberg, 2012). Family therapists have led the way in identifying that work with African Americans should employ a 'strengths perspective' instead of focusing on pathology (Bell-Tolliver, Burgess & Brock, 2009). The strengths, Bell-Tolliver et al. suggest, should be

the focus of therapy, and include things like recognising strong kinship bonds, strong religious orientation and adaptability of family roles. Bell-Tolliver et al. propose that recognising these values and beliefs can help build trust between clinician and client (Bell-Tolliver et al., 2009).

Whilst family therapy may be an appropriate treatment option for our African clients, within mainstream services this fact raises challenges. In an individualistic society, the law serves to reinforce the autonomy of over-eighteens. They are adults and are entitled to access services confidentially. There are ethical and legal implications of working systemically for some, including knowing when it is appropriate to involve the family, and how to recognise the family as stakeholders in the treatment whilst negotiating our professional guidelines that respect client wishes and a right to confidentiality as an individual. Procedural solutions could be to offer clients the option of engaging in family work, and/or asking clients to consent to information being shared with their family. Neither cultural norm should be imposed on a client, and strategies should reflect an emphasis on patient-centred care.

B.13.4.2. Modify interventions

The Ghanaian clinicians in this study modified Western psychological interventions to meet the needs of their patients. This research supports others in suggesting that for African clients, modifications could include involving family members more, educating patients and their families about our approach and encouraging them to share their explanation for their experience by creating a therapeutic relationship that is respectful, collaborative and willing to incorporate a person's spirituality. International research offers support to the idea that CBT can be adapted to be more culturally sensitive (Rathod, Kingdon, Phiri & Gobbi, 2010; Wilson, 2009; Rathod, Phiri, Harris, Underwood, Thagadur, Padmanabi & Kingdon 2013; Hays, 1995) and can involve spirituality (Rosmarin, Auerback, Bigda-Peyton, Björgvinsson & Levendusky, 2011). It is suggested that adaptations in content, format and delivery are needed before CBT can be employed in non-Western cultures (Naeem et al., 2011) and therefore in the UK with non-Western clients. It is necessary to first understand sources of conflict between the cultural values of ethnic minorities and the more mainstream values often underpinning conventional psychotherapies (Nagayama-Hall, 2001).

A pilot scheme aimed at developing CBT to be more culturally sensitive in the treatment of psychosis for ethnic minority patients (specifically Black British, Black Caribbean, Black African, Bangladeshi and Pakistani) reported findings that seem remarkably similar to the findings of this research (Clinical Trailblazers' programme, Hampshire Partnership NHS Foundation Trust, cited in Wilson, 2009). The study documented differences in health beliefs, help-seeking behaviours and pathways which influence their choices on whether to engage with

mainstream services or revert to traditional approaches, and suggested strategies to make CBT more culturally sensitive. More pre-engagement, an understanding of a perspective where family and religion are at the centre of a person's thinking and an understanding of a client's cultural background were highlighted as important factors. Again, much like this research, the issue of culturally specific expectations of the therapeutic relationship was raised, as some of the people interviewed saw the therapist as the 'expert' and expected them to have all the answers (Wilson, 2009). A similar study in America found CBT could be successfully modified for African-American women by adding 'culturally specific therapy modules' such as 'spirituality/ religiosity' 'family issues' and 'healthy relationships' (Kohn, Oden, Munoz, Robinson & Leavitt, 2002). Research has supported the idea that when cultural factors are recognised in therapy, African-American clients are more likely to rapport positive outcomes (e.g. Sue et al., 1991).

Modifying interventions involves understanding what matters to a client, and also involves understanding a client's expectations of therapy and the therapeutic relationship. Jenkins (1991) reported that African-Americans preferred a more 'interpersonal' relational style with mental health clinicians, particularly during the early stages of engagement. In a more recent qualitative study, researchers found cultural differences in the relational preferences of ethnicities, suggesting African Americans placed an emphasis on feeling like their clinician listened to them and 'trusted their own knowledge about themselves' (Mulvaney-Day, Earl, Diaz-Linhart & Alegría, 2011, p. 37). The study also found there to be cultural differences in how people viewed the social position of the therapist. The evidence suggests that modifying interventions to meet the cultural needs of clients is complex, and likely to impact even the earliest expectations for contact. Clinicians can modify communication styles, and create space for culture, if they are equipped with enough information to feel confident doing so.

Successfully modified CBT should help inform policy development, and efforts to develop more culturally sensitive psychotherapies should be encouraged. African practitioners have tried to develop different forms of psychotherapy that fit the clinical context in Africa, and these theories may offer something to culturally sensitive service development. Ebigbo et al. (1995) developed 'Meserun Therapy' and 'Harmony Restoration Therapy'. Binitie (1991) described 'Psychotherapy Through Environmental Manipulation', which is inspired by the recognition that some symbolic rites prescribed by alternative healers are forms of environmental manipulation of psychotherapeutic values (Binitie, 1991; Prince, 1961; Aina, 2006). The dissatisfaction with the discipline's ability to incorporate values and beliefs operating outside Eurocentric culture, and the relationship between Black people and mainstream psychology, has resulted in separate branches of psychology which can be understood in terms of the historical context. However, the statistics demonstrating the degree of multiculturalism in Britain

highlight the need to integrate cultural psychology into the mainstream. Psychologists currently involved in 'Black psychology' and 'African psychology' should be viewed as a resource for learning how we can modify existing services, and develop new, more culturally sensitive, treatment options that clients would be willing to engage in.

B.13.4.3. Incorporate spirituality

In the earlier chapters of this project, research was cited that suggests that our African clients feel alienated if they feel their spirituality or religiosity is not accepted (e.g. Copsey, 1997; Nicholls, 2002). This project further described the way Ghanaian mental health professionals recognise spirituality as a significant component of their work, and how they incorporate spirituality into their practice. However, the duality of Ghanaian mental health professionals' own allegiances enables this process to be done intuitively, organically and congruently. What, then, for British psychologists without faith? The scientist/rationalist paradigm has exerted a powerful influence on the development of healthcare practices (Capra, 1983; McSherry & Draper, 1998; Swinton, 2001), and spirituality does not easily fit in with the professional and secular image of the discipline (West, 2000). MacDonald and Holland (2003) reviewed literature and concluded that, currently, the discipline of psychology has not yet given spirituality enough attention.

In Cook, Powell and Sim's book, *Spirituality and Psychiatry*, the authors describe psychiatry's gradual shift from a time when much psychiatric care was provided within a spiritual or religious context to the middle 20th century where realism, science and modernism dominated medicine (Cook et al., 2009). '*The God Delusion*' is a text that represents this position: Dawkins questions why intelligent human beings persist in holding beliefs that are seemingly irrational or inconsistent with empirical evidence (Dawkins, 2006).

Cook et al (2009) pointed out that over two-thirds of the UK population have a stated religion, 93% of whom are Christian. In contrast with the general population, only a minority of psychiatrists in Britain hold religious beliefs: 73% of psychiatrists reported no religious affiliation, as compared with 38% of their patients, and 78% attended religious services less than once a month (Neeleman & King, 1993). Research documents similar low levels of religious beliefs and affiliation amongst psychologists (Ecklund & Scheitle, 2007), suggesting we are the least religious of all scientists (Gross & Simmons, 2009). These statistics suggest that because religion does not feature within mental health professionals' own values, it is neglected. However, Gubi (2007) suggests that practitioner vulnerability may account for some of the reluctance for spirituality not being better encompassed by psychology.

Swinton alerts us to the need for practitioners to be willing to feel comfortable with uncertainty and suggests thoughtfulness, flexibility and creativity are required to explore the spiritual side of a person (Swinton, 2001). There are several action-orientated strategies described by the data collected for this research, and from other literature. A culturally competent clinician should recognise several things about spirituality: it should be asked about during the assessment (Cornah, 2006; Swinton, 2001), there should be space for it within sessions (Crossley & Salter, 2005; Clarkson, 2002; King-Spooner, 2001; Purton, 1998), they should feel comfortable encouraging the client to engage with religious/spiritual figures and that the clinician should have enough knowledge of a person's worldview to be able to sensitively reframe their beliefs without pathologising, dismissing or ignoring them. This issue is complex. A failure to incorporate spirituality and religiosity can mean clients with strong religious beliefs may be wary of seeking therapy in non-religious settings because of such fears (Mayers, Leavey, Vallianatou & Barker, 2007; Coyle & Lochner, 2011), and if they do engage, they may be unwilling to disclose potentially intimate material during assessment, especially if they fear that this might be evaluated negatively (Coyle & Lochner, 2011).

Spirituality is increasingly being included as a component of psychological treatment, although the statistics demonstrate that this is a less congruent process to that described by the Ghanaian data (instead of operating within a shared faith). Neeleman and King's study suggests 92% of psychiatrists in Britain believed that religion and mental illness were connected and that religious issues should be addressed in treatment (Neeleman & King, 1993), which seems to contradict the statistics which suggest mental health professionals are some of the least religious of individuals. How can non-religious clinicians incorporate spirituality into their treatment? What guidelines are there for this process? Does clinical training adequately equip practitioners to work with religious beliefs? What is the evidence that guides how spirituality can be incorporated into psychological therapy?

Research suggests that many clinicians report waiting for a client to raise spiritual issues (Crossley & Salter, 2005), an approach which is problematic for a number of reasons. Pargament (2007) recommends using a few basic questions to explore the salience of spirituality and religious affiliation of the client. This should involve more than asking about whether the person is 'religious': the clinician should be flexible and help service users to identify those aspects of life that provide them with meaning, hope, value and purpose (Cornah, 2006).

Research emphasises the importance of a therapeutic space that enables the client to bring in issues relating to religion or spirituality (Clarkson, 2002; King-Spooner, 2001; Purton, 1998). West (2000) proposes that the therapeutic space can be viewed as a spiritual space and that recognising this fact can enable dialogue. Clinicians must explore a client's belief system

proactively, which is not yet a component of standard practice (Coyle & Lochner, 2011; Pargament, 2007). Instead, they have tended to regard religious beliefs and practices as lying outside the remit of the clinical encounter, or as part of pathology when these are implicated in clients' problems (King- Spooner, 2001: Coyle & Lochner, 2011). This research project joins others in emphasising that mental health professionals must avoid pathologising, dismissing or ignoring the religious or spiritual experiences of service users (Cornah, 2006). For this to happen, assessments and sessions must incorporate a person's spirituality, and the mental health professionals' training should equip them to understand the beliefs associated with different cultures, religions and faiths.

The Ghanaian data emphasised the importance of homing in on the positive aspects of a belief. Other literature suggests there are many ways that spirituality and religion can improve mental health outcomes (Koenig, 2005; Bergin, 1988; Larson, Swyers & McCullough, 1997; Martsolf & Mickley, 1998). Cook et al (2009) argue that 'pathological' forms of spirituality could be detrimental to treatment. How, then, do psychologists feel confident harnessing the positive aspect? Crossley and Salter (2005) researched clinical psychologists' experience of addressing spiritual beliefs in therapy. The study reported responses to religious or spiritual issues raised by clients ranging from withdrawing from the client, referring the client on to a religious or spiritual practitioner, and reframing the belief with the client. Coyle and Lochner (2011) describe the latter strategy as a 'complex response' that requires the clinician to have considerable knowledge of the client's belief system. Thus, the issue of relevant clinical training that adequately equips clinicians with the skills to have an informed dialogue with their service users is revisited. This needs to be accompanied by training for supervisors so that practitioners can feel comfortable and confident in exploring religious and spiritual issues within supervision (Aten & Hernandez, 2004; Coyle & Lochner, 2011).

The Ghanaian data suggests clinicians can encourage clients to engage with religious practices as a behavioural activation tool and to harness the positive aspects of a person's spirituality or faith. Interestingly, Gartner, Larson and Allem (1991) found behavioural measures of religious participation were more powerfully associated with mental health than attitudinal measures. Other evidence shows a positive association between church attendance and lower levels of depression amongst adults, children and young people (Cornah, 2006). Prayer can be viewed as a therapeutic tool (Ulanov & Ulanov, 1982, 1992; Leech, 1980; Gubi, 2000): it can move one's locus of evaluation, fostering authenticity and self-worth (Gubi, 2007) and encourage forgiveness and confession (Ulanov & Ulanov, 1982). The Ghanaian data documented that some Ghanaian psychologists ask the client if they can pray for them, whilst others described encouraging the client to talk to God to increase their perceived resilience. The limited available research suggests prayer can impact recovery (Palmer, Katerndahl & Morgan-Kidd, 2004; Chibnall, Jeral & Cerullo, 2001; Cha & Wirth, 2001). Much research points to the fact that

prayer is beneficial to mental well-being (e.g. Davis, 1986; Herbert, Dang & Schulz, 2007; Tuckwell & Flagg, 1995), although Dossey (1993) suggests these studies do not prove the credibility of prayer, as it is a concept that is difficult to measure scientifically. However difficult it is to measure, and however difficult it is to marry conceptually with the philosophical underpinnings of psychology, prayer has been used to aid coping with difficult life experiences for a long time (McCullough, 1995). Much more research is required to establish the usefulness of prayer, and to provide clinicians with clinical guidelines. At the very least, treatment should involve a client being offered access to safe spaces where users can pray, meditate, worship or practice their faith (Cornah, 2006).

The Mental Health Foundation commissioned a review of the literature and concluded that the potential benefits of spiritual and religious expression and activity should not be overlooked by those in mental health services (Cornah, 2006). Negotiating boundaries between disciplines may be challenging and require careful handling so that religion is not imposed on to clients or potentially vulnerable people. However, it is important to provide opportunities for service users to discuss their spirituality or religion with others, and to ensure that all service users, including those who do not regard themselves as spiritual or religious, are offered the opportunity to speak with a chaplain or other spiritual leader if desired (Cornah, 2006). A failure to do this could be viewed as an imposition of the discipline's lack of spirituality. Other literature expands on the issue of clinicians' own cultural bias by highlighting that many non-religious clinicians hold a misconception that religion is associated with negative things such as guilt (Lowenthal & Lewis, 2011), and as Coyle and Lochner argue, 'within Western liberal social discourse, religion has often been associated with negative qualities such as conflict, control, judgementalism and anti- intellectualism' (Coyle & Lochner, 2011, p. 264). There is a fear amongst clinicians that religious beliefs encourage experiences of voices, visions and demons, and that despite research illustrating zero or negative correlation between measures of religiosity and schizotypy (e.g. Joseph & Diduca, 2001), religious beliefs and practices can be misdiagnosed (Lowenthal & Lewis, 2011). There is a challenge implicit in preventing bias from our own spiritual, religious or non-religious beliefs from taking precedence over professional practice whilst taking action to promote religious and spiritual tolerance, liberty and respect (Altermeyer, 2003). Research suggests that understanding and respecting patient/client spirituality and religiosity are important in conducting culturally sensitive research, psychological assessment and treatment (Hathaway, Scott & Garver, 2004; McCullough, 1999; Richards & Bergin, 1997; Worthington & Sandage, 2001). However, *how* to do this without stepping out of our professional training raises serious challenges and calls for further debate between religion and psychology.

Further research is required in this area. However, within psychology, religion is often treated as a peripheral special interest. Collicutt (2011) suggested psychologists specialising in the

areas of religion feel the area lacks credibility, and research suggests that the 'repression of religion' (King & Dein, 1998) also impacts the discipline (Sherill & Larson, 1994; Swinton, 2001). Indeed, this project joins other literature in highlighting that the nature and location of the boundaries between mystical and psychotic experiences are blurred (Coyle & Lochner, 2011; Loewenthal & Lewis, 2011). This is an area of continuing debate.

Many people with mental health problems want their spirituality recognised within their treatment (Swinton, 2001). The limited available research suggests that spiritually integrated psychotherapy may be desired by, and be beneficial to, a subset of our clients (e.g. Rosmarin et al., 2011). Regardless of any personal scepticism, a respectful, postmodern acknowledgement of the validity of alternative explanatory frameworks may be essential for therapeutic progress (Cook et al., 2009). As Bergin and Payne (1991, p. 201) put it:

> *'Ignorance of spiritual constructs and experience predispose a therapist to misjudge, misinterpret, misunderstand, mismanage, or neglect important segments of a client's life which may impact significantly on adjustment or growth.'*

Perhaps the future for research in the longer term will explore the benefits of indigenous African values and culture to be incorporated in the next wave of therapeutic interventions? Holistic treatments are becoming more popular in the West (Singh, 1999). The recent popularisation of Third Wave approaches (e.g. Hayes, Strosahi & Wilson, 1999), with its roots in ancient eastern philosophies, gives hope that the future of the discipline will incorporate the culture and beliefs of the vast African continent.

B.13.4.4. Increase client confidence

The Ghanaian data suggests a vital component of psychological work with a client whose health beliefs differ from our own treatment approaches is to increase the client's confidence in the service, which is necessary to address attitudinal barriers to positive service experience. Many modified interventions for clients of African descent suggest that developing trust (Willis, 1988) and increasing client confidence (Hines & Boyd-Franklin, 1982) are important issues. Acknowledging that Black service users may be less socialised to the idea of therapy than their White counterparts should result in the clinician taking time to explain their approach and what they are trying to achieve (Grevious, 1985) so that they increase their understanding that there is something to be gained by not disengaging (Willis, 1988). Carers want information on the illness and how they can help support their patient relative (Sashidharan, 2003): educating family members can serve to increase their confidence in the treatment approach and to reduce

the likelihood of family members reinforcing beliefs that undermine mainstream treatment (Singh, 1999). Whatever strategies are employed, the expectations African service users might have for treatment may differ, which is an important issue to recognise and manage.

The Ghanaian mental health professionals also spoke of offering their clients testimonials of other clients that had been treated successfully with their approach, and involving family members as 'allies' in their treatment plan. Whilst there are ethical issues associated with incorporating 'testimonials', it is an interesting idea and one approach to improving this client group's perception of the discipline. The word-of-mouth recommendations works for other healing approaches, so perhaps an alternative strategy could involve focusing on improving the experience of the BME clients we have, to hope their experiences create a ripple effect of people willing to engage in services earlier.

Some theorists suggest that it is factors like discrimination and racism that result in Black service users placing their trust within their kinship and church, rather than external professionals (McAdoo, 1977). Since counsellors or mental health professionals are considered outsiders (Willis, 1988), they may be viewed as a threat, resulting in Black service users being less willing to disclose personal thoughts (Boyd-Franklin, 1984).

B.13.4.5. Working in the community

This research project suggests a vital strategy to getting clients to engage in mainstream services in Ghana relates to proactive community engagement strategies. The Ghanaian mental health professionals described the importance of effective links with religious and spiritual groups in the local community, a sentiment echoed by British research (Copsey, 1997; Cornah, 2006; Jassi, 2008).

In the UK, the introduction of Community Development Workers (CDWs) demonstrates an attempt to engage the community and address attitudinal barriers to engagement in mainstream health services, addressing stigma and educating people about psychological/ psychiatric models and treatment approaches. One CDW wrote about the importance of engaging community members and religious leaders, stressing the importance of joint work both within planning and service provision (Jassi, 2008). Community workers are in a position to forge links with local community faith leaders and healers, which could be vital in effective collaborative service development, community education and addressing stigma and ignorance surrounding mainstream services. Similarly, the voluntary sector in this country has led the development of culturally appropriate services for minority ethnic groups; collaboration with local voluntary services offers another way of engaging with the community (Sashidharan, 2003). The research

indicates a recognition that community involvement is a key component in addressing inequalities in service use and service experience. It is hoped that mainstream services will continue to learn from the community they serve.

B.13.4.6. Clinical training

As in Ghana, training establishments should recognise the importance of equipping clinicians with enough basic knowledge to feel confident to have dialogues with clients about their spirituality and health beliefs. Clearly, in multicultural Britain, this process is more complex. It would be impossible to cover the specifics of the myriad of cultures and beliefs that exist, none of which are static or fixed; however, clinicians should be taught to recognise their allegiance to their own approach and culture, and learn to incorporate belief systems that differ from their own. The Ghanaian data referenced the fact that clinical training involved lectures about traditional African healing practices and encouraged visits to local healing centres.

In the UK, training and education of the workforce is one important way of addressing inequality within the health service (Sashidharan, 2003; Jassi, 2008). The Department of Health action plan, 'Delivering Race Equality programme', identified a need for training materials to aid cultural competencies of staff (DoH, 2005). The Race Equality and Cultural Capability (RECC) training materials and the Race Equality Cultural Awareness Programme (RECAP) were developed to help mental health professionals develop their knowledge and understanding of racism and cultural differences, and promote positive work in the area of cultural difference (Department of Health, 2005).

Professional training is, at present, devoid of a cultural component and training leading to professional qualifications should include cultural competency components as a minimum requirement (Sashidharan, 2003). Similarly, employers should ensure employees' continuing professional development activities include adequate preparation to practice in a multicultural context (Sashidharan, 2003). Experts in the health field suggest that there is a link between both cultural competence and cultural sensitivity and the elimination of racial and ethnic health disparities, as increased cultural competence and sensitivity on the part of the provider often results in positive health outcomes for the patient (Betancourt, Green, Carrillo & Park, 2005).

B.13.4.7. The law

The mental health professionals in Ghana voiced a need to regulate healers and distinguish between safe and unsafe healers. They described government strategies that aimed to regulate alternative healers. Participants described a licence that alternative healers could apply for which helped them be identified. Internationally, the WHO (2002) report on traditional medicine calls for policymakers to develop national policies on traditional medicine with specific regulatory capacity. The paper highlights that scientific evidence is lacking regarding the safety and efficacy of some of these approaches and suggests practitioners of traditional medicine should have to register for a licence, be regulated and work safely, supporting clinical research to develop national standards (WHO, 2002).

In the UK, laws like those outlined in the Health and Safety Act, Environmental Health and the Consumer Protection Division may impact healers setting up a practice as they apply to anyone offering a service for money. Similarly, the local authority may require licences and/or a published code of conduct for the practice. The NHSTA offers a directory of Complementary and Alternative Practitioners and is an association of the NHS Trusts. However, currently, associations and forums for healers operating outside mainstream (NHS) services exist (e.g: the European Herbal and Traditional Medicine Practitioners' Association, the National Federation of Spiritual Healers, the Unified Register of Herbal Practitioners and the Healer Practitioner Association) but seem to offer an appealing way for healers to share information and gain business. It is unclear if faith healers without formal qualifications are registered with or regulated by any governing body. Research is necessary to explore *who* is offering informal or formal treatment for those with mental health problems in specific contexts, and what such interventions involve.

Whilst it seems imperative to identify and understand healing approaches that exist outside the dominant mainstream health care system, the issue of whether legal restrictions would result in more secrecy of healing approaches is a concern (Larkin, 1998). The message from Ghana suggests that the implicit power imbalance between worldviews can result in strategies that aim to improve the safety of healing practices being viewed as an endorsement of such practices. Similarly, if not handled sensitively, attempts to regulate healers could force practices further underground and alienate the people that we should be trying to collaborate with. The Ghanaian data suggests that whilst legal constraints might help protect vulnerable people from harmful practices, the best strategy to reduce risk and address attitudinal barriers to mainstream/medical treatment has to be done via community-based collaborative strategies that offer mutual learning. The discipline must attempt to bridge the gap between approaches, rather than increase the distance between us.

B.13.4.8. Collaboration

In Ghana, the respondents described collaborative strategies they felt benefited their clinical practice. Individual clinicians described reaching out to healers in the community who had their patients' confidence. Many participants mentioned an organisation, 'BasicNeeds', as the driving force behind collaboration. Its model had five key stages: identify the traditional healers, build relationships with these healers, encourage experience sharing and good practice, teach healers about Western approaches and encourage regular interactions and reviews across disciplines.

In the UK, Community Development Workers were introduced to bridge the gap between BME communities and health and social care services. Christie (2003) reviewed voluntary sector services that have successfully engaged Black service users and identified a number of recommendations for good practice, including outreach work to engage positively with people and involving families and the community in care. These strategies represent a similar model of working to that described by BasicNeeds.

Dr Nigel Copsey describes his work as 'co-ordinator for spiritual, religious and cultural care in the mental health services of East London' and highlights that within his trust, the multi-disciplinary team represents a mixture of faiths and ethnicities that are working to forge links with the community and train staff to become more sensitive to the spiritual and cultural needs of service users (Copsey, 1997). Copsey depicts a philosophy of collaboration and attempts to develop partnerships with community groups, including faith groups and spiritual resources, relevant to mental health care. Others have led the way in generating ideas for integration between traditional healing and psychotherapy (e.g: Sima, 2005; Anderson, 2005; Sollod, 2005; Moodley & West, 2005). In their book '*Integrating Traditional Healing Practices into Counseling and Psychotherapy*' Moodley and West explore various healing approaches and highlight potential links between traditional healing and psychotherapy (Moodley & West, 2005). In Paris, Nathan has developed an effective service for immigrant clients by integrating traditional and modern methodologies, adopting some of the techniques used by traditional healers (Nathan, 1993, 1994). Such schemes offer valuable experience regarding the complexities and challenges of marrying different approaches and could be used to inform similar projects. In America, many African American therapists have expressed interest in traditional African healing, suggesting that they would like to learn how to incorporate some aspects of traditional healing in counselling (Vontress, 2005). This research supports other research that suggests there are benefits associated with alternative healing which need to be better understood and applauds efforts to harness the active ingredient thought to be associated with some traditional African healing practices. There is no place for a predominantly

Eurocentric approach to the delivery of physiological therapies, and alternative approaches must be explored and integrated into the mainstream.

There is very little available research to gauge the willingness of alternative healers and religious/ spiritual leaders to work with psychologists. Vassol (2005) reported that African-American pastors were concerned about the mental health of their congregation and were willing to work with mental health professionals. Other research highlights the need to collaborate with African churches due to the importance of these churches to the community (McRae, Thompson & Cooper, 1999; Sanford, 2010). If potential service users are seeking help at religious or spiritual sources, the type of information they get will significantly impact their experience and likelihood of engaging at mental health services. Stanford (2007) assessed the attitudes and beliefs that mentally ill Christians encountered when they sought help at their church. The study concluded that 30% of the Christian sample experienced interactions that were counterproductive to successful treatment. Attributing blame, or feeling dismissed, were common accounts. Stanford and McAlister (2008) explored the perceptions encountered in the local church by 85 individuals diagnosed with a mental disorder and found that the church had dismissed the diagnoses of a significantly large number of the study's participants (41.2%). More work should be done to maximise the potential positives associated with religious support, and to reduce the amount of religious leaders who are not well informed about mental illness and relevant services: 'education and collaboration are our best tools to overcome this problem' (Stanford, 2007, p. 448). Future efforts to bring the mental health and faith communities together must focus more on the specific conservative and charismatic doctrinal issues that presently limit such collaborations (Stanford & Philpott, 2011; Stanford, 2007; Stanford & McAlister, 2008).

B.13.5. Conclusion

This chapter explores the similarities and differences between this research and research from the UK. The intention is not to directly generalise information from one context to another, but the apparent overlap is interesting when reflecting on the challenges facing the UK. In both contexts, research suggests that there are specific challenges resulting from a clash of cultures, as well as strategies that can minimise these challenges. Understanding the challenges, and generating strategies to respond to these challenges, should be a primary agenda for mainstream psychology, and cease existing on the periphery. Britain is multicultural. The developing world is importing our approach. The discipline must strive to a position of universal relevance and equality. I propose that, fundamentally and philosophically, this involves a willingness to learn from others.

B.14. Conclusion

The final chapter concludes the research project. The methodology is evaluated and the limitations of the design are recognised. The implications of this project are considered in relation to policy and practice and future research.

B.14.1. Evaluation of methodology

During the process of this research project, I have been plagued by the notion that thematic analysis was not a deep enough methodology for doctoral research. At this level of study we are expected to move from a level of *discussing* something, to a level where we are considered to *contribute* something original to our disciplines. A criticism of thematic analysis is that it is merely a descriptive method of analysis; Boyatzis (1998) characterises it not as a specific method but as a tool to use across different methods. Similarly, Ryan and Bernard (2000) locate thematic coding as a process performed within 'major' analytic traditions (such as grounded theory), rather than a specific approach in its own right. Braun and Clarke (2006) argue that thematic analysis should be considered a method in its own right and that analytic claims need to be grounded in, but also go beyond, the surface of the data.

There were several advantages to the methodological design. The researcher's naivety to the culture, paired with enough basic understanding of Ghanaian culture, enabled the research to facilitate an interesting perspective on the challenges facing the UK. The methodological design was mindful of systemic and environmental variables that could impact the experimenter/participant relationship as the historical and social context of Black/White relations and the global dominance of Eurocentric values and knowledge exaggerated the potential power imbalance inherent in all researcher/participant relationships.
As a result of this awareness, the research methodology was keen to avoid the use of observational data collection and opted for interviews with a sample that represented a facet of similarity to the researcher. Whilst cultural background was different between researcher and participants, the shared understanding of psychological theory enabled the obstacle of 'foreignness' to be minimised.

Another significant advantage of the research design was that a focus group took place, which enabled a much freer debate. As any interviewer effect was lesser in this context, it is encouraging to note that the data generated in the focus group was in keeping with the findings

of the individual interviews. Similarly, the process of validating the results did not reveal any difficulties.

Coding is a process of selective attention and no analysis can merely give voice to the data. The coding of information was shaped by the research aims and the situation in the UK. The data generated was in keeping with the research objectives, and some aspects were strikingly similar to the findings of the limited research conducted in the UK regarding improving the BME service user experience of mainstream mental health approaches. This fact may represent a strength of the methodological design, as the similarities suggest a degree of generalisability or commonality. However, alternatively, the similarities between the findings from British research and this research may indicate my own process of selective attention. I acknowledge that selectively attending to aspects of the data is difficult to avoid; however, I hope that the approach, and the exploratory design, enabled me to present a fair and accurate summary of everything I learnt from my Ghanaian colleagues. Essentially, I propose that my ignorance reduced the potential bias associated with coding the data.

Retrospectively, there are aspects of the methodological design that could have been improved. As discussed in earlier chapters, there are moments in the interviews where my difference feels like an obstacle to the process. Respondents' shifts between the use of 'us' and 'them' whilst describing African beliefs were particularly revealing, and the suggestion that I marry one of the respondents' family members revealed that a White woman was viewed as someone of financial and social privilege. My white skin made me easily identifiable as different. Essentially, my naivety towards the subject matter facilitated relevant questions and can be viewed as a strength of the methodological design. However, my difference to the sample may have impacted the process of data collection, impacting what participants felt comfortable telling me based on how my white skin colour was experienced. The use of some local words and self-disclosure helped reduce this effect. For example, on disclosing that I stayed in one of the poorest areas of the city seemed to surprise the participants, many of whom exclaimed: 'Well then you are Ghanaian!' These moments reflect my desire to demonstrate an appreciation and respect of Ghanaian culture, and reveal that my relationship with Ghana went beyond tourist research.

There are different methodological forms that this research could have taken, each with their own advantages and disadvantages. Perhaps a Black British researcher could have evoked different information from the participants. Similarly, a more thorough and valid account of the experiences of Ghanaian psychologists could have been researched by a Ghanaian psychologist; however, the approach taken by an English researcher aimed to shed light on the hypothesised culture clash between mainstream approaches and spiritual, religious and traditional ideas. If the researcher had an abundance of experience of alternative healing, some of the naive questions

would not have been asked: the data collected, though it may have been richer or more detailed, would be less relevant to Counselling Psychology in the UK. Similarly, whilst this research aimed to present a description of *most* of the data, an interesting research project could focus on smaller topics within the data. Data was organised into themes that aimed to present a surface-level description of the entire data, rather than a more in-depth analysis of one particular theme. Also, it is recognised that Ghana is just one example of a cultural centre of alternative beliefs. Similar research could be conducted in many other contexts, cultures and countries, which could aid the discipline's understanding of working with clients of different cultural backgrounds.

Participatory action research (PAR) is an approach that could have been used for this project. PAR is an approach to research that aims to understand and improve the world by changing it (Baum, MacDougall & Smith, 2006). Participants engage in a collaborative process aimed at constructing meaning and enacting change (McIntyre, 2008). The pursuit of knowledge is explicitly driven by action, and action is achieved by a solution-focused reflective cycle in which the researchers are active participants. PAR is increasingly used in public health research and is beginning to be recognised as a useful tool in indigenous health research (Baum, MacDougall & Smith, 2006). I underestimated how much my research was driven by a desire to change something in which I was participating, a realisation that dawned on me retrospectively. I am not Ghanaian, nor am I African or of African descent. However, I am a trainee psychologist in a world where discrepancies and inequalities amongst BME groups are well documented in terms of use and experience of psychological services. Reflecting on the experience of researching, I realised how much my own experience acted as a catalyst for embarking on this research. Having had sufficient exposure to African ideas and culture, I felt frustrated by the lack of attention African health beliefs were given by the discipline and in my own training. I wanted to address the gaps in my own knowledge and clinical skills.

For the purpose of this study, I was put off by the fact that PAR can be a lengthy process, as well as unpredictable and difficult to contain. As a trainee, I needed to demonstrate autonomy as a researcher. However, whilst evaluating the process along the way, I frequently revisited a fear of conducting research that involved researcher dominance. Power is a crucial concept in PAR, which aims to achieve the empowerment of those involved and recognises the importance of lived experience (Baum, MacDougall &Smith, 2006). For future research, PAR offers an excellent framework for collaborative, action-orientated strategies to be developed: '*it is an obligation undertaken by all people at all levels who seek to develop the quality of their work and the symmetry and reciprocity of their relationship with others*' (McTaggart, 1997, p. 6), one in which *'education between scientists and the public must take place in both directions'* (Wing, 1998).

B.14.2. Limitations

The project aimed to offer an interesting perspective on the challenges facing psychological services in multicultural Britain. A limitation of this research is that no research was conducted in the UK; therefore, hypotheses generated by the Ghanaian data were not tested in the context of the UK. No claims are made that the data is directly transferable, although similarities and differences are highlighted between this project and research that has been conducted in the UK. Ideally, ideas generated by this research could have been explored by research conducted with professionals, service users and patients' families within the UK. However, the practical considerations of time, feasibility and cost resulted in this research project needing to be contained to a realistic piece of work, given the requirements and constraints of the doctoral course.

The researcher's difference to the sample pose a risk to an accurate understanding of the material. Consultation with a Ghanaian colleague during the analysis process, and regular questions aimed at clarifying information during the data collection process, were both strategies used to minimise this risk.

Other limitations were the result of more practical considerations. Ideally, the validation of the results would have been done via face-to-face interviews and focus groups that would have enabled some information to be revisited in more detail and questions raised by other interviews could have been discussed. Financial considerations and time commitments meant that a third trip to Ghana was not feasible.

This project makes several references to 'BME communities', whilst clearly researching the experience of Ghanaian mental health professionals working in Ghana. The data sheds light on some more general African beliefs, although a serious limitation of this research is that it reflects the expertise of only a small sample population working in a specific country and system. Further research should build on this project by exploring the experience of other countries and cultures that are in the process of importing psychological approaches based on Eurocentric knowledge and values. The appeal of Ghana was that it occupies a relatively modern position in terms of its mental health services, as well as being a country that has a strong underpinning in African values and tradition, but it is acknowledged that the same project could have been conducted in several other countries.

B.14.3. Implications for policy and practice

Whilst direct suggestions for policy and practice should be considered tentatively and whilst acknowledging the need for research in the UK to add to the work of this research project, the data suggests that several strategies should be considered to attempt to address inequalities in service use and experience of mainstream psychological services by BME communities.

A fundamental lesson for practitioners relates to the Ghanaian mental health professionals ability to occupy multiple positions in terms of worldview; they described respecting and understanding where their patients were coming from. The data makes a thought-provoking read to a Eurocentric practitioner whose training privileges proving or disproving information from a scientific viewpoint. By being willing to park suspicions or ignorance, and being willing to ask, and listen to the explanatory models of our clients will aid culturally sensitive interventions. Recognising the things that matter to an individual may involve a negotiation of agendas, and being willing to incorporate a person's values, which may be culturally influenced. Policy makers must also reflect the same flexibility whilst considering the needs of the people they serve.

A key theme of this project related to the relationship between mainstream approaches and spiritual/traditional and alternative approaches. Practitioners should be aware of the areas of commonality between approaches as well as sources of tension. Policies should reflect an intention to uphold the commitments outlined by the Department of Health and the Race Relations Act. This project suggests policy makers should create links with the community they serve. Forging links with the community, and healers operating within the community, could serve to address the inequalities in service use and over-representation of some BME groups in involuntary admissions. The belief systems operating within a community should be understood, and representatives of mainstream services are key in gaining this information, identifying which healing practices and health beliefs are operating and who is performing these practices. Relationships must be forged with these people to help reduce the challenges associated with engaging and working with these clients. Information should be shared, service development should be collaborative and healers should be recognised for the positive aspects of their work whilst trying to introduce mainstream services. The Ghanaian data describes referrals from alternative healers, and if a similar collaborative relationship could be fostered in the UK, perhaps the discrepancies in service use might be reduced.

The structural and attitudinal barriers that are preventing some ethnic groups from engaging in mainstream services must be broken down. A key component of the work described in the Ghanaian context related to engaging community members and religious leaders and collaborative working. Joint work with the voluntary community sector and faith groups, both

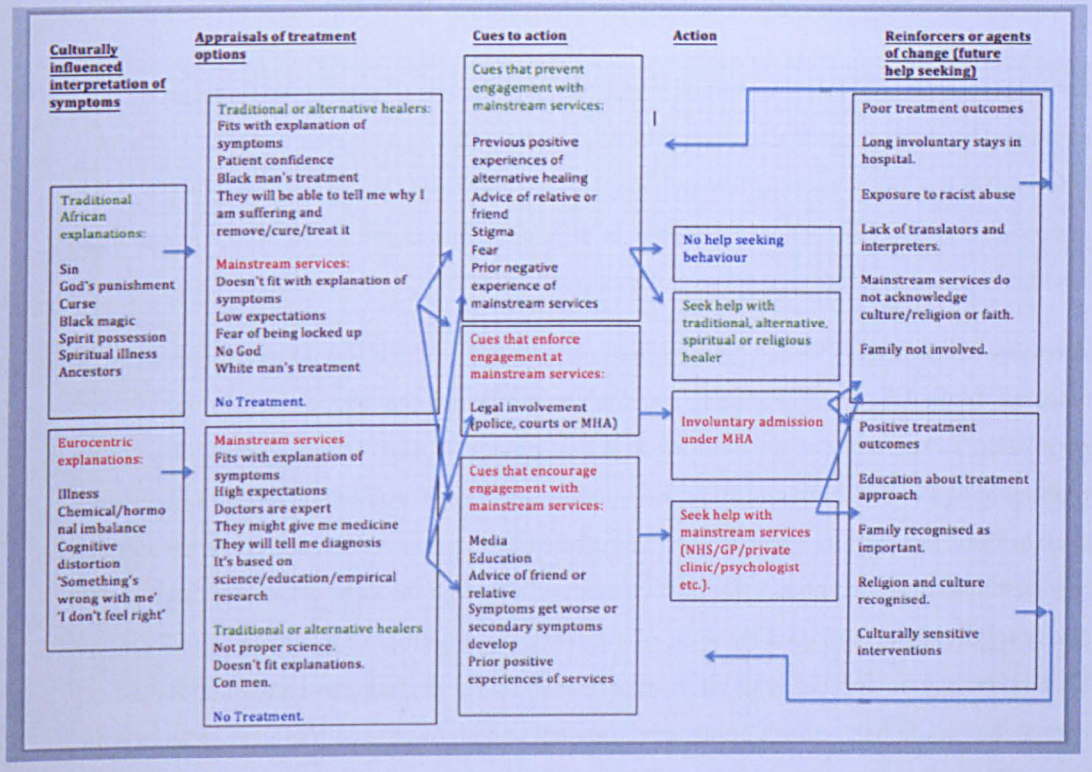
within planning and service provision, is a strategy that can foster mutual learning and collaborative work. CPNs and other community workers are key in forging these links, in addition to breaking down the attitudinal and structural barriers to engagement, and they can also promote available services. Policy makers are responsible for being the driving force in enhancing pathways to mainstream services, not least by empowering individual practitioners to work creatively. The Ghanaian data suggests that an important way of increasing engagement in services is by addressing stigma and lack of awareness about mental health services via community engagement strategies and community education programmes. Once engaged, the experience and outcome of services must also be improved for the ethnic groups that experience our services less well than the White majority.

By enhancing pathways to treatment, it is necessary to improve the experience of some BME service users if successfully engaged. National policy should address a Eurocentric bias by improving clinical training to incorporate modules on culturally specific health beliefs, encouraging clinicians to recognise the way in which the culture of mainstream psychology could be an obstacle to working with some clients. The Ghanaian data described ways of adapting existing psychological approaches to meet the needs of specific individuals and communities. The strategies they described have implications for policy and practice. Incorporating spirituality, being mindful of a client's expectations of the therapeutic relationship, recognising that a client may not be forthcoming disclosing information they feel might be devalued or pathologised by mainstream approaches and by actively trying to address ignorance on both sides of a therapeutic encounter should be aspects of standard practice. The cultural values and beliefs of a person should be recognised and treated respectfully, which involves recognising our own cultural values as a discipline. Policy makers should ensure all staff have sufficient training to feel confident working creatively in a culturally sensitive way. Figures from 2008 suggest that only 7.5% of clinical psychologists identify themselves as belonging to a black or minority ethnic group (Cape, Thompson, Roth et al, 2008) which is significantly less than the general public; policy makers should consider strategies to promote diversity within its workforce. In Ghana, the advantages of operating within a shared culture supports the need for more BME professionals to be working within mainstream services, particularly in areas with large ethnic minority communities. Respecting an individual's cultural values and spiritual/religious beliefs may involve collaborative work with faith leaders, being mindful not to reject or restrict a person's spirituality/religiosity via attitudinal or structural barriers and/or by incorporating the person's faith into psychological therapy. This project suggests clinicians can involve family members in patient treatment with good results. Policies that currently reflect the western emphasis on the individual need to be carefully considered to make space for individuals who place a greater emphasis on connectedness to their family.

Another challenge for policy makers and practitioners alike relates to formulating client presentations when culturally specific health beliefs are encountered by mainstream services. The challenge of using a culturally influenced diagnostic manual is highlighted by the Ghanaian data, which has implications for mainstream services in the UK. A shift towards individual, culturally sound formulations may require a departure from an approach that relies on applying diagnostic labels whose validity has been seriously challenged.

A significant recommendation of this project is that clinical training be improved in regards to its treatment of culture. If clinical training incorporates alternative or foreign worldviews of psychological illness and healing, clinicians are better equipped to explore these issues confidently, sensitively and respectfully, without pathologising experiences that *our* own culture deems bizarre. 'Culture' is not a term that denotes the foreign. A western emphasis on the individual and empiricism heavily influences the *culture* of psychology. I propose that The Health Belief Model (HBM) by Rosenstock, Strecher and Becker (1988) can be adapted to provide a useful learning tool in teaching clinicians to formulate cultural differences in explanatory models, help seeking behaviour and expectations for treatment (see figure B11).

Figure B11: Teaching aid: Adapted version of Health Belief Model



In Ghana, all mental health professionals had training on healing practices and health beliefs operating within the community. In the UK, the myriad of cultures and influences would make equipping clinicians with an understanding of every community very challenging, however, clinical training must teach clinicians to recognise what is Eurocentric about mainstream psychology, which will in turn equip them with ways of formulating differences in the way some ethnic minorities may use psychological services. The adapted HBM (figure B11) offers a useful teaching aid for clinical training and policy makers, established practitioners alike. The model I present captures the lessons I learnt by participating in research that aimed to explore the implications of delivery Eurocentric psychology with clients whose culture is different.

B.14.4. Implications for future research

The interface between culture and mental illness is complex and much more research is required in this area. Local explanations of psychological distress and illness, and the signs and meanings used to interpret it, must be understood as a foundation for service development (Desjarlais et al., 1995; Bhugra, 2001). A philosophical clash of cultures can result in problems such as reluctance to engage in mainstream services, negative service user experience and poor treatment outcomes. This culture clash will maintain discrepancies in service engagement and experience amongst ethnic minorities unless the discipline can adapt.

Future research should explore ethnic variations in pathways to care as the findings are not fully explained by differences in diagnosis, social circumstances and the involvement of others (Morgan et al., 2005), and this research suggests an emphasis should be placed on understanding health beliefs associated with different cultures and faiths, whilst generating strategies aimed at improving services for these clients.

A review of research evidence highlights significant gaps, which should be addressed by future research. In the UK, we do not understand the health beliefs that shape many of our population's experience of mental illness. We do not know who is offering religious, spiritual, traditional and/or alternative healing. No attempts have been made to quantify the prevalence of such healers, nor explore specific practices offered by alternative healers. There has not been research to indicate the popularity of such healers, although the very limited qualitative data does suggest healers are used by some of our BME communities (e.g. Copsey, 1997). Understanding the popularity of alternative healers by using qualitative and quantitative approaches could help inform policy development and highlight geographical areas in which community education and collaborative approaches should be prioritised.

This research project suggests further research should attempt to learn from other international contexts and cultures that have a different emphasis to the values intrinsic to modern, westernised life. Attempts to learn from professionals operating in international cultural centres of health beliefs should accompany research that enhances our understanding of the health beliefs and help-seeking behaviours of the British population. British research should explore culturally specific health beliefs and the relationship between culture and symptom expression. Similarly, research is needed to explore mental health professionals' understanding of alternative explanations of symptoms, and alternative healing approaches, to aid the development of training packages. Research should continue to explore the relationship between culture and diagnosis and endeavour to create diagnostic criteria that have universal usefulness. This process of evaluation may reveal that a focus on an individual's experience is more useful than standardised tools.

Research should continue to explore how to adapt psychological interventions to better serve groups of people that rate services less positively than their White counterparts. Research should continue to focus on piloting schemes that demonstrate successful engagement with a community, improved engagement and positive service user experience. These schemes can generate knowledge that can inform national policy and service development.

For mainstream services to meet the needs of an increasingly diverse population, some significant philosophical shifts are necessary, marking a shift from a 'one size fits all' treatment approach. The Western tradition of proving and disproving knowledge to categorise in a hierarchy of legitimacy must be addressed as efforts are made to identify, reach out – and learn from – the vast assortment of values, beliefs and worldviews that exist within modern-day Britain. The discrepancies in service user experience by ethnicity are unacceptable and we are legally required to offer a service that is as satisfying and effective for the BME population as it is for the White majority. Expanding on the attempts of the DRE and CDWs, psychology needs to branch out by building relationships of mutual respect and information-sharing with practitioners whose approaches differ starkly from mainstream Western approaches.

B.14.5. A personal reflection on conducting this research

Conducting this research was a powerful experience for me, both professionally and personally. Being a minority in an African country, and easily identifiable as a member of the White west, antagonised a fear of what I represented. The historical and social context of Black/White relations felt closer than when in my home country, I felt a sense of guilt on some level. I noticed a desire to actively challenge the assumptions I feared people held about me. My white skin felt celebrated, which I internalised in a way that felt uncomfortable. I would almost have been more at ease with having to overcome mistrust or suspicion versus an overwhelmingly welcoming reception. I wanted to ask why people were so happy to see a White face given the history between our two cultures. The reality is that my skin colour represented power, social and financial privilege and demonstrated real global inequalities. Living in a country where my skin colour felt more significant than usual was an interesting experience for me. Despite the fact that I was not experiencing living in a skin colour that felt devalued, I experienced feeling different which was alienating in its own way. It was also very humbling to realise how many advantages I took for granted.

By conducting this research I feel I have actively participated in something. There are difficulties in trying to explore a phenomenon from an outsiders position, however, sharing what I was told during the interviews is worthwhile, even if it is taken for what it was, a conversation between professionals in a specific window of space and time. An interesting comment from my viva voce related to the way I struggled to translate the experience into academic research, defending the work with comments about it's 'validity' or 'generalisability'. I was encouraged to feel confident that I did not need to offer more than presenting an interesting account of what happened with this research, and that this process revealed processes relating to my own cultural influences about what constitutes knowledge.

The experience of conducting this project was invaluable in addressing my own ignorance, and as I serve as a barometer of what is useful to many practitioners with similar cultural influences and training backgrounds to my own, I feel convinced that the lessons I learnt are worth sharing. I have gained an understanding of the significance of my own culture and feel a sense of social responsibility to address the parts of my professional culture that maintain inequality. I was confronted with the cultural specificity of my discipline and my professional identity in a way that I had failed to predict. Professionally, I have come out of this process more confidently rooted in a position of social constructionism. I have added dimensions to my work, and have become more pluralistic in my approach. Personally, I have begun to question the significance of my own lack of spirituality. Or perhaps I have come to recognise that my spiritual self needs nurturing, I suspect I have always been more spiritual than I had recognised. My training never encouraged such soul-searching, nor does it feel very academic or clinical. I have considered

these matters to be personal before now, naively thinking that my own religiosity or spirituality has no relevance to my professional identity. I was raised in a Christian way by Christian parents; I attended a primary school that was attached to my village church and learnt about the Bible from a young age. However, at the time of commencing this research, I rarely identified myself as a 'Christian' perhaps because of some of the things I felt that represented. My view of organised religion at that time was negative: I now acknowledge the influence that a culture of science and empiricism has on my identity. My cultural influences led me to cherish what I felt could be proven and 'known' versus what I *believed.*

At the time of conducting this research I attended a Buddhist Centre infrequently to participate in group meditation and discussions I felt encouraged personal growth. The Buddhist belief system seemed to clash less with my Eurocentric way of privileging the scientific than Christianity. However, as I complete this project I find myself questioning the way I identify with my spiritual self. I believe my relationship with my faith has been enhanced by the experience and I have recognised that my faith does influence my professional self. I felt empowered to revisit a relationship with a Supreme Being and blind faith in something bigger than me. There are limits to what a scientific approach can explain, and I feel more comfortable believing in something I cannot fully understand. I have started to recognise when a need to intellectualise something serves as a defense mechanism, and I feel more comfortable with uncertainty.

Faith, the power of belief, is the foundation of religion. Faith shapes how our clients interpret their experiences and will impact their recovery. When trying to understand the workings of a person's mind, it must be necessary to understand the beliefs that work that mind, otherwise all one does is impose their own constructs. Failure to sympathise and connect with a person's religious belief will impact negatively on their treatment. Without this connection, communication will not become intimate. Allowing space for my own uncertainty aids my clinical practice. I am willing to attend fully to the client's experience, taking it as real for them, without an arrogant, Eurocentric trait of devaluing the 'un-scientific'. I am becoming more aware of the way psychological theory can be held as a defence against uncertainty, almost representing a church of its own, as it's disciples *believe* in what they do. I do have faith in talking therapies, but my view of psychological therapies now recognises the culture in which the theories were born.

Reflecting on this process, as a member of mainstream psychology and the White culture psychology's values mirror, I feel in many ways I have subverted my initial position. There are shifts in my language which reveal this process as I am confronted with ideas that challenge many of the assumptions I held. My relationship with diagnostic labels shifts significantly, as

does my relationship with faith. I gained confidence rejecting the medical model as my defences against 'not-knowing' were threatened. My initial frustration with understanding how Ghanaian mental health professionals could be so comfortable straddling both worldviews was replaced with feeling envious that they should be able to integrate ideas that seemed to challenge each other. I realise that so much of what we 'know' is really what we 'believe' and I feel more at peace with allowing fact and faith to co-exist. The experience has aided my clinical practice and my clients have responded well to feeling that their spiritual self is acknowledged in therapy. The experience was empowering as I gained confidence in a stance that reflects values of pluralism, social justice and my own moral compass.

B.14.6. Conclusion

The challenges relating to achieving equality are vast and not amenable to either simple solutions or a single approach. The data from Ghana offers a thought-provoking read to the Eurocentric clinician. Most importantly, it recommends that a holistic approach is adopted, and that a preventative rather than reactive approach is taken to address the challenges facing psychology in multicultural Britain. Instead of focusing on explaining higher rates of mental illness amongst Black communities, efforts should be focused on learning how better to engage and serve these clients. Services should be developed from the bottom up and in collaboration with the community. The complexity and significance of culture in relation to health beliefs and experiences of mental ill health are highlighted and the data calls for further research to explore this relationship more fully. The data highlights the dominance of Eurocentric ideas and values and raises some serious philosophical and ethical questions about the tension between mainstream psychology and worldviews operating outside dominant scientific/modern knowledge.

There is an indisputable need for culturally competent healthcare services in order to address the health needs of an increasingly diverse pluralistic world, eliminate existing health disparities for minorities and mend a fragmented system of care where some receive better services than others. Moodley and West (2005) suggest that 'crisis could lead to creativity' if psychology embraced a conceptual shift by including and integrating traditional healing methods (Moodley and West, 2005). This process is undeniably complex, although this research suggests that a fundamental component of progress will result from clinicians being willing to learn about worldviews that differ from the philosophical underpinnings of mainstream psychology. There are serious challenges associated with a post-modern analysis of ancient healing practices (Moodley & West, 2005) and an awareness and sensitivity are required to facilitate mutual learning. Clinical training programmes and employers have a responsibility to incorporate these ideas into training requirements and professional development. This research highlights the

potential challenges in marrying two starkly different worldviews whilst sticking to your own professional remit. An understanding of alternative worldviews and the social, political and historical context of our own approach will aid this process of negotiation, as will the generation of action-orientated strategies that equip clinicians to feel comfortable incorporating aspects of culture and faith that differ from their own.

B.15. References

Adebimpe, V. R. (1982). Psychiatric symptoms in Black patients. In S. Turner & R. Jones (Eds.). *Behaviour modification in Black populations: Psychosocial issues and empirical findings*. New York: Plenum. 57-59.

Adebimpe, V. R. (1997). Mental illness among African Americans. In: I. Al-Issa & M. Tousignant (Eds.). *Ethnicity, immigration and psychopathology*. New York & London: Plenum Press. 95-107.

Adebimpe, V. R., Klein, H. E., & Fried, J. (1981). Hallucination and delusions in Black psychiatric patients. *Journal of the National Medical Association, 73*, 517-520.

Ae-Ngibse, K., Cooper, S., Adiibokah, E., Akpalu, B., Lund, C., Doku, V., & the MHAPP Research Consortium. (2010). 'Whether you like it or not people with mental problems are going to go to them': A qualitative exploration into the widespread use of traditional and faith healers in the provision of mental health care in Ghana. *International Review of Psychiatry, 22*(6), 558-567.

Aina, O. F. (2006). 'Psychotherapy by environmental manipulation' and the observed symbolic rites on prayer mountains in Nigeria. *Mental Health, Religion & Culture, 9*, 1-13.

Al-Issa, I. (1995). The illusion of reality or the reality of illusion: Hallucinations and culture. *British Journal of Psychiatry, 166*, 368-373.

Altermeyer, B. (2003). Why do religious fundamentalists tend to be prejudiced? *International Journal for the Psychology of Religion, 13*, 17-28.

Anderson, J. E. (2008). *Hoodoo, voodoo, and conjure: A handbook*. Westport, Connecticut: Greenwood Press.

Anderson, M. (2005). *Psychotherapy as ritual: connecting the concrete with*

the symbolic. In R. Moodley, & W. West (2005). *Integrating traditional healing practices into counseling and psychotherapy.* Thousand Oaks, Calif.: Sage Publications.

Angermeyer, M. C., Breier, P., Dietrich, S., Kenzine, D., & Matschinger, H. (2005). Public attitudes toward psychiatric treatment: An international comparison. *Journal of Social Psychiatry and Psychiatric Epidemiology, 40,* 855-864.

Annorbah-Sarpei, J. (1990). *The rise of prophetism: A socio-political explanation in the rise of independent churches in Ghana.* Asempa Publishers: Accra.

Antaki, C., Billig, M., Edwards, D., & Potter, J. (2002). Discourse analysis means doing analysis: A critique of six analytical shortcomings. Online version. Last accessed July 2012, at http://extra.shu.ac.uk/daol/articles/open/2002/002/antaki2002002-paper.html

Arksey, H., O'Malley, L., Baldwin, S., Harris, J., Mason, A., & Golder, S. (2002). Literature review report: Services to support carers of people with mental health problems. *National Co-ordinating Centre for NHS Service Delivery and Organisation, London.*

Ashcroft, B., Griffiths, G., & Tiffin, H. (1998). *Post-colonial studies: The key concepts.* London: Routledge.

Aten, J. D. & Hernandez, B. C. (2004). Addressing religion in clinical supervision: A model. *Psychotherapy: Theory, Research, Practice, Training, 41,* 152-160.

Attride-Stirling, J. (2001). Thematic networks: An analytic tool for qualitative research. *Qualitative Research, 1,* 385-405.

Bannister, D. (1968). The logical requirements of research into schizophrenia. *British Journal of Psychiatry, 114,* 181-188.

BasicNeeds Photo Book (2011). Ghana: A picture of mental health. Photographed by Nyani Quarmyne (www.nqphotography.com). Last accessed December, 2012 at

http://www.basicneeds.org/download/PUB-OnScreenAPictureOfMentalInGhana.pdf

Baum, F., MacDougall, C., & Smith, D. (2006). Participatory action research. *Journal of Epidemiology and Community Health, 60*, 854-857.

Bebbington, P. E., Hurry, J., & Tennant, C. (1981). Psychotic disorders in selected immigrant groups in Camberwell. *Social Psychiatry, 16*, 43-51.

Belgrave, F., Clark, T., & Nasim, A. (2009). Drug use among African American youth: Implications for prevention. In Neville, H., Tynes, B. M., & Utsey. (Eds). *Handbook of African American psychology*. (pp. 469-491). Sage publications: California.

Bell-Tolliver, L., Burgess, R., & Brock, L. (2009). African American therapists working with African American families: An exploration of the strengths perspective in treatment. *Journal Of Marital & Family Therapy, 35*(3), 293-307.

Bentall, R.P. (2004). *Madness explained: Psychosis and human nature*. 656. Penguin.

Bentall, R. P., Jackson, H. F., & Pilgrim, D. (1988) The concept of schizophrenia is dead: Long live the concept of schizophrenia? *Journal of Clinical Psychology, 21*, 329-331.

Bentall, R. P., Jackson, H. F., & Pilgrim, D. (1988). Abandoning the concept of schizophrenia: Some implications of validity arguments for psychological research into psychotic phenomena. *British Journal of Clinical Psychology, 27*, 303-324.

Bergin, A. E. (1988). Three contributions of a spiritual perspective to counselling, psychotherapy and behavior change. *Counselling and Values, 32*, 21-31.

Bergin, A. E. & Payne, I. R. (1991). Proposed agenda for a spiritual strategy in personality and psychotherapy. *Journal of Psychology and Christianity, 10*, 197-210.

Bernard, H. R. & Ryan, G. (1998). Text analysis: Qualitative and quantitative

methods. In H. R. Bernard (Ed.), *Handbook of methods in cultural anthropology* (pp. 595–645).

Betancourt, J. R., Green, A. R., Carillo, J. E., & Park, E. R. (2005). Cultural competence and health care disparities: Key perspectives and trends. *Health Affairs, 24,* 499-505.

Beyers, J. (2010). What is religion? An African understanding. *HTS Theological Studies 66*(1), 341.

Bhatti, R. S. & Varghese, M. (1995). Family therapy in India. *Indian Journal Social Psychiatry, 11*(1), 30-34.

Bhugra, D. & Bhui, K. (1998). Cross-cultural aspects of psychotherapy. *British Journal of Psychotherapy, 14,* 310-326.

Bhugra, D. & Littlewood, R. (2001). *Colonialism and psychiatry.* New Delhi: Oxford University Press.

Bhugra, D. (2001). Services for ethnic minorities: Conceptual issues. In: Bhugra, D. & Cochrane, R. (Eds.) *Psychiatry in multicultural Britain.* London: The Royal College of Psychiatrists: Gaskell publishing (pp. 330-349).

Bhugra, D., Hilwig, M., Hossein, B., Marceau, H., Neehall, J., Leff, J., Mallett, R., & Der, G. (1996). First-contact incidence rates of schizophrenia in Trinidad and one-year follow-up. *The British Journal of Psychiatry, 169*(5), 587-592.

Bhui, K. (1998). London's ethnic minorities and the provision of mental health services. In S. Johnson et al. (Eds). *London's mental health.* London: Kings Fund.

Bhui, K. (2001) Over-representation of Black people in secure psychiatric facilities. *British Journal of Psychiatry, 178*(6), 575.

Bhui, K., Bhugra, D., & Goldberg, D. (2002). Causal explanations of distress and general practitioners' assessments of common mental disorder among Punjabi and English attendees. *Social Psychiatry and Psychiatric Epidemiology, 37,* 38-45.

Bhui, K., Stansfeld, S., Hull, S., Priebe, S., Mole, F., & Feder, G. (2003). Ethnic variations in pathways to and use of specialist mental health services in the UK: Systematic review. *British Journal of Psychiatry, 182,* 105-116.

Bindman, J., Johnson, S., Wright, S., Szmukler, G., Bebbington, P., Kuipers, E., &Thornicroft, G. (1997). Integration between primary and secondary services I the care of the mentally ill: Patients and general practitioners views. *British Journal of Psychiatry, 171,* 169-174.

Binitie, A. (1991). Brief psychotherapy for African patients: Psychotherapy through environmental manipulation. *Nigeria Journal of Psychiatry, 1,* 36-44.

Birchwood, M., Cochrane, R., Macmillan, F., Copestake, S., Kucharska, J., & Carriss, M. (1992). The influence of ethnicity and family structure on relapse in first-episode schizophrenia: A comparison of Asian, Afro-Caribbean, and White patients. *British Journal of Psychiatry, 161,* 783-790.

Bird, C. M. (2005). How I stopped dreading and learned to love transcription. *Qualitative Inquiry, 11*(2), 226-248.

Bogdan, R. & Taylor, S. J. (1975). *Introduction to qualitative research methods.* New York: John Wiley.

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development.* Sage.

Boyd-Franklin, N. (1984). Issues in family therapy with black families. *Clinical Psychologist,* 37(2), 54-58.

Boydell, J., Van Os, J., Mckenzie, K., Allardyce, J., Goel, R., Mccreadie, G., & Murray, R. M. (2001). Incidence of schizophrenia in ethnic minorities in London: Ecological study into interactions with environment. *British Medical Journal, 323,* 1336-1338.

Boyle, M. (2002). It's all done with smoke and mirrors. Or, how to create the illusion of a schizophrenic brain disease. *Clinical Psychology* Issue 12, 9-16

BPS - Code of Human Research Ethics. Last accessed on January 10th, 2013 at: http://www.bps.org.uk/sites/default/files/documents/code_of_human_research_ethics.pdf

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77-101.

Bruwer, B., Sorsdahl, K., Harrison, J., Stein, D. J., Williams, D., & Seedat, S. (2011). Barriers to mental health care and predictors of treatment dropout in the South African stress and health study. *Psychiatric Services,* 62(7), 774-781.

Bryman, A. (1988). *Quantity and quality in social research.* London: Routledge.

Bulmer, M. (1979). Concepts in the analysis of qualitative data. *Sociological Review,* 27(4): 651-77.

Burnett, R., Mallett, R., Bhugra, D., Hutchinson, G., Der, G., & Leff, J. (1999). The first contact of patients with schizophrenia with psychiatric services: Social factors and pathways to care in a multi-ethnic population. *Psychological Medicine, 29*, 475-483.

Callan, A. & Littlewood, R. (1998). Patient satisfaction: Ethnic origin or explanatory model? *International Journal of Social Psychiatry, 44,* 111.Caplan, P. J. (1995). *They say you're crazy: How the world's most powerful psychiatrists decide who's normal.* Reading, MA: Addison-Wesley.

Capra, F. (1983). *The turning point: Science, society and rising culture.* London: HarperCollins.

Carothers, J. C. (1951). Frontal lobe function and the African. *Journal of Mental Science, 97,* 12-48.

Central Intelligence Agency (CIA). (2012). The world fact book: Africa: Ghana. Available: https://www.cia.gov/library/publications/the-world-factbook/geos/gh.html. Last accessed 16th October, 2012.

Cha, K. Y. & D. P. Wirth. (2001). Does prayer influence the success of in

vitro fertilization-embryo transfer? Report of a masked, randomized trial. *Journal of Reproductive Medicine, 46,* 781-787.

Chavunduka, G. L. (1999). Christianity, African religion and African medicine. *World Council of Churches, Current dialogue*, Issue 33, July 1999. Last access September 30th at http://wcc-coe.org/wcc/what/interreligious/cd33-02.html

Chibnall, J. T., Jeral, J. M., & Cerullo, M. A. (2001). Experiments on distant intercessory prayer: God, science, and the lesson of Massah. *Archives Internal Medicine*, 161, 2529-2536.

Christie, Y. (2003). *Black spaces project: A report of seven Black voluntary sector projects*. London: Mental Health Foundation.

Clarkson, P. (2002). *The transpersonal relationship in psychotherapy.* London: Whurr.

Cochrane, R. & Bal, S. S. (1989). Mental hospital admission rates of immigrants to England. *Social Psychiatry and Psychiatric Epidemiology, 24,* 2-11.

Cochrane, R. & Sashidharan, S. P. (1996). Mental health and ethnic minorities: A review of the literature and implications for services. In *Ethnicity and Health.* CRD Report 5. York: NHS Centre for Reviews and Dissemination, Social Policy Research Unit, University of York.

Cocks, M. & Moller, V. (2002). Use of indigenous and indigenized medicines to enhance personal well-being: A South African case study. *Social Science & Medicine, 54,* 387-398.

Cohen, M. H. (1995). The triggers of heightened parental uncertainty in chronic, life-threatening childhood illness. *Qualitative Health Research, 5*(1), 63-77.

Coid, J., Kahtan, N., Gault, S., & Jarman, B. (2000). Ethnic differences in admissions to secure forensic psychiatry services. *British Journal of Psychiatry, 177,* 241-247.

Cole, E., Leavey, G., King, M., Johnson-Sabine, E., & A. Hoare. (1995). Pathways to care for patients with a first episode psychosis: A

comparison of ethnic groups. *British Journal of Psychiatry, 167*, 770-776.

Collicutt, J. (2011). Psychology, religion and spirituality. *The Psychologist, 24*(4), 250-251.

Comas-Díaz, L. & Padilla, A. M. (1992). The English-only movement: Implications for mental health services. *American Journal of Orthopsychiatry, 62*, 6.

Commander, M. J., Cochrane, R., Sashidharan, S. P., Akilu, F., & Wildsmith, E. (1999). Mental health care for Asian, Black and White patients with non-affective psychoses: Pathways to the psychiatric hospital, in-patient and after-care. *Social Psychiatry and Psychiatric Epidemiology, 34*, 484-491.

Cook, C. C. H., Powell, A., & Sims, A. (2009). (Eds). *Spirituality and Psychiatry.* London: Royal College of Psychiatrists Press.

Copsey, N. (1997). Keeping faith: The provision of community mental health services within a multi-faith context. *The Sainsbury's Centre for Mental Health.* Available: http://www.centreformentalhealth.org.uk/pdfs/keeping_faith.pdf. Last accessed 29th October 2012.

Cornah, D. (2006). The impact of spirituality on mental health. *Mental health foundation.* Last accessed March, 2013 at: http://www.mentalhealth.org.uk/content/assets/PDF/publications/impact-spirituality.pdf?view=Standard

Coyle, A. & Lochner, J. (2011). Religion, spirituality and therapeutic practice. *The Psychologist, 24*(4), 264-266.

Crossley, J. P. & Salter, D. P. (2005). A question of finding harmony: A grounded theory study of clinical psychologists' experience of addressing spiritual beliefs in therapy. *Psychology and Psychotherapy: Theory, Research and Practice, 78*, 295-313.

Crowley, J. J. & Simmons, S. (1992) Mental health, race and ethnicity: A retrospective study of the care of ethnic minorities and Whites in a

psychiatric unit. *Journal of Advanced Nursing, 17,* 1078-1087.

Danquah, S. A., & Opok, J. Y. (2008). Ghana national tour. *International Journal of Psychology, 44* (Suppl. 1).

Davies, S., Thornicroft, G., Leese, M., Higgingbotham, A., & Phelan, M. (1996). Ethnic differences in risk of compulsory psychiatric admission among representative cases of psychosis in London. *British Medical Journal, 312,* 533-537.

Davis, T. N. (1986). Can prayer facilitate healing and growth? *Southern Medical Journal, 79*(6), 733-735.

Dawkins, R. (2006). *The God delusion.* London: Bantam Press.

Dean, G., Walsh, D., Downing, H., & Shelley, E. (1981). First admission of native born and immigrants to psychiatric hospitals in South-East England 1976. *British Journal of Psychiatry, 139,* 506-512.

Dearnley, C. (2005). A reflection on the use of semi-structured interviews. *Nurse Researcher, 13*(1), 19-28.

Demjaha, A., Morgan, K., Morgan, C., Dazzan, P., Landua, S., Dean, K., Fearon, P., Leff, J., Jones, P., & Murray, R. (2006). Symptom dimensions and ethnicity in the AESOP first onset psychosis study. *Schizophrenia Research, 81,* Supplement 1, 233.

Department of Health. (2005). *Delivering race equality in mental health care: An action plan for reform inside and outside services and the Government's response to the Independent inquiry into the death of David Bennett.* London: DH.

Department of Health. (2009). *New Horizons: Towards a shared vision for mental health – consultation.* London: Department of Health. www.dh.gov. uk/en/consultations/liveconsultations/ dh_103144

Department of Health/HM Treasury. (2002). *Tackling health inequalities: Cross cutting review,* London: Department of Health/HM Treasury.

Desjarlais, R., Eisenberg, L., Good, B., & Klienman, A. (1995). *World mental*

health. New York: Oxford University Press.

Di Forti, M. D., Morgan, C., Dazzan, P., Pariante, C., Mondelli, V., Marques, T. R., Handley, R., Luzi, S., Russo, M., Paparelli, A., Butt, A., Stilto, S., Wiffen, B., Powell, J., & Murray, R. M. (2009). High-potency cannabis and the risk of psychosis. *The British Journal of Psychiatry, 195*(6), 488-491.

Doku, V., Ofori-Atta, A., Akpalu, B., Read, U., Osei, A., Ae-Ngebise, K., Awenva, D., Lund, C., Flisher, A. J., Petersen, I., Bhana, A., Bird, P., Drew, N., Faydi, E., Funk, M., Green, A., & Omar, M. (2008). A situation analysis of mental health policy development and implementation in Ghana. *Accra: Mental health and poverty project. Inhouse publication: MHaPP.*

Dossey, L. (1993). *Healing words: The power of prayer and the practice of medicine.* San Francisco, CA: HarperCollins.

Doumbia, A. & Doumbia, N. (2004). *The way of the Elders: West African spirituality and tradition.* Llewellyn Publications: USA.

Dunn, J. & Fahy, T. A. (1990). Police admissions to a psychiatric hospital: Demographic and clinical differences between ethnic groups. *British Journal of Psychiatry, 156,* 373-378.

Ebigbo, P. O., Oluka, J. I., Ezenwa, M., Obidigbo, G., & Okwaraji, F. (1995). Harmony restoration therapy: An African contribution to psychotherapy. In *The practice of psychotherapy in Africa.* Paper presented at Proceedings of the First National Conference on Psychotherapy organised by the international Federation for Psychotherapy, Lagos, Nigeria, November, 1995 (pp. 10-32)

Ecklund, E. & Scheitle, C. (2007). Religion among academic scientists. *Social Problems, 54,* 289-307.

Ellis, A. B. (1980). *The Ewe-speaking peoples of the slave coast of West Africa: Their religion, manners, customs, laws, languages etc.* London: Chapman & Hall.

Ely, M., Vinz, R., Downing, M., & Anzul, M. (1997). *On writing qualitative*

research: Living by words. Routledge/Falmer.

Ewusi-Mensah, I. (2001). Postcolonial psychiatric care in Ghana. *Psychiatric Bulletin, 25,* 228-229.

Ferguson, G.O. (1916). *The psychology of the Negro.* Negro Universities Press.

Fernando, S. (1995). Study did not deal with "category fallacy". *British Medical Journal, 310,* 331-332.

Fernando, S. (1998). *Race and culture in psychiatry.* London: Routledge.

Field, M. J. (1955). Witchcraft as a primitive interpretation of mental disorder. *Journal of Mental Science, 101,* 826-33.

Field, M. J. (1960). *Search for security: An ethno-psychiatric study of rural Ghana.* W. W. Norton & Company.

Fine, M. (2002). *Disruptive voices: The possibilities for feminist research.* University of Michigan Press.

Forster, E. B. (1962). The theory and practice of psychiatry in Ghana. *American Journal of Psychotherapy, 16,* 17-51.

Foster, J. J. & Parker, I. (1995). *Carrying out investigations in psychology: Methods and statistics.* Leicester, UK: BPS Books.

Fountain, J. & Hicks, J. (2010). *Delivering race equality in mental health care: Report on the findings and outcomes of the community engagement programme 2005-2008:* Full Report. Last accessed 26th November, 2012: http://www.uclan.ac.uk/schools/school_of_social_work/files/DRE_CE_full_report.pdf

Freeman, D. (1986). *The fateful hoaxing of Margaret Mead: A historical analysis of her Samoan researches.* Boulder, Colo.; Oxford: Westview. (Reprinted 1999)

Freud, S. (1913). *Totem and taboo: Resemblances between the psychic lives of savages and neurotics.* First published 1913; translated by A.

A.Brill. New York: Vantage Books.

Frith, H. & Gleeson, K. (2004). Clothing and embodiment: Men managing body image and using thematic analysis in psychology 99 appearance. *Psychology of Men and Masculinity, 5,* 40-48.

Furnham, A., Ota, H., Tatsuro, H., & Koyasu, M. (2000). Beliefs about overcoming psychological problems among British and Japanese students. *The Journal of Social Psychology, 140*(1), 63-74.

Gartner, J., Larson, D. B., & Allen, G. D. (1991). Religious commitment and mental health: A review of the empirical literature. *Journal of Psychology and Theology, 19*(1), 6-25.

Gater, R., de Almeida e Sousa, Barrientos, G., Caraveo, J., Chandrashekar, C. R., Dhadphale, M., Goldberg, D., Al Kathiri, A. H., Mubbashar, M., Silhan, K., Thong, D., Torres-Gonzales, F., & Sartorius, N. (1991). The pathways to psychiatric care: A cross-cultural study. *Psychological Medicine 21,* 761-774.

Ghana Evangelism Committee (eds) (1989). *National survey: Facing the unfinished task of the church in Ghana.* Accra: Ghana Evangelism.

Ghana High Commission Website (Ottowa, Canada). Culture and tourism. http://www.ghc-ca.com/frm-e-culture-tourism.html last accessed 27th October, 2012

Ghana International Journal of Mental Health (http://ghana-ijmh.org)

Ghana Nation News headlines. (06/10/2012) Horror: Patients in Ghana mental hospitals chained for months http://news1.ghananation.com/headlines/278320-horror-at-mental-hospitals-in-ghana-video.html

Ghana: Ministry of Health (2001). *The Health of the Nation.* Last accessed January, 2013: http://www.moh-ghana.org/UploadFiles/Publications/5Yr%20POW%20I%20(1997-2001)120422153313.pdf

GhanaWeb. (2012). Ethnic groups of Ghana. http://www.ghanaweb.com/GhanaHomePage/tribes/ Last accessed 25th October 2012.

Gifford, P. (2004). *Ghana's new Christianity: Pentecostalism in a globalizing African economy*. Bloomington and Indianapolis: Indiana University Press.

Gillam, S., Jarman, B., White, P., & Law, R. (1989). Ethnic differences in consultant rates in urban general practice. *British Medical Journal, 299*, 953-958.

Glaser, B. G. & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago, IL: Aldine.

Gordon, H. L. (1934). Psychiatry in Kenya colony. *Journal of Mental Science, 80,* 167-71.

Government of Ghana. (2012). About Ghana. Available: http://www.ghana.gov.gh/index.php/about-ghana/ghana-at-a-glance/1237-know-more-about-ghana. Last accessed 16th October 2012.

Grant-Thompson, S. K. & Atkinson, D. R. (1997). Cross-cultural mentor effectiveness and African American male students. *Journal of Black Psychology, 23*, 120-134.

Grevious, C. (1985). The role of the family therapist with low-income black families. *Family therapy, 12*(2), 115-122.

Gross, N. & Simmons, S. (2009). The religiousity of American college and university professors. *Sociology of Religion, 70*, 101-129.

Guba, E. G. (1978). *Toward a methodology of naturalistic inquiry in educational evaluation*. Los Angeles: UCLA Center for the Study of Evaluation.

Gubi, P. M. (2000). *Prayer and psychotherapy: An exploration of the therapeutic nature of Christian prayer and its possible use with Christian clients in secular psychotherapy.* Unpublished MTheol dissertation, University College Chester (University of Liverpool), UK.

Gubi, P. M. (2007). *Prayer in counselling and psychotherapy: Exploring a hidden meaningful dimension.* Jessica Kingsley Publishers.

Guest, G., MacQueen, K.M., & Namey, E. E. (2012). *Applied thematic analysis.* Los Angeles: Sage Publications.

Hall, C. & Sandberg, J. (2012). "'We shall overcome": A qualitative exploratory study of the experiences of African Americans who overcame barriers to engage in family therapy. *American Journal Of Family Therapy, 40*(5), 445-458.

Hammersley ,M. (1992). *What's wrong with ethnography? Methodological explorations.* London: Routledge.

Hammersley, M. (1996). *The relationship between qualitative and quantitative research: Paradigm loyalty versus methodological eclecticism.* In J. T. E. Richardson (Ed), *Handbook of qualitative research methods for psychology and the social sciences,* pp. 75-85. Leicester: BPS books.

Harrison, G., Holton, A., Neilson, D., Owens, D., Boot, D., & Cooper, J. (1989). Severe mental disorder in Afro-Caribbean patients: Some social, demographic and service factors. *Psychological Medicine, 19,* 683-696.

Harrison, G., Owens, D., Holton, A., Neilson, D., & Boot, D. (1988). A prospective study of severe mental disorder in Afro-Caribbean patients. *Psychological Medicine, 18,* 643-657.

Hathaway, W. L., Scott, S. Y., & Garver, S. A. (2004). Assessing religious/spiritual functioning: A neglected domain in clinical practice? *Professional Psychology: Research and Practice, 35,* 97-104.

Hayes, S., Strosahl, K., & Wilson, G. (1999). *Acceptance and commitment therapy: An experiential approach to behaviour change.* The Guildford Press: New York.

Hays, P. (1995). Multicultural applications of cognitive-behavioural therapy. *Professional Psychology: Research and Practice, 26*, 309-315.

Hebert, R. S., Dang, Q. Y., & Schulz, R. (2007). Religious beliefs and practices are associated with better mental health in family caregivers of patients with dementia: Findings from the REACH study. *American Journal of Geriatric Psychiatry, 15*, 292-300.

Hemsi, L. K. (1967) Psychotic morbidity of West Indian immigrants. *Social Psychiatry, 2*, 95-100.

Henwood, K. L. & Pidgeon. N. F. (1992) Qualitative research and psychological theorising. *British Journal of Psychology, 83*, 97-111.

Herrstein, R. J. & Murray, C. (1994). *The bell curve.* New York: Free Press.

Hewson, M. G. (1998). Traditional healers in southern Africa. *Annuals of Internal Medicine, 128*, 1029-1034.

Hickling, F.W. & Rodgers-Johnson, P. (1995). The incidence of first contact schizophrenia in Jamaica. *British Journal of Psychiatry, 167*, 193-196.

Hickling, F.W., McKenzie, K., Mullen, R., & Muray, R. (1999). A Jamaican psychiatrist evaluates diagnosis at a London psychiatric hospital. *British Journal of Psychiatry, 175*, 283-285.

Hines, P., & Boyd-Franklin, N. (1982). Black families. In M. McGoldrick, M. J. Pearce, & J. Giordano (Eds), *Ethnicity and family therapy.* New York: Guildford Press.

HM Government and Department of Health. (2009). *New Horizons: A shared vision for mental health.* Available: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_109708.pdf. Last accessed 16th October 2012.

Hoare, J. (2009). Home Office Statistical Bulletin 12/09. London, UK: Home Office. *Drug Misuse Declared: Findings from the 2008/09 British Crime Survey.*

Holloway, I. & Todres, L. (2003). The status of method: Flexibility, consistency and coherence. *Qualitative Research, 3,* 345-57.

Holmes, L, D. (1987). *Quest for the real Samoa: the Mead/Freeman controversy and beyond.* South Hadley, MA: Bergin & Garvey.

Human Development Report. (2011). United Nations Development Programme. Last accessed January, 2012 at http://hdrstats.undp.org/en/countries/profiles/GBR.html

Hutchinson, G., Takei, N., Fahy, T. A., Bhugra, D., Gilvarry, C., Moran, P., Mallet, R., Sham, P., Leff, J., & Murray, R. M. (1996). Morbid risk of schizophrenia in first-degree relatives of white and African-Caribbean patients with psychosis. *The British Journal of Psychiatry, 169*(6), 776-780.

Hutchinson, G., Takei, N., Sham, P., Harvey, I., & Murray, R. M. (1999). Factor analysis of symptoms in schizophrenia: Differences between White and Caribbean patients in Camberwell. *Psychological Medicine, 29,* 607-612.

Imasogie, O. (2008). *African traditional religion.* Imasogie Publishers.

Ineichen, B., Harrison, G., & Morgan, H. G. (1984). Psychiatric hospital admissions in Bristol: Geographical and ethnic factors. *British Journal of Psychiatry, 145,* 600-604.

Jackson, M. (2001). Psychotic and spiritual experience: A case study comparison. In *Psychosis and spirituality: Exploring the new frontier.* (ed. I. Clarke), Ch 10 pp. 165-190. London and Philadelphia: Whurr Publishers.

Jackson, M. & Fulford, K. W. M. (1997). Spiritual experience and psychopathology. *Philosophy, Psychiatry and Psychology, 4,* 41-65.

Jacob, K. S., Sharan, P., Mirza, I., Garrido-Cumbrera, M., Seedat, S., Mari, J. J., Sreenivas, V., & Saxena, S. (2007). Mental health systems in

countries: Where are we now? *The Lancet, 370*, 1061-1077.

Jacobs, M. (1999). *Psychodynamic counselling in action*. London: Sage.

Jassi, C. (2008). Improving access to psychological therapies for Black minority ethnic communities: A short review and guide for implementation. *Advancing Practice in Bedfordshire, 5*(3). Last accessed on January 8th 2013 http://www.advancingpractice.co.uk/5(3)%20access%20to%20psychol%20therapies%20for%20bme.pdf

Jenkins, A. (1991). A humanistic approach to black psychology. In R. Jones (Ed.), *Black psychology* (pp. 79-98). Berkley, CA: Cobb and Henry.

Jervis, M. (1986). "Female, Asian and isolated." *Open Mind,* (April/May): 10-12.

Johns, L. C., Nazroo, J. Y., Bebbington, P., & Kuipers, E. (1998). Occurrence of hallucinations in a community sample. *Schizophrenia Research, 29*, 23.

Joseph, S. & Diduca, D. (2001). Schizotypy and religiosity in 13-18 year old school pupils. *Mental Health, Religion & Culture, 4*, 63-70.

Kasket, E. (2012). The counselling psychologist researcher. *Counselling Psychology Review*, *27*(2), 64-73.

Katon, W. & Kleinman, A. (1981). Doctor-patient negotiation and other social strategies in patient care. In *Relevance of Social Science for Medicine* (eds L. Eisenberg & A. Kleinman). Dordrecht: D. Reidel.

Katz, J. (1985). The socio-political nature of counselling. *The Counselling Psychologist, 13,* 615-624.

Kaye, C. & Lingiah, T. (Eds.) (2000). *Race, culture and ethnicity in secure psychiatric care: Working with difference*. London, UK: Jessica Kingsley.

Keating, F. & Robertson, D. (2004). Fear, black people and mental illness: A vicious circle? *Health & Social Care in the Community, 12*(5), 439-447.

Keating, F., Robertson, D., McCulloch, A., & Francis, E. (SCMH) (2002). Breaking the circles of fear: A review of the relationship between mental health services and the African and Caribbean communities in London. *The Sainsbury Centre for Mental Health.*

Keller, R. C. (2001). Madness and colonialism: Psychiatry in the British and French empires, 1800-1962. *Journal of Social History, 35,* 295-326.

Kiev, A. (1964). *Magic, faith and healing.* New York: Free Press.

Kiev, A. (1965) Psychiatric morbidity of West Indian immigrants in an urban group practice. *British Journal of Psychiatry, 111,* 51-56.

King, M. B. & Dein, S. (1998). The spiritual variable in psychiatric research. *Psychological medicine, 28*(6) 1259-1262.

King-Spooner, S. (2001). The place of spirituality in psychotherapy. In S. King-Spooner & C. Newnes (Eds.) *Spirituality and psychotherapy.* Ross-on-Wye: PCCS Books.

Kleinman, A. (1978). Concept and a model for the comparison of medical systems as cultural systems. *Social Science and Medicine, 12,* 85-93.

Koenig, H. G. (2005). *Faith and mental health.* Templeton.

Koffman, J., Fulop, N. J., Pashley, D., & Coleman, K. (1997) Ethnicity and use of acute psychiatric beds: One-day survey in North and South Thames regions. *British Journal of Psychiatry, 171,* 238-241.

Kohn, L. P., Oden, T., Munoz, R. F., Robinson, A., & Leavitt, D. (2002). Brief report: Adapted cognitive behavioral group therapy for depressed low-income African American women. *Community Mental Health Journal, 38,* 497-504.

Koss, J. (1987). Ethnomedical categories in the diagnosis and treatment of Hispanic patients: A review of the studies and implications for research, pp. 187-206. Simon Bolivar Research Monograph, Chicago, IL: University of Illinois Press.

Koss-Chioino, J. D. (2005). Spirit healing, mental health and emotion regulation, Zygon. *Journal Of Religion & Science, 40,*(2), 409-421.

Kriegler, S. (1993). Options and directions for psychology within a framework for mental health services in South Africa. *South African Journal of Psychology, 23,* 64-70.

Krüger, J. S., Lubbe, G. J. A., & Steyn, H. C. (2009). *The human search for meaning: A multi-religion introduction to the religions of humankind.* Van Schaik Publishers, Pretoria.

Larkin, M. (1998). Faith healing implicated in preventable child fatalities. *The Lancet, 351,* 9109, 1109.

Larson, D. B., Swyers, J. P., & McCollough, M. (1997). Scientific research on spirituality and health: A consensus report. *National Institute for Healthcare Research.*

Lawson, W. B., Yesavage, J. A., & Werner, P. D. (1984) Race, violence and psychopathology. *Journal of Clinical Psychiatry, 45,* 294-297.

Lee, C. C., Oh, M. Y., & Mountcastle, A. R. (1992). Indigenous models of helping in non-western countries: Implications for multi-cultural counselling. *Journal of Multicultural Counselling and Development, 20,* 3-10.

Leech, K. (1980). *True prayer: An introduction to Christian spirituality.* London: Sheldon Press.

Littlewood, R. & Lipsedge, M. (1978). Migration, ethnicity and diagnosis. *Psychopathology, 11*(1), 15-22.

Littlewood, R. & Lipsedge, M. (1981) Some social and phenomenological characteristics of psychotic immigrants. *Psychological Medicine, 11,* 289-302.

Lloyd, K. & Moodley, P. (1992). Psychotropic medication and ethnicity: An inpatient survey. *Social Psychiatry and Psychiatric Epidemiology, 27,* 95-101.

Loveday, R. (2001). *Prevention in traditional Africa. HIV/AIDS care and counselling: A multi-disciplinary approach.* Cape Town: Pearson Education.

Lowenthal, K. M. & Lewis, C. A. (2011). Mental health, religion and culture. *The Psychologist, 24*(4) 256-259.

MacDonald, D. A. & Holland, D. (2003). Spirituality and the MMPI-2. *Journal of Clinical Psychology, 59,* 399-410.

Macpherson, W. (1999). *The Stephen Lawrence inquiry: Report of an inquiry by Sir William Macpherson of Cluny advised by Tom Cook, The Right Reverend Dr John Sentamu, Dr Richard Stone.* London, The Stationery Office.

Madden, R. (2010). *Being ethnographic: A guide to the theory and practice of ethnography.* London: Sage.

Magesa, L. (2002). *African religion: The moral traditions of abundant life.* Orbis Books, Maryknoll.

Mahy, G., Mallett, R., Leff, J., & Bhugra, D. (1999). First-contact incidence rate of schizophrenia in Barbados. *British Journal of Psychiatry, 175,* 28-33.

Maiello, S. (1999). Encounter with an African healer. *Journal of Child Psychotherapy, 25*(2), 217.

Mallett, R., Leff, J., Bhugra, D., Pang, D., & Zhao, J. H. (2002) Social environment, ethnicity and schizophrenia: A case-control study. *Social Psychiatry and Psychiatric Epidemiology, 37,* 329-335.

Marshall, C. & Rossman, G. B. (2006). *Designing qualitative research.* Thousands Oaks: Sage Publications.

Martsolf, D. S. & Mickley J. R. (1998). The concept of spirituality in nursing theories: Differing world-views and extent focus. *Journal of Advanced Nursing, 27,* 294-303.

Mattis, J. S. & Watson, C. R. (2009). Religion and spirituality (pp. 91-102). In H. Neville, B. M. Tynes, & S. O. Utsey (Eds.), *Handbook of African American psychology.* California: Sage publications.

Maultsby, M. C., Jr. (1982). *A historical view of Blacks' distrust of psychiatry.* In S. M. Turner & R. T. Jones (Eds.), *Behaviour modification in Black populations* (pp. 39-55). New York: Plenum.

Max, J. (1989). *Assimeng, religion and social change in West Africa: An introduction to the sociology of religion.* University Press. Accra, Ghana.

Maxwell, J. (1996). *Qualitative research design: An interactive approach.* Thousand Oaks, CA: Sage.

Mayers, C., Leavey, G., Vallianatou, C., & Barker, C. (2007). How clients with religious or spiritual beliefs experience psychological help-seeking and therapy: A qualitative study. *Clinical Psychology and Psychotherapy, 14,* 317-327.

Mbiti, J. S. (1975). *Introduction to African religion* (2nd edn.). Heinemann International Literature and Textbooks (reprinted in 1991): USA.

Mbiti, J. S. (1990). *African religions and philosophy (*2nd edn.). Heinemann Educational Publishers, Oxford.

McAdoo, H. (1977). Family therapy in the black community. *American Journal of Orthopsychiatry, 47*(1), 75-79.

McCreadie, R. G., Leese, M., Tilak-Singh, D., Loftus, L., MacEwan, T., & Thornicroft, G. (1997). Nithsdale, Nunhead, and Norwood: Similarities and differences in prevalence of schizophrenia and utilisation of services in rural and urban areas. *British Journal of Psychiatry, 170,* 31-36.

McCulloch, J. (1995). *Colonial psychiatry and 'the African mind'.* Cambridge: Cambridge University Press.

McCullough, M. E. (1995). Prayer and health: Conceptual issues, research review and research agenda. *Journal of Psychology and Religion, 23*(1), 15-29.

McCullough, M. E. (1999). Research on religion-accommodative counseling: Review and meta-analysis. *Journal of Counseling Psychology, 46,* 92-98.

McDonald, G. (2000). Cross-cultural methodological issues in ethical research. *Journal of Business Ethics, 27*(1/2), 89-104.

McGovern, D. & Cope, R. (1987). First psychotic admission rates of first- and second-generation African-Caribbeans. *Social Psychiatry, 22,* 139-149.

McGuire, P. K., Jones, P., Harvey, I., Bebbington, P., Toone, B., Lewis, S., & Murray, R. M. (1994). Cannabis and acute psychosis. *Schizophrenia Research, 13*(2), 161-167.

McIntyre, A. (2008). *Participatory action research.* SAGE.

McKenzie, K., Fearon, P., & Hutchinson, G. (2008). Migration, ethnicity and psychosis. In C. Morgan, K. McKenzie, & P. Fearon (Eds.), *Society and psychosis.* Cambridge, UK: Cambridge University Press; 2008. p. 143-160.

McLeod, J. (1996). Qualitative research methods in counselling psychology. In W. Dryden & R. Wolfe (Eds.) *Handbook of counselling psychology,* pp. 65-86. London: Sage.

McRae, M. B., Thompson, D. A., & Cooper, S. (1999). Black churches as therapeutic groups. *Journal of Multicultural Counseling and Development, 27* (4), 207-221.

McSherry, W. & Draper, P. (1998). The debates emerging from the literature surrounding the concept of spirituality as applied to nursing. *Journal of Advanced Nursing, 27,* 683-691.

McTaggart, R. (1997). *Participatory action research: International contexts and consequences.* SUNY Press.

Mead, M. (1928). *Coming of age in Samoa.* New York: Morrow.

Meissner, O. (2004). The traditional healer as part of the primary health care team? Retrieved January 25, 2013, from http://www.hrhresourcecenter.org/node/2690

Mensah, E. N. (2000). *Traditional medicine in Ghana: Situation, policies, development and challenges of the 21st century.* Presented at the International Congress on Traditional Medicine, Beijing, China, 22-24 April 2000.

Metropolitan Police. (2010). Project violet. Last accessed January 2013 at http://content.met.police.uk/Article/Abuse-linked-with-spirit-possession/1400010000897/1400010000897

MHAC (2008). *Risk, rights, recovery: The Mental Health Act Commission Twelfth Biennial Report 2005-2007.*

MHAC (2009). *Coercion and consent: Monitoring the Mental Health Act 2007–2009. The Mental Health Act Commission Thirteenth Biennial Report 2007–2009.*

ModernGhana. (2012) http://www.modernghana.com/lifestyle/3068/16/parliament-passes-mental-health-bill.html

Moodley, P. & Perkins, R. E. (1991) Routes to psychiatric inpatient care in an inner London Borough. *Social Psychiatry and Psychiatric Epidemiology, 26,* 47-51.

Moodley, P. & Thornicroft, G. (1988). Ethnic group and compulsory detention. *Medicine Science and Law, 28,* 324-328.

Moodley, R & West, W. (2005). *Integrating traditional healing practices into counseling and psychotherapy.* Thousand Oaks, Calif.: Sage Publications.

Moore, T. H., Zammit, S., Lingford-Hughes, A., Barnes, T. R., Jones, P. B., Burke, M., & Lewis, G. (2007). Cannabis use and risk of psychotic or affective mental health outcomes: A systematic review. *The Lancet, 370,* 319-328.

Morgan, C., Charalambides, M., Hutchinson, G., & Murray, R. (2010). Migration, ethnicity, and psychosis: Toward a sociodevelopmental model. *Schizophrenia Bulletin, 36*(4), 655-664.

Morgan, C., Mallet, R., Hutchinson, G., Bagalkote, H., Morgan, K., Fearon, P., Dazzan, P., Boydell, J., McKenzie, K., Harrison, G., Murray, R., Jones, P., Craig, T., Leff, J., & AESOP Study Group. (2005). Pathways to care and ethnicity: 2. Source of referral and help seeking. *British Journal of Psychiatry, 186,* 290-296.

Moodley, R & West, W. (2005). *Integrating traditional healing practices into counseling and psychotherapy.* Thousand Oaks, Calif.: Sage Publications.

Morgan, C., Mallett, R., Hutchinson, G., Bagalkote, H., Morgan, K., Fearon, P., Dazzan, P., Boydell, J., McKenzie, K., Harrison, G., Murray, R., Jones, P., Craig, T., Leff, J., & AESOP Study Group. (2005). Pathways to care and ethnicity: 1. Sample characteristics and compulsory admission. *British Journal of Psychiatry, 186,* 281-289.

Morse, E., Morse, P., Klebba, K., Stock, M., Forehand, R., & Panayotova, E. (2000). The use of religion among HIV-infected African American women. *Journal of Religion and Health, 39,* 261-276.

Mukherjee, S., Shukla, S., Woodle, J., Rosen, A. M., & Olarte, S. (1983). Misdiagnosis of schizophrenia in bipolar patients: A multiethnic comparison. *The American Journal of Psychiatry, 140*(12), 1571-1574.

Mulvaney-Day, N. E., Earl, T. R., Diaz-Linhart, Y., & Alegría, M. (2011). Preferences for relational style with mental health clinicians: A qualitative comparison of African American, Latino and Non-Latino White patients. *Journal of Clinical Psychology, 67*(1), 31-44.

Naeem, F., Waheed, W., Gobbi, M., Ayub, M., & Kingdon, D. (2011). Preliminary evaluation of culturally sensitive CBT for depression in Pakistan: Findings from Developing Culturally-sensitive CBT Project (DCCP). *Behavioural and Cognitive Psychotherapy 39,* 165-173.

Nagayama Hall, G. C. (2001). Psychotherapy research with ethnic minorities: Empirical, ethical and conceptual issues. *Journal of Consulting and Clinical Psychology, 69,* 502-510.

Naidoo, A.V. (1996). Challenging the hegemony of Eurocentric psychology. *Journal of Community and Health Sciences, 2*(2), 9-16.

Nathan, T. (1994). *L'influence qui guérit [Healing influence].* Paris: Editions Odile Jacob.

Nathan, T. (1993). Ethnopsy 93 [Ethnopsychiatry 93]. *Nouvelle Revue d'Ethnopsychiatrie, 20,* 7- 14.

National Association for Black for Black Mental Health. (2002). *Tell it as it is.* London, NABMH.

Ndetei, D. M. & Vadher, A. (1985) A comparative cross-cultural study of the frequencies of hallucination in schizophrenia. *Acta Psychiatrica Scandinavica, 70,* 545-549.

Neeleman, J. & King, M. B. (1993). Psychiatrists' religious attitudes in relation to their clinical practice: A survey of 231 psychiatrists. *Acta Psychiatrica Scandinavica, 88,* 420-424.

Newbigging, K. (2000). *Report from the carers' event: Making space.* Manchester, North West Mental Health Development Centre.

Newhill, C. E. (1990). The role of culture in the development of paranoid symptomatology. *American Journal of Orthopsychiatry, 60,* 176-185.

NHSTA: NHS directory of alternative and complimentary healers. Last accessed January, 2013 at: www.nhstadirectory.org

Nicholls, M. (2002). Strategies for living: Spirituality and mental health. *The Mental Health Foundation, Updates, 4,* (6).

Nickerson, K. J., Helms, J. E., & Terrell, F. (1994). Cultural mistrust, opinions about mental illness, and Black students' attitudes toward seeking psychological help from counselors. *Journal of Counselling Psychology, 41,* 378-385.

NSDUH (The National Survey on Drug Use and Health). (2005). *Substance abuse and mental health services administration,* Office of Applied Studies. Last accessed January, 2013 at: http://www.samhsa.gov/data/nsduh/2k4nsduh/2k4results/2k4Results.htm#7.1.4

O'Reilly, K. (2009). *Key concepts in ethnography.* London: Sage.

Odell, S. M., Surtees, P. G., Wainwright, N. W., Commander, M. J., & Sashidharan, S. P. (1997). Determinants of general practitioner recognition of psychological problems in a multi-ethnic inner-city health district. *British Journal of Psychiatry, 171,* 537-541.

Office for National Statistics. (2011). *Statistical bulletin: Population Estimates by Ethnic Group 2002-2009.* Available: http://www.ons.gov.uk/ons/publications/index.html?pageSize=50&sortBy=none&sortDirection=none&newquery=ethnic&content-type=publicationContentTypes. Last accessed 29th October 2012.

Ofori-Atta, A., Cooper, S., Akpalu, B., Osei, A., Doku, V., Lund, C., Flisher, A., & the MHAPP Research Programme Consortium. (2010). Common understandings of women's mental illness in Ghana: Results from a qualitative study. *International Review of Psychiatry, 22*(6), 589-598.

Ofori-Atta, A., Read, U. M., Lund, C., & MHaPP Research Programme Consortium. (2010). A situational analysis of mental health services and legislation in Ghana: Challenges for transformation. *African Journal of Psychiatry.* http://www.dfid.gov.uk/r4d/PDF/Outputs/MentalHealth_RPC/A_situation_analysis_of_mental_health_Ghana.pdf

Olabisi Abimbola, A. (2008). *Missionary encounters and the development of Yoruba women's spirituality 1842-1930.* (Thesis). Last accessed January, 2013 at: http://ethos.bl.uk/OrderDetails.do?uin=uk.bl.ethos.490643

Onyinah, O. (2002). *Akan witchcraft and the concept of exorcism in the church of Pentecost.* Last accessed 12th June, 2012 at: http://etheses.bham.ac.uk/1694/1/Onyinah02PhD.pdf

Onyinah, O. (2012). *Pentecostal exorcism: Witchcraft and demonology in Ghana.* Dorset, UK: Deo Publishing.

Oppenheim, A. (1992). *Questionnaire design, interviewing and attitude measurement.* London: Pinter.

Osei, A. O. (2001). Types of psychiatric illness at traditional healing centres in Ghana. *Ghana Medical Journal, 35*, 106-110.

Owens, D., Harrison, G., & Boot, D. (1991) Ethnic factors in voluntary and compulsory admissions. *Psychological Medicine, 21*, 185-196.

Oyebode, F. (2006). History of psychiatry in West Africa. *International Review of Psychiatry, 18*(4), 319-325.

Palmer, R. F., Katerndahl, D., & Morgan-Kidd, J. (2004). A randomized trial of the effects of remote intercessory prayer: interactions with personal beliefs on problem-specific outcomes and functional status. *Journal of Alternative and Complementary Medicine, 10*(3), 438-448.

Pargament, K. I. (2007). *Spiritually integrated psychotherapy: Understanding and addressing the sacred.* New York: Guilford Press.

Parkman, S., Davies, S., Leese, M., Phelan, M,. & Thornicroft, G. (1997). Ethnic differences in satisfaction with mental health services among representative people with psychosis in south London: PRiSM study 4. *British Journal of Psychiatry, 171,* 260 -264.

Parrinder, G. (1951). *West African psychology. A comparative study of psychological and religious thought.* Cambridge: Lutterworth Press. Reprinted in 2002.

Patel, K, & Hegginbotham, C. (2007). Institutional racism in psychiatry does not imply racism in individual psychiatrists: Commentary on institutional racism in psychiatry. *Psychiatric Bulletin, 31,* 367-368.

Patel, V. & Winston, M. (1994). "Universality of mental illness" revisited: Assumptions, artifacts and new directions. *British Journal of Psychiatry, 165,* 437-440.

Patterson, L. (2001). *Traditional medicine in Ghana.* Paper presented at the Second Annual International Conference on Traditional Medicine, Ghana, Accra. Available at http://www.ccnh.edu/community/newsletter/holtimesv8n4/ht_v8n4.pdf (accessed 11 December 2011).

Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd edn.). Sage.

Perdersen, P. B. (1988). The multicultural perspective as a fourth force in counselling. *Journal of Mental Health Counselling, 12,* 93-95.

Perkins, R. E. & Moodley, P. (1993). Perception of problems in psychiatric inpatients: Denial, race and service usage. *Social Psychiatry and Psychiatric Epidemiology, 28,* 189-193.

Persons, J. B. (1986). The advantages of studying psychological phenomena rather than psychiatric diagnoses. *American Psychologist, 41,* 1252-1260.

Pidgeon, N. (1996) Grounded theory: Theoretical background. In J. T. E. Richardson (Ed), *Handbook of qualitative research methods for psychology and the social sciences*, pp. 75-85. Leicester: BPS books.

Pidgeon, N. & Henwood, K. (1996) *Grounded theory: Practical implementation.* In J. T. E. Richardson (Ed), *Handbook of qualitative research methods for psychology and the social sciences*, pp. 86-101. Leicester: BPS books.

Pinto, R., Ashworth, M., & Jones, R. (2008). Schizophrenia in black Caribbeans living in the UK: An exploration of underlying causes of the high incidence rate. *The British Journal of General Practice, 58*(551), 429-434.

Pipe, R., Bhat, A., Matthews, B., & Hampstead, J. (1991). Section 136 and African/Afro-Caribbean Minorities. *International Journal of Social Psychiatry, 37*(1), 14-23.

Poland, B. D. (2002). Transcription quality. In J. F. Gubrium & J. A. Holstein (Eds.), *Handbook of interview research: Context & method,* pp. 629-649. Thousand Oaks, CA: Sage.

Poston, W. C., Craine, M., & Atkinson, D. R. (1991). Counselor dissimilarity confrontation, client cultural mistrust, and willingness to disclose. *Journal of Multicultural Counselling and Development, 19,* 65-73.

Pote, H. L. & Orrell, M. W. (2002). Perceptions of schizophrenia in multicultural Britain. *Ethnicity and Health, 7,* 7-20.

Potter, J. & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behaviour.* Sage.

Prince, R. (1960). The brain fag syndrome in Nigerian students. *Journal of Mental Science, 106,* 559-70.

Prince, R. (1961). Yoruba native healers and their management of mental illness. In T. A. Lambo (Ed.), *Report of the first pan-African psychiatric conference.* Abeokuta, Nigeria: Government Printer.

Prince, R. (1967). The changing picture of depressive syndromes in Africa: Is it fact or diagnostic fashion? *Canadian Journal of African Studies, 1,* (2) (Nov., 1967), 177-192.

Prince, R. (2000). Transcultural psychiatry: Personal experiences and Canadian perspectives. *Canadian Journal of Psychiatry, 45,* 431-437.

Prins, H. (1993). *Report of the committee of inquiry into the death of Orville Blackwood and a review of the deaths of two other Afro-Caribbean Patients: 'Big, black and dangerous?'* London: Special Hospitals Services Authority.

Puckree, T., Mkhize, M., Mgobhozi, Z., & Lin, J. (2002). African traditional healers: What health care professionals need to know. *International Journal of Rehabilitation Research, 25,* 247-251.

Purton, C. (1998). Unconditional positive regard and its spiritual implications. In B. Thorne & E. Lambers (Eds.) *Person-centred therapy: A European perspective.* London: Sage.

Race Relations (Amendment) Act. Government Legislation. (2000). *Chapter 34. Further extension of 1976 Act to police and other public authorities.* Available: http://www.legislation.gov.uk/ukpga/2000/34/introduction. Last accessed 12th October 2012.

Rathod, S., Kingdon, D., Phiri, P., & Gobbi, M. (2010). Developing culturally sensitive cognitive behaviour therapy for psychosis for ethnic minority patients by exploration and incorporation of service users' and health professionals' views and opinions. *Behavioural and Cognitive Psychotherapy, 38*(5), 511-533.

Rathod, S., Phiri, P., Harris, S., Underwood, C., Thagadur, M., Padmanabi, U., & Kingdon, D. (2013). Cognitive behaviour therapy for psychosis can be adapted for minority ethnic groups: A randomised controlled trial. *Schizophrenia Research, 143*(2-3), 319-326.

Reiheld, A. (2010). Patient complains of ... How medicalization mediates power and justice. *International Journal of Feminist Approaches to Bioethics, 3*(1), 72-98.

Rethink mental illness. (2012). *Black & minority ethnic groups: Engaging with mental health services.* Last accessed October 19th, 2012. http://www.rethink.org/about_mental_illness/who_does_it_affect/Black_minority_ethnic_groups/engaging_with_mental.html

Richards, P. S. & Bergin, A. E. (2000). *Toward religious and spiritual competency for mental health professionals.* In P. S. Richards & A.E. Bergin (Eds.), *Handbook of psychotherapy and religious diversity,* pp. 3-26. Washington, DC: American Psychological Association.

Richardson J. T. E. (1996) (Ed). *Handbook of qualitative research methods for psychology and the social sciences.* Leicester: BPS books.

Ridley, C. R. (1984). Clinical treatment of the nondisclosing Black client: A therapeutic paradox. *American Psychologist, 39,* 1234-1244.

Riessman, C. K. (1993). *Narrative analysis.* Newbury Park, CA: Sage.

Ritchie, J. F. (1943). *The African as a suckling and as adult: a psychological study.* First published in 1943. Reprinted in 1968 by Rhodes-Livingstone Institute: Manchester.

Roberts, H. (2001). A way forward for mental health care in Ghana? *The Lancet, 357,* 1859.

Rogers, C. R. (2003). *Client centred therapy: Its current practice, implications and theory* (New edn.). Constable.

Rogers, C. R. (2007). *Counselling and psychotherapy.* Read Books.

Romme, M. A. & Escher, S. (1993). *The new approach: A Dutch experiment.* In M.A. Romme & S. Escher (Eds.) *Accepting voices*, pp.11–27. London: Mind Publications.

Romme, M.A., Honig, A., Noorthoorn, E.O., & Escher, S. (1992). Coping with hearing voices: An emancipatory approach. *British Journal of Psychiatry, 161,* 99-103.

Rosenstock, I.M., Strecher, V.J., & Becker, M.H. (1988). Social learning theory and the Health Belief Model. *Health Education Quarterly*, 15,2: 175-183

Rosmarin, D. H., Auerbach, R. P., Bigda-Peyton, J. S., Björgvinsson, T., & Levendusky, P. G. (2011). Integrating spirituality into cognitive behavioral therapy in an acute psychiatric setting: A pilot study. *Journal of Cognitive Psychotherapy, Winter 2011, 25*(4) , 287-303. 17p. DOI: 10.1891/0889-8391.25.4.287.

Rousseau, J. J. (1755). *A discourse on inequality.* Translated with an introduction by M. Cranston (1984 edn.), London: Penguin.

Russell, D. (1994). *Psychiatric diagnosis and the interests of women.* In J. Z. Sadler, O. P. Wiggins, & M. A. Schwartz (Eds.), *Philosophical perspectives on psychiatric diagnostic classification*, pp. 246-258. Baltimore: Johns Hopkins University Press.

Rwegellera, G. G. (1980). Differential use of psychiatric services by West Indians, West Africans and English in London. *British Journal of Psychiatry, 137,* 428-432.

Ryan, G. W. & Bernard, H. R. (2000). *Data management and analysis methods.* In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd edn.), pp. 769-802. Thousand Oaks, CA: Sage.

Sadowsky, J. H. (1999). *Imperial bedlam: Institutions of madness in colonial southwest Nigeria.* Berkeley: University of California Press.

Sainsbury Centre for Mental Health (2006) Policy paper 6. *The costs of race inequality*. London: SCMH.

Samoulihan, T. & Seabi, J. (2010). University students' beliefs about the causes and treatments of mental illness. *South African Journal of Psychology, 40,* 74-89.

Sanford, G. J. (2010). *Increasing mental health awareness and utilization of services among African Americans: A church-based program.* Spalding University.

Sashidharan, S. P. (1993) Afro-Caribbeans and schizophrenia: The ethnic vulnerability hypothesis re-examined. *International Review of Psychiatry, 5,*129-144.

Sashidharan, S. P. (2001). Institutional racism in British psychiatry. *The Psychiatric Bulletin, 25,* 244-247.

Sashidharan, S. P. (for the National Institute of Mental Health and the Department of Health). (2003). *Inside outside: Improving mental health services for Black and minority ethnic communities in England.* London: Department of Health, NIMHE. Last accessed January 2nd, 2013. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4019452.pdf

Schnittker, J., Freese, J., & Powell, B. (2000). Nature, nurture, neither, nor: Black-White differences in beliefs about the causes and appropriate treatment of mental illness. *Social Forces, 78,* 1101-1133.

Schräm, R. (1971). *A history of the Nigerian health services.* Ibadan University Press.

Selby, H. (2008). *Mental illness, prayer camps and society: A factor of human rights abuse.* Ghanaian Chronicle.

Shapiro, J., Hollingshead, J., & Morrison, E. H. (2002). Primary care resident, faculty, and patient views of barriers to cultural competence, and the skills needed to overcome them. *Medical Education, 36,* 749-759.

Sharpley, M. S. & Peters, E. (1999) Ethnicity, class and schizotypy. *Social Psychiatry and Psychiatric Epidemiology, 34,* 507-512.

Sharpley, M., Hutchinson, G., McKenzie, K., & Murray, R. (2001). Understanding the excess of psychosis among the African Caribbean population in England: Review of current hypotheses. *British Journal Of Psychiatry, 178* (40), 60-68.

Sherill, K. A. & Larson, D. B. (1994). The anti-tenure factor in religious research in clinical edipemiology and aging. In J. S.Levin (Ed.) *Religion in aging and health.* California: Sage.

Sima, R.G. (2005). Sharing healing secrets. In R. Moodley, & W. West (2005). *Integrating traditional healing practices into counseling and psychotherapy.* Thousand Oaks, Calif.: Sage Publications.

Singh, A. N. (1999). Shamans, healing, and mental health. *Journal of Child & Family Studies, 8*(2), 131-134.

Singh, S. P., Croudace, T., & Beck, A. et al. (1998). Perceived ethnicity and the risk of compulsory admission. *Social Psychiatry and Psychiatric Epidemiology, 33,* 39-44.

Slade, P. D. & Cooper, R. (1979). Some conceptual difficulties with the term 'schizophrenia': An alternative model. *British Journal of Social and Clinical Psychology, 18,* 309-317.

Smartt, C. G. F. (1956). Mental maladjustment in the East African. *British Journal of Mental Science, 102,* 441-66.

Smith, E. J. (1981). Cultural and historical perspectives in counselling blacks. In D. W. Sue (Ed.), *Counselling the culturally different.* New York: John Wiley & Sons.

Smith, J. A. (1996). Evolving issues for qualitative psychology. In J. T. E. Richardson (Ed.), *Handbook of qualitative research methods for psychology and the social sciences*, pp. 189-201. Leicester: BPS books.

Smith, J. A. & Osborn, M. (2003). Interpretative phenomenological analysis. In Smith, J. A. (Ed.), *Qualitative psychology: A practical guide to methods*. Sage.

Smith, J. A., Jarman, M., & Osborn, M. (1999). Doing interpretative phenomenological analysis. In Murray, M. & Chamberlain, M. M. K. (Eds.), *Qualitative health psychology: Theories and methods*. Sage.

Snow, L. F. (1983). Traditional health beliefs and practices among lower class black Americans. *Cross-Cultural Medicine, 139*, 820-828.

Snowden, L. R. (2003). Bias in mental health assessment and intervention: theory and evidence. *American Journal of Public Health, 93*, 239-243.

Snowdon, I. & Cheung, F. (1990). Use of inpatient mental health services by members of ethnic minority groups. *American Psychologist, 45*, 347-355.

Sodi, T. (1996). Towards recognition of indigenous healing: Prospects and constraints. *Journal of Comprehensive Health, 7*, 5-9.

Sollod, R.N. (2005). *Spiritual and healing approaches in psychotherapeutic practice.* In R. Moodley, & W. West (2005). *Integrating traditional healing practices into counseling and psychotherapy*. Thousand Oaks, Calif.: Sage Publications.

Somé, M. P. (1998). *The healing wisdom of Africa: Finding life purpose through nature, ritual and community*. Tarcher: Penguin, New York.

Stanford, M. & Philpott, D. (2011). Baptist senior pastors' knowledge and perceptions of mental illness. *Mental Health, Religion & Culture, 14*, (3), 281-290.

Stanford, M. S. (2007). Demon or disorder: A survey of attitudes toward mental illness in the Christian church. *Mental Health, Religion & Culture, 10,* 445-449.

Stanford, M. S. & McAlister, K. R. (2008). Perceptions of serious mental illness in the local church. *Journal of Religion, Disability & Health, 12*(2), 144-153.

Strauss, A. & Corbin, J. (1998). *Basics of qualitative research: Technique and procedure for developing grounded theory* (2nd edn.). Thousand Oaks, CA: Sage.

Strauss, A. L. (1987). *Qualitative analysis for social scientists*. Cambridge University Press.

Strauss, A. L. & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques* (2nd edn.). Thousand Oaks, CA: Sage.

Suddaby, R. (2006). What grounded theory is not. *Academy of Management Journal, 49,* 633-642.

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counselling competencies and standards: A call to the profession. *Journal of Multicultural Counselling and Development, 20,*64-88.

Sue, S., Fujino, D. C., Hu, L., Takeuchi, D. T., & Zane, N. W. S. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consulting and Clinical Psychology, 59,* 533-540.

Sugarman, P. A. & Craufurd, D. (1994). Schizophrenia in the Afro-Caribbean community. *British Journal of Psychiatry, 164,* 474-480.

Sundermeier, T. (1990). Nur gemeinsam können wir leben: Das Menschenbild schwarzafrikanischer Religionen [*Only together can we live: The humanity of Black African religions]*. Gütersloher Verlagshaus Gerd Mohn, Gütersloh.

Swinton, J. (2001). *Spiritualty and mental health care: Rediscovering a 'forgotten' dimension.* London: Jessica Kingsley Publishers.

Szasz, T. (1976). Schizophrenia: The sacred symbol of psychiatry. *British Journal of Psychiatry, 129,* 308-316.

Szasz, T. S. (1971). Sane slave: Social control and legal psychiatry. *The. American Criminal Law Review, 10,* 337.

Tabi, M. (1994). Nursing in Ghana. *Journal of Nursing Administration, 24,* 17-18.

Tabi, M. & Frimpong, S. (2003). HIV infection of women in developing countries. *International Nursing Review, 50,* 40-50.

Tabi, M., Powell, M., & Hodnicki, D. (2006). Use of traditional healers and modern medicine in Ghana. *International Nursing Review, 53,* 52-58.

Takei, N., Persaud, R., Woodruff, P., Brockington, I., & Murray, R. M. (1998). First episodes of psychosis in Afro-Caribbean and White people: An 18-year follow-up population-based study. *British Journal of Psychiatry, 172,* 147-153.

Tanner, R. E. S. (1999). Concern, cooperation, and coexistence in healing. *British Medical Journal, 319,* 133.

Taylor, G. W. & Ussher, J. M. (2001). Making sense of S&M: A discourse analytic account. *Sexualities, 4,* 293-314.

Terman, L. (1916). *The measurement of intelligence.* Houghton Mifflin Company. Retrieved from http://archive.org/details/measurementofint008006mbp

Terrell, F. & Terrell, S. L. (1984). Race of counselor, client sex, cultural mistrust level, and premature termination from counselling among Black clients. *Journal of Counselling Psychology, 31,* 371-375.

Terrell, F. & Terrell, S. L., (1981). An inventory to measure cultural mistrust among Blacks. *Western Journal of Black Studies, 5,* 180-184.

The Africa Guide Website (2012). *People and culture of Ghana.* http://www.africaguide.com/country/ghana/culture.htm last accessed 27th October 2012.

The Central Press newspaper. April 9th, 2012, *Mental health in Ghana.* (Editorial). Last accessed June, 2012 at http://centralpressnewspaper.blogspot.co.uk/2012/04/mental-health-in-ghana-editorial.html

The European Herbal and Traditional Medicine Practitioners Association http://ehtpa.eu

The Ghana International Journal of Mental Health (website). Last accessed January, 2013 at http://ghana-ijmh.org

The Guardian. (2011)*Ghana's new mental health bill aims to address stigma.* . http://www.guardian.co.uk/global-development/2011/aug/29/ghana-new-mental-health-bill

The Royal College of Psychiatrists Special Interest Group. *Spirituality and psychiatry.* http://www.rcpsych.ac.uk/members/specialinterestgroups/spirituality.aspx

The Tavistock Institute. (2008). *Celebrating the launch of our new African healing for wellbeing website.* Last accessed on January 12th, 2012 at http://www.tavinstitute.org/news/detail.php?nid=42

Thomas, C. S., Stone, K., Osborn, M., Thomas, P. F., & Fisher, M. (1993). Psychiatric morbidity and compulsory admission among UK-born Europeans, Afro-Caribbeans and Asians in central Manchester. *The British Journal of Psychiatry, 163*(1), 91-99.

Thompson, C. E., Worthington, R., & Atkinson, D. R. (1994). Counselor content orientation, counselor race, and Black women's cultural mistrust and self-disclosure. *Journal of Counselling Psychology, 41,* 155-161.

Toch, H., Adams, K., & Greene, R. (1987). Ethnicity, disruptiveness, and emotional disorder among prison inmates. *Criminal Justice and Behaviour, 14*(1), 93-109.

Tooth, G. (1950). *Studies in mental illness in the Gold Coast.* London: HMSO.

Trochim, W. & Donnelly, J. P. (2007). *The research methods knowledge base* (3rd edn.). Atomic Dog Publishing.

Tucker, C. M., Ferdinand, L. A., Mirsu-Paun, A., Herman, K. C., Delgado-Romero, E., van den Berg, J. J., & Jones, J. D. (2007). The roles of counseling psychologists in reducing health disparities. *The Counseling Psychologist, 35*, 650-678.

Tuckett, A. G. (2005). Applying thematic analysis theory to practice: A researcher's experience. *Contemporary Nurse, 19,* 75-87.

Tuckwell, G. & Flag, D. (1995). *A question of healing: The reflections of a doctor and a priest.* London: Fount.

Turaki, Y. (1999). *Christianity and African gods: A method in theology.* Potchefstroomse Universiteit vir Christelike Hoër Onderwys, Potchefstroom.

Twumasi, P.A. (1979). Community involvement in health care: The kintampo experience in Ghana: A study in the changing health model. *Ghana Medical Journal*, 80-84.

Ulanov, A. & Ulanov, B. (1982). *Primary speech: A psychology of prayer.* Atlanta, GA: John Knox Press.

Ulanov, A. & Ulanov, B. (1992). Prayer and personality: prayer as primary speech. In C. Jones, G. Wainwright, & E. Yarnold (Eds.), *The study of spirituality.* London: SPCK.

Ullmann, L. & Krasner, L. (1975). A psychological approach to abnormal behaviour. New York: Appleton-Century-Crofts.

Utley, I. (2009). *Ghana: The essential guide to customs and culture.* London: Kuperard.

Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing & Health Sciences.* Epub ahead of print. Last accessed August 2013 at: www.ncbi.nim.nih.gov/pubmed/23480423

Van der Geest, S. (1997). Is there a role for traditional medicine in basic health services in Africa? A plea for community perspective. *Tropical Medicine & International Health, 2,* 903-911.

van Ryn, M. & Fu, S. S. (2003). Paved with good intentions: Do public health and human service providers contribute to racial/ethnic disparities in health? *American Journal of Public Health, 93,* 248-255.

Vassol, E. L. (2005). *African American pastors' perceptions of their congregants' mental health needs.* Kansas State University. Dissertation. Last accessed July, 2013 at: http://krex.k-state.edu/dspace/handle/2097/114

Vaughan, M. (1991). *Curing their ills: Colonial power and African illness.* Stanford, CA: Stanford University Press.

Victoria Climbié Inquiry Report. (2003). *Sixth Report of Session 2002–03 Report, and formal minutes together with oral evidence.* House of Commons Health Committee. Ordered by The House of Commons to be printed 5 June 2003. Last accessed January 10th, 2013 at http://www.publications.parliament.uk/pa/cm200203/cmselect/cmhealth/570/570.pdf

Vontress, C. E. (1991). Traditional healing in Africa: Implications for cross-cultural counselling. *Journal of Counselling & Development, 70*(1), 242-249.

Vontress, C. E. (1999). Interview with a traditional African healer. *Journal of Mental Health Counselling, 21*(4), 326.

Vontress, C. E. (2001). Cross-cultural counselling in the 21st century. International *Journal for the Advancement of Counseling, 23*, 83-97.

Vontress, C. E. (2005). *Animism: foundation of traditional healing in Sub-Saharan Africa.* In R. Moodley, & W. West (2005). *Integrating traditional healing practices into counseling and psychotherapy.* Thousand Oaks, Calif.: Sage Publications.

Vontress, C. E., & Naiker, K. S. (1995). Counselling in South Africa: Yesterday, today and tomorrow. *Journal of Multicultural Counselling and Develeopment, 23,* 149-157.

Warren, R., Jackson, A., Nugaris, J. et al. (1973). Differential attitudes of Black and White patients towards treatment in a child guidance clinic. *American Journal of Orthopsychiatry, 43,* 384-395.

Watkins, C. E. & Terrell, F. (1988). Mistrust level and its effects on counselling expectations in the Black client-White counselor relationship: An analogue study. *Journal of Counselling Psychology, 35,* 194-197.

Watkins, C. E., Terrell, F., Miller, F. S. & Terrell, S. L. (1989). Cultural mistrust and its effects on expectational variables in Black client-White counselor relationships. *Journal of Counselling Psychology, 36,* 447-450.

Watters, E. (2011). *Crazy like us.* Robinson Publishing.

Weber, R. P. (1990). *Basic content analysis.* Sage Publications.

West, W. (2000). *Psychotherapy & spirituality: Crossing the line between therapy and religion.* Sage Publications Ltd.

Whaley, A. L. (1998). Cross-cultural perspective on paranoia: A focus on the Black American experience. *Psychiatric Quarterly, 69,* 325-343.

Whitley, R., Prince, M., McKenzie, K., & Stewart, R. (2006). Exploring the ethnic density effect: A qualitative study of a London electoral ward. *International Journal of Social Psychiatry, 52,* 376-391.

WHO - World Health Organisation. (2001). *Legal status of traditional medicine and complementary/alternative medicine: A worldwide review.* Last accessed on 26th August, 2012 at http://apps.who.int/medicinedocs/pdf/h2943e/h2943e.pdf

WHO - World Health Organisation. (2002). *Policy perspectives on traditional medicine. Traditional medicine: Growing needs and potential.* Available: http://whqlibdoc.who.int/hq/2002/WHO_EDM_2002.4.pdf. Last accessed 20th August, 2012.

Widdicombe, S. & Wooffitt, R. (1995). *The language of youth subcultures: Social identity in action.* Harvester Wheatsheaf.

Wilkinson, S. (2000). Women with breast cancer talking causes: Comparing content, biographical and discursive analyses. *Feminism & Psychology, 10*(4), 431-460.

Williams, D. R. & Earl, T. R. (2007). Commentary: Race and mental health — more questions than answers. *International Journal of Epidemiology, 36,* 758-760.

Willig, C. (1999). Beyond appearances: A critical realist approach to social constructionism. In D. J. Nightingale & J. Cromby (Eds.), *Social constructionist psychology: A critical analysis of theory and practice,* pp. 37-51. Buckingham, UK: Open University Press.

Willig, C. (2001). *Introducing qualitative research in psychology.* Berkshire, UK: Open University Press.

Willig, C. & Stainton-Rogers, W. (Eds.). (2013). *The Sage handbook of qualitative research in psychology.* Sage Publications Ltd.

Willis, J. (1988). An effective counseling model for treating the black family. *Family Therapy: The Journal Of The California Graduate School Of Family Psychology, 15*(2), 185-194.

Wilson, M. (1993). *Mental health and Britain's Black communities.* London: Kings Fund.

Wilson, M. (2009). Department of Health, National Programme Lead, Delivering Race Equality (DRE) in mental health care. *Delivering race equality in mental health care: A review*. Available: http://www.nmhdu.org.uk/silo/files/delivering-race-equality-in-mental-health-care-a-review.pdf. Last accessed 17th November, 2012.

Wing, S. (1998). Whose epidemiology, whose health? *International Journal of Health Service, 28,* 241-52.

Wintrob, R. (2006). Raymond Prince: Reflections on his career contributions to transcultural psychiatry. *Transcultural Psychiatry, 43*(4), 523-532.

Woolley, D. E. & Lowenberg, D. (1997) *Ethnocentrism can hinder communication among those of differing worldviews.* Retrieved from http://www.dougandmarsha.com/essays-seminary/ch15_ethnocentrism.htm

Worthington, E. L. & Sandage, S. J. (2001). Religion and spirituality. *Psychotherapy, 38,* 473-478.

Wrenn, C. G. (1962). The culturally encapsulated counselor. *Harvard Educational Review, 32,* 444-449.

ya Azibo, D. A. (Ed.) (1996). *African psychology in historical perspective and related commentary.* Trenton, New Jersey: Africa World Press, Inc.

Yaro, P. (2012). *BasicNeeds news: Ghana the passage of the Mental Health Bill into Law.* Last accessed January 2013 at: http://www.basicneeds.org/html/newsstory.asp?newsstory=155

Yaro, P., Deme-Der, D. N. W., Antwi-Bekoe, T., & Donnir, G. M. (2009). Psychotropic medicine shortages in Ghana: A situational analysis. *The Ghana International Journal of Mental Health, 1*(1), 157-170.

B.16. Appendix

B.16.1. Tables - Information about Ghana

B.16.1.1. Table of languages spoken in Ghana (percentages of total population)

Language spoken	% Of population
Asante	14.8%,
Fante	9.9%
Ewe	12.7%
Ga	3.4%
Boron (Brong)	4.6%
Dagomba	4.3%
Dangme	4.3%
Dagarte (Dagaba)	3.7%,
Akyem	3.4%
Akuapem	2.9%,
Other (includes English (official))	36.1%

(2000 census, cited in CIA 2012)

B.16.1.2. Table of ethnic groups of Ghana (percentages of total population)

Ethnic group	% Of population
Akan	45.3%
Mole-Dagbon	15.2%
Ewe	11.7%
Ga-Dangme	7.3%
Guan	4%
Gurma	3.6%
Grusi	2.6%
Mande-Busanga	1%
Other tribes	1.4%
Other	7.8%

(Data from 2000 census, cited in CIA 2012).

B.16.1.3. A comparison between Ghana and the UK in terms of indicators of development based on Human development report data (2011).

	Ghana	United Kingdom
Population	24,965.8 thousand	62,417.4 thousand
Health	Expenditure on health (% of GDP) 4.3%	Expenditure on health (% of GDP) 6.9%
	64.2 years life expectancy	80.2 years life expectancy
Education	33.9% female 83.1% male with at least secondary school education	68.8% female 67.8% male with at least secondary school education
	(Mean years of schooling 7.1)	(Mean years of schooling 9.3)
Economy	1,410 GDP per capita (2005 PPP $)	32,147 GDP per capita (2005 PPP $)
	Percentage of the population living below the international poverty line $1.25 (in purchasing power parity terms) a day = 30	Percentage of the population living below the international poverty line $1.25 (in purchasing power parity terms) a day = n/a
Human Development Index Ranking	135th	28th

Data from Human Development Report, 2011

B.16.1.4. Percentages of religious beliefs in Ghanaian population

Christian	Pentecostal/Charismatic 24.1%,	68.8%
	Protestant 18.6%,	
	Catholic 15.1%,	
	Other 11%),	
Muslim		15.9%,
Traditional		8.5%,
Other		0.7%,
None		6.1%

Ghana census, 2000 (taken from Central Intelligence Agency, 2012).

B.16.2. Media coverage of alternative African healing approaches in UK

'Witchcraft' trial: there may be similar unreported cases, say police

In wake of convictions, police warn that ritualised abuse of children branded as witches is often hidden crime in UK

Alexandra Topping
guardian.co.uk, Thursday 1 March 2012 19.06 GMT

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Children 'abused in exorcism rites'

David Batty and agencies
guardian.co.uk, Friday 25 February 2005 14.37 GMT

The Metropolitan police force is investigating allegations that children have been abused in exorcisms at African churches across London, it emerged today.

Children from African communities have been assaulted and made to endure exorcism rites because their parents believe they are demonically possessed, according to social workers and other child protection experts.

The news comes on the fifth anniversary of the death of Victoria Climbié, the eight-year-old who was tortured to death by her great aunt, Marie-Thérèse Kouao, and her lover, Carl Manning. A church minister told the

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1 March 2012

Witchcraft murder: Couple guilty of Kristy Bamu killing

A couple have been found guilty of murdering a teenager they had accused of using witchcraft.

Eric Bikubi, 28, and Magalie Bamu, aged 29, from Newham, east London, had denied killing Bamu's 15-year-old brother Kristy.

Kristy drowned in a bath on Christmas Day in 2010, during torture to produce exorcism, an Old Bailey jury heard.

Bikubi had admitted manslaughter on the grounds of diminished responsibility, but the prosecution rejected his plea.

Family statement: "We will strive to move forward as a family"

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THE Sun
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Malaysian toddler killed in suspected exorcism

Police in Malaysia say a toddler has died after seven of her family members and a maid piled on top of her in a suspected exorcism.

The three-year-old girl's parents were among the adults who carried out the ritual late on Sunday in the town of Bukit Mertajam, a police chief said.



Police 'are too PC to prevent abuse linked to witchcraft'

POLITICAL correctness is preventing police from stopping child abuse in communities that believe in witchcraft, a minister said yesterday.

Tim Loughton warned that a "wall of silence" surrounded the problem.

Police and social workers are to receive additional training amid fears of a rise in witchcraft-related murders and attacks on children.

In the high-profile cases of Kristy Bamu and Victoria Climbie, both victims were murdered because family members believed they were possessed.

Ministers are concerned that faith-based abuse is underreported and misunderstood, and the Metropol-

By Christy Walker
Political Correspondent

Ian Police admits that its officers are rarely able to spot the signs that a youngster is being subjected to abuse, despite the rise in witchcraft cases in the last decade.

Mr Loughton, the children's minister, said: "I never we need to make a stand. There has been only very gradual progress in understanding the issues over the last several years – either because community leaders have been reluctant to challenge beliefs which risk leading to real abuse in their midst, or because authorities misunderstand the causes of or are cowed by political correctness.

He added: 'Child abuse is appalling and unacceptable wherever it occurs and whatever form it takes. Abuse linked to faith or belief in spirits, witchcraft or possession is a horrific crime, condemned by people of all cultures, communities and faiths – but there has been a wall of silence around its scale and extent.

Yesterday a Nigerian couple who claimed their children were possessed by evil spirits were jailed for seven years. Following a decade-long campaign of abuse that came to light only after their eldest daughter threw a note out of her bedroom window pleading for help.

The case follows that of Magaie Bamu, who was jailed for life in March after torturing her 15-year-old brother Kristy to death because she thought he was practising witchcraft. She and boyfriend Eric Mbiyavi, who was also jailed for life, inflicted more than 130 injuries over the course of four horrific days in Newham, east London.

The death echoed that of eight-year-old Victoria Climbie, who was tortured and starved to death in 2000 after her carers became convinced that she was possessed.

The National Action Plan to Tackle Child Abuse Linked to Faith or Belief, drawn up after Kristy Bamu's murder, urges greater engagement with communities, while other measures include better support for victims so that more prosecutions can be secured.

Detective Superintendent Tony Sharpe, who led the Bamu case, said: "It may be very difficult for the children themselves to come forward or, if it is a young pastor worship, for people to report their religious leaders. Our key goals has been to empower the professionals to raise awareness of the signs.

Bishop Joe Aldred, part of the Clearview Together in Unity and Power group, said people would not turn a blind eye to the possibility that children are in danger in religious settings. "Everybody has to be aware, be alerted."

Andrew Flanagan, head of the NSPCC added: "The vast majority of people in communities where witchcraft is practised are horrified by these acts. We must not be afraid to raise this issue so the offenders can be exposed."

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Britain's voodoo killers: This week a minister warned of a wave of child abuse and killings linked to witchcraft. Alarmist? This investigation suggests otherwise

By SUE REID

PUBLISHED: 00:49, 16 August 2012 | **UPDATED:** 19:15, 17 August 2012

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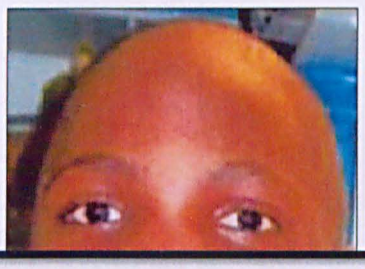
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They appeared to be upright and decent members of our society. She dressed smartly, and had worked for Marks & Spencer.

He drove a top-of-the-range Mercedes and spent his spare time coaching a local women's football team.

But unbeknown to their neighbours and friends, this couple living in their suburban London flat led a terrifying secret life.

They practised African black magic or voodoo, and on Christmas Day in 2010 they murdered a teenage boy in the belief he was a witch.



theguardian TheObserver

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Churches blamed for exorcism growth

An Old Bailey case has highlighted growing worries about the links between child abuse and religion, reports Tony Thompson

Tony Thompson
The Observer, Sunday 5 June 2005

The advertisement leaves little doubt about the strength of the Professor's powers. 'Your partner left you? She/he will be back and follow you like a dog obeys his master. Fast results.' Another aims to comfort those who fear they have been cursed, offering to 'break all types of black magic or witchcraft' while a third promises assistance with 'evil bothering'.

Although advertisements for psychics and tarot readers now appear in almost every newspaper, the spiritualists or 'marabouts' who aim their services at members of Britain's African community stand out because of the sheer bravado of their claims - demonic forces, infertility, business difficulties, immigration problems, weight loss and general bad luck can all be dealt with and results are guaranteed, apparently.

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News › UK news

Churches to attend ritual abuse summit

Lucy Ward, social affairs correspondent
The Guardian, Tuesday 12 July 2005 01.30 BST

Representatives of African churches in the UK are to meet ministers and police and social services chiefs at a government summit to tackle ritualistic faith-related child abuse.
The meeting, hosted by the children's minister, Beverley Hughes, could see tighter entry rules for religious leaders from some African states seeking to travel to Britain, but is mainly aimed at identifying the extent of a little-researched issue.

The summit, scheduled for next week, follows the jailing of three people at the Old Bailey after being found guilty of involvement in physical abuse of an eight-year-old girl they accused of being a witch.

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1 March 2012 Last updated at 14:22

Witchcraft murder: Killers' 'obsession' took on 'feral character'

By Andy Dangerfield
BBC News, London

It was the 2010 Christmas holidays and teenager Kristy Bamu and his siblings were staying with their sister in east London during a visit from Paris.

But this was no happy family gathering.

When paramedics entered the eighth floor apartment on Christmas Day they found the walls, ceiling and furniture spattered with blood.

Kristy, 15, had died from drowning and being beaten with a metal bar in the Forest Gate flat.

His face was covered in deep cuts and bruising, his arms and back bore cuts and lacerations and his teeth were missing or loose.

The teenager had sustained 101 injuries during a ferocious attack stretching over days.



Kristy Bamu was visiting London from Paris during the Christmas holidays

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Beyond Belief: Witchcraft & Child Abuse



BBC Radio 4 / **20 August 2012**
Ernie Rea explores the relationship between African churches, **witchcraft** & child abuse with expert guests: Pastor Mahale Tangata, pastor of a...

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12 October 2011 Last updated at 22:14

African children trafficked to UK for blood rituals

By Chris Rogers
BBC News, Kampala and London

Over the last four years, at least 400 African children have been abducted and trafficked to the UK and rescued by the British authorities, according to figures obtained by the BBC. It is unclear how they are smuggled into the country but a sinister picture is emerging of why.

Whether it is through leaflets handed out in High Streets or small ads in local newspapers, witch-doctors and traditional African spiritual healers are becoming ever more prominent in Britain.



Some 9,000 children have gone missing in Uganda over the past four years, according to a UN report

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Torturing teenagers has nothing to do with culture or race, the evil zealots behind disturbing rise in African witchcraft MUST be stopped

By LINDSAY JOHNS
UPDATED: 13:41, 6 March 2012

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News › Society › Children

Minister to host 'exorcism' summit

Staff and agencies
Society Guardian, Monday 11 July 2005 11.31 BST

The children's minister, Beverley Hughes, is holding a summit with child protection experts and African church leaders next week in a bid to combat the abuse of children through ritual exorcisms, it emerged today.

The summit, which will also involve Home Office ministers, immigration officials and the police, could result in religious leaders from certain African states being barred from entering the UK, said Ms Hughes.

The move comes after three people were jailed at the Old Bailey last week for what the trial judge termed a "campaign of torture" against an eight-year-old they accused of being a witch.

Mail Online

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Hundreds of children being accused of witchcraft 'as belief in demonic possession spreads across the UK'

By ROD COOPER
UPDATED: 12:36, 14 May 2011





THE Sun

Saturday, August 25, 2012

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ROD LIDDLE: Salute MP fighting Stone Age beliefs

By ROD LIDDLE Published: 18th August 2012

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MAYBE it's the spirit of the Olympics still lingering on, who knows – but at last a British politician has talked some sense.

And not just a politician but a Conservative politician. Put out the flags, crack open the bubbly, give him a gold medal etc.

The politician in question is a man you've never heard of, and I'd never heard of. It's quite possible his family have never heard of him either, but never mind.



Talking sense ... Tim Loughton

His name is Tim Loughton and he is responsible for children and families in our Coalition Government. He has said that the police have been hampered by political correctness when trying to crack down on horrific cases of child abuse by African immigrants who practise witchcraft.

BBC SPORT FOOTBALL

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Last Updated: Monday, 4 April 2005, 10:58 GMT 11:58 UK

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Does 'juju' have a place in football?

Got an opinion? Express it here!

Each week we throw up a different subject to let followers of African sport have their say.

On our Interactive edition of Fast Track on Friday 1 April, Kashimawo Laloko, the technical director of the Nigeria Football Association, told our listeners he believes 'juju' (witchcraft) can change the course of a football match.

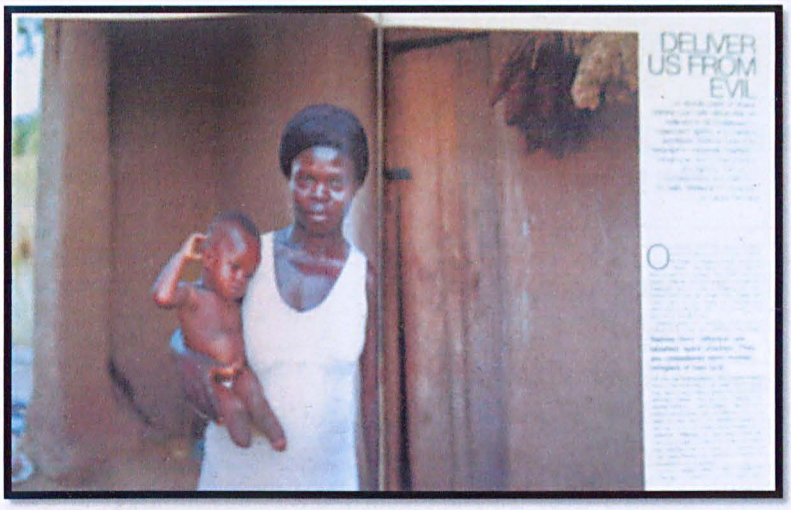
"I believe that it does exist. As an African, we have our customs and traditions," Laloko told the BBC World Service programme on Friday.

Laloko was sent off before the start of the 2000 African Cup of Nations quarter-final between Nigeria and Senegal, for removing what he believed to be a talisman that was near Senegal's goal.



"As an African, we have our customs and traditions"

Kashimawo Laloko, technical director of the Nigeria Football Association



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14 August 2012 Last updated at 17:45

Witchcraft-based child abuse: Action plan launched

The government has launched an action plan to tackle child abuse linked to witchcraft or religion in England.

High-profile cases include the murders of Kristy Bamu and Victoria Climbie but experts fear much more abuse is hidden.

The key aims are to raise awareness and set out "urgent practical steps to identify and protect children at risk".



Perpetrators sometimes believe they are driving out evil spirits possessing a child

Children's Minister Tim Loughton said: "Child abuse is appalling and unacceptable wherever it occurs and whatever form it takes.

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News › UK news

Witchcraft torturers jailed

Helen Carter
The Guardian, Saturday 9 July 2005 10.06 BST

Three people were jailed yesterday for torturing a child they accused of being a witch with powers to change from human to animal form.
The child, who was eight at the time of the offences, was cut with a knife on her chest, beaten, kicked, starved, whipped with a belt and had chilli peppers rubbed in her eyes.

An aunt and another female relative wept as they were jailed for 10 years at the Old Bailey. A male relative was jailed for four years for aiding and abetting child cruelty.

Judge Christopher Moss told them they had mounted a campaign of cruelty that amounted to a campaign of torture. "It is the very pinnacle of cruelty to a child that demands the maximum sentence," the judge said.

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Pastor's wife 'stole baby from ho

Five appear before Kenya court over 'miracle babies'
investigate claims that church is a front for smugglin

Patrick Barkham
The Guardian, Wednesday 1 September 2004 14.35 BST

The British wife of an evangelical pastor who claims to help infertile women have "miracle babies" has been charged with stealing a child from a hospital in Kenya.

Mary Deya appeared in court in Nairobi with another British woman and three other people who claim to have had babies through the power of prayers directed by Gilbert Deya, the charismatic leader of Gilbert Deya Ministries, a rapidly-expanding church based in south London.

Kenyan police yesterday confirmed they are investigating allegations that the self-styled archbishop's church, which boasts 36,000 members in Britain, is a front for a child smuggling ring that steals the "miracle babies" from impoverished mothers in the backstreets of the Kenyan capital.

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WITCHCRAFT DUO SENTENCED

Witchcraft murderers sentenced

last updated Mon 5 Mar 2012

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Thousands of child 'witches' turned on to the streets to starve

Kinshasa sects make fortunes from exorcisms

Richard Dowden in Kinshasa
The Observer, Sunday 12 February 2006

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Witchcraft Trial: Murder Was 'Wild And Feral'

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Could spiritual healing actually work?

By Dr DANNY PENMAN

Last updated at 14:42 03 October 2008

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B.16.3. List of potential sources of participants identified in Ghana - written to prior to visit to recruit

- Accra Psychiatric Hospital
- Ankaful Hospital
- Patang Hospital
- College of Health, Kintampo (The Kintampo Project)
- Korle-Bu Teaching hospital, Department of Psychology
- University of Ghana, Department of Psychology
- Valley View Clinic (private medical and psychiatric clinic)
- Serenity Centre (private therapy)
- Global Books & Counselling Services (private counselling)
- International Health Care Centre (private health clinic)
- Kad Int. (NGO offering counselling and advice)
- Power Chapel Worldwide (private counselling)
- Professional Christian Counselling Clinic
- Self Search Ghana Ltd. (counselling and advice and training service)
- Soul Survivor International (counseling and advice)
- The Caleb Generation (charity offering counselling and advice)
- West Africa Behavioural Health Addiction & Recovery Management
- Ghana Psychological Foundation (Founded 2000)
- Mindscare Ghana
- Progressive life centre (Private clinic employs several 15+ psychologists and psychiatrists also coordinates activities of the NGO operations)
- Other private psychologists identified:
- Anita Wiafe
- Roland Baah Teye
- Prof. Danquah
- Dr. Afrifa
- Sr. Wiafe
- Mawusi Glozah
- Dr. Erica Dickinson.
- Ludmilla Sauvage - Psychologist (French / English)
- Seth Oppong - Organisational Psychologist
- Sameul Yawson- Clinical Psychologist at Mindscare Ghana
- Benedictus Wozuame - Psychologist/Cognitive Behavioural Psychotherapist at Health Calls
- Charlotte Omane Kwakye-Nuako at Mindscare Ghana
- Kate Naa Deedee Fiscian
- Araba Sefa-Dedeh - Clinical
- Asafo Seth ...
- Billie Richardson

B.16.4. Coding manual for data analysis

		Definition	*Example*
Theme 1 **1. Parallel belief systems**			
1.a	**Mental health professionals**	Data that explains participant's belief system	*''I believe in tradition and I believe in medicine...' participant 5*
1.b	**Alternative healers**	Data that explains participant's view of healer's belief system	*'They say it's a White man's treatment...'*
1.c	**Patients**	Data that explains Ghanaian patients health beliefs	*Ghanaians are very eclectic in that way you know.. In a sense that they can, erm we can accept different views of illness*
Theme 2 **2. The relationship between Western approaches and alternative healing approaches**			
2.a	**Tension between approaches**	Data that reveals tension between approaches	*'There is mutual suspicion from both sides...' Participant 3*
2.b	**Commonality**	Data that describes similarities and commonalities between approaches (alternative and mainstream)	*'I think they employ principles of psychotherapy in a way...' Participant 2*
2.c	**Collaboration between approaches**	Data that describes collaboration between approaches (mainstream and alternative)	*'You must work together, you cannot build walls between us.' Participant 5(2)*
2.d	**Negotiating boundaries between approaches**	Data that relates to Ghanaian mental health professionals describing negotiating boundaries between approaches	*'But as a clinician I am not a reverend, a minister or something...' Participant 4*
Theme 3 **Multiple positions, multiple pathways**			
3.a	**Help-seeking behaviour: Who goes where?**	Data that relates to patient help seeking behaviour and pathways into treatment	*''You'll be sure that the majority of the patients you'll be seeing do not choose you as a doctor as a first option.' Participant 2*
3.b	**Systemic strategies to address the attitudinal barriers to**	Data that relates to strategies to engage clients earlier... longer term strategies. Mental health bill.	*'Eventually people will start seeing the benefits of orthodox treatment...' Particpant 2*

	engagement: Enhancing pathways to care	Regulating traditional healers.	
Theme 4 **Eurocentric theory in the Ghanaian context: What happens in the therapy room?**			
4.a	**Confidence in and expectations for treatment**	Data that describes the participant's view of patient confidence and expectations for treatment and how this impacts the therapeutic relationship	*'So they are not even thinking that it will work in the first place.' Participant 2*
4.b	**Formulating client presentation**	Data relating to challenges of Western diagnostic criteria	*'Mmm. No they are not delusions, they are really, real because these are beliefs.' Participant 4*
4.c	**Specialist knowledge/ shared culture**	Data relating to cultural awareness or advantages of working within a shared culture	*'Yes, we grow up with these things being said and hear about them and things like that.' Participant 7*
4.d	**Incorporating spirituality**	Data that reveals how Ghanaian mental health professionals incorporate spirituality. Working within belief system. Harness positive aspect of belief.	*'But I think that is what is not being addressed from the mainstream Western medical, spirituality.' Participant 3*
4.e	**Action-orientated strategies to maximise effectiveness of therapeutic interventions**	Descriptions of action-orientated strategies to aid working with African clients. Practical strategies. Modifying Western tools. Psychoeducation. Involve family.	*'You have to demystify things. You have to teach people it's not a curse, it's not by the devil, it's a condition...' Participant 5 (1)*
Evaluation of methods	**Data relating to evaluation of interview process**	Process notes.	*'You don't believe that?'* *'You are Ghanaian!'*

B.16.5. Covering letter to accompany advertisement for participant recruitment



CITY UNIVERSITY LONDON

Email: Rebecca.Ker.1@city.ac.uk

To xxxxxxxxxxxx,

We are sending information about an international piece of research that we hope you will find interesting. We have enclosed information about a project being conducted by City University London.

We would be very grateful if you could pass brochures on to any psychologists, counsellors or any other individuals with experience of offering psychological help within your organisation.

With the publication of The Ghana International Journal of Mental Health, and the increasing numbers of psychologists and counsellors working in Ghana, the time has been described as a 'new dawn in psychology' in West Africa. This research aims to give Ghanaian psychologists and counsellors the opportunity to educate colleagues working all over the world about how best to work with African clients and African belief systems. This research aims to celebrate the advances in mental health care in Ghana, raise the profile of the work you are doing and help address inadequacies in the mental health care of African clients in the rest of the world.
The researchers are offering to buy lunch at La Palm or a similar Accra Hotel, or to travel to your place of work if that is more convenient. The primary researcher, Rebecca, has a personal attachment to Ghana and is keen to make contact with Ghanaian colleagues for the purpose of this research and also with a desire to forge longer term links with Ghanaian mental health care services. Rebecca would be happy to visit services and organisations to learn more about your work, to meet your staff and clients and would be glad to talk to trainee psychologists or counsellors about her experience in the UK if they are interested.
There is a limited amount of time and interview opportunities. Please get in touch if you are interested in being involved in this research or if you have any questions. We look forward to hearing from you.

Yours sincerely,

Dr. Courtney Raspin and Rebecca Ker, on behalf of City University London

B.16.6. Advertisement for research project

Are you a psychologist or counsellor?

Your experience could help psychologists working in the UK...



We want the opportunity to learn from Ghanaian colleagues, with the aim of considering how to improve services for Africans living in the UK. Research strongly indicates that in the UK, there are barriers to adequate mental health care for African service users. We are looking for Ghanaian psychologists and counsellors to offer their experience with working with this client group to share their expertise. The aim of the research is to understand how, in a country where traditional African belief systems exist more abundantly than in the UK, psychologists work.

We are asking for psychologists to take part in interviews which will take up to 2 hours, which will include an interview and time for an informal chat and lunch after the interview. Interviews will be taped on an audio recorder. Participants will be contacted again to check that the researcher's findings are valid and that their answers have not been misunderstood. All people that agree to take part in the study have the right to change their minds and withdraw their answers from the research.

The research is being conducted by Rebecca Ker as part of her doctorate level training. Rebecca used to live in Ghana and feels strongly that the National Health Service in England needs to better understand African clients and their health beliefs, and how to modify mainstream interventions to engage and work with these service users more effectively.

The project has passed ethical standards in accordance with the British Psychological Society. The research supervisor for this study is Dr Courtney Raspin. Please feel free to contact her, or Rebecca, if you have any questions or concerns about the project.

Primary researcher: Rebecca.Ker.1@city.ac.uk

Research supervisor: Courtney.Raspin.1@city.ac.uk

• Have you been working in Ghana as a mental health professional, offering psychological help, for more than five years?
• Have you got experience of working with clients who attribute their symptoms to traditional explanations?
• Are you available to participate in an interview (approximately 2 hours) during July, August or September 2011?
• Do you speak English?
• Is it possible for you to be contacted via email with regard to this research?
• Do you give your permission for the interview to be taped? The audio files will be used for analysis purposes and will be disposed of on completion of the study.

If you have answered 'yes' to all of the questions above, or if you have any questions about the project, we would love to hear from you. Please get in touch via email or post.

Email: Rebecca.Ker.1@city.ac.uk

Post: Rebecca Ker, PO BOX MP1196, Mamprobi, Accra.

In your message please say where you work, where you would like to meet, and when you are available to be interviewed.

Interviews can take place at La Palm Hotel, Labardi Hotel or Novotel, Accra, or at your place of work, if that is more convenient.

We are happy to buy you lunch to thank you for your time, and to enable an informal chat after the interview.

Thank you.

B.16.7. Informed consent form for participation in research

CITY UNIVERSITY LONDON

Informed Consent Form for participation in interviews for the research undertaken by Rebecca Ker, in conjunction with City University.

Name of Project:

Lessons from Ghanaian colleagues: Working with African clients.

Contact details:

Principle Investigator - Rebecca Ker R.Ker.1@city.ac.uk

Name of Organisation - City University, Northampton Square, London, England.

Research supervisor – Dr. Courtney Raspin C.Raspin.1@city.ac.uk

Introduction

Research strongly indicates that in the UK, there are barriers to adequate mental health care for African service users. Psychologists at City University, England, are appealing to Ghanaian colleagues for help relating to working with clients. Western psychologists want the opportunity to learn from Ghanaian colleagues, with the aim of considering how to improve services for Africans living in the UK.

Type of Research Intervention

The research involves meeting for an interview that will last approximately one hour. Participants will be asked to discuss and reflect on the role of traditional healers and psychology in a semi-structured interview.

The discussion will be audio recorded and the tapes will be transcribed. Participants will be asked to provide an email address that they can be contacted on. Preliminary conclusions will be shared with participants and their feedback will be invited.

Participants have the right to change their mind and withdraw their answers from the study.

Participant data will be confidential and will be stored in a locked cabinet and destroyed upon completion of the study.

Risks

The interviews have been designed to pose a minimal risk to the participants and researcher. The project has passed ethical standards in accordance with the British Psychological Society. The research supervisor for this study is Dr. Courtney Raspin. Please feel free to contact her, or Rebecca, if you have any questions or concerns about the project, or if you feel you were negatively affected by taking part in the study.

Benefits

The benefits of this research include being involved in improving mental health care services for Africans living in the UK. The research also aims to celebrate the advances in mental health care in Ghana, and hopes to publish findings both in the UK and in Ghana.

Voluntary Participation

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I feel I understand the nature of this study and I consent voluntarily to be a participant. I am also happy to be contacted regarding my participation in this study, and to discuss preliminary findings with the researcher.

Print Name of Participant _____

Signature of Participant _____

Email: _____

Phone number: _____

Date _____ Day/month/year

Participant ID number: _____ (to be allocated by researcher)

B.16.8. Validating results: Covering letter, a summary of preliminary results and prompt questions for participants

City University,
Northampton Square,
London,
EC1V 0HB

Email: Rebecca.Ker.1@city.ac.uk

Date

Dear Dr XXXXXXX,

I hope this message finds you well. I was very sorry to hear about the loss of President John Evans Atta Mills and I am thinking of your country at this difficult time.

I hope you remember meeting me? You kindly took part in an interview with me as part of my doctoral research project. I have now completed the data collection and preliminary analysis and I wanted to ask the people that took part in the research to share their reactions to the data. I was a guest in Ghana and it is very important to me that my results are valid and accurately reflects the participants' responses. I understand that your time is precious and I would be pleased to receive your feedback.

I am sending you a summary of the main themes I found in the data I collected and invite you to comment as you see fit. Please read the summary of my preliminary results section and feedback your reactions. I have included prompt questions about the data and about the experience of being interviewed. There are lots of prompt questions and I am not asking people to answer all of them. Please choose four or five questions to answer or offer your reaction to the data in any format. Please feel free to suggest improvements or amendments, or to expand on any of the points. I am also happy to answer questions about the project or the data. Please feel free to contact me via email. I would be very grateful if you could find the time to do this over the next four weeks as I am working under time restrictions and am keen to include all the feedback I receive. Please email your feedback to Rebecca.Ker.1@city.ac.uk.

As before, your identifying details will be respected and kept confidential and you have the right to withdraw from this project at any time. The results from this project will help inform

practice for clinicians working in the UK and offer them the opportunity to learn from your experience and expertise. I would be very happy to offer you a copy of the completed project if it would be of interest to you.

I was very pleased to hear about the passing of the Mental Health Bill. Congratulations to all of you that worked so hard pushing for it to be passed. Once again, I would like to thank you for your time and support with this project. I had a fantastic stay in Ghana and hope to visit again soon. Please keep in touch.

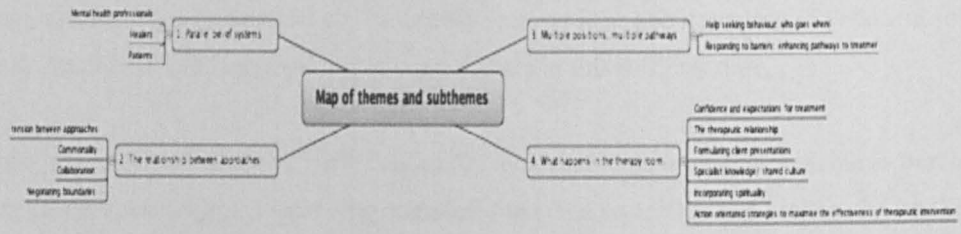
Best wishes,

Rebecca Ker, Counselling Psychologist in doctorate level training

Results

The diagram below outlines the main themes and subthemes I found in the data. Each theme is further explained in the pages to follow. On the last page, you will find prompt questions to help you feedback your reaction to my preliminary analysis. Please feel free to feedback in any format. Thank you.

Diagram 1: Map of how the interview data was organised into themes.



Theme One: Parallel belief systems

Understanding that Ghanaians can congruently occupy multiple positions in terms of worldviews, and integrate and consolidate these approaches, is of fundamental importance in understanding the data. The participants introduced the idea that fact and faith can co-exist with apparent ease, a notion that represented an advantage of the Ghanaian mental health professionals and highlighted a significant component of their ability to understand their patients. This theme explores the duality and plurality of Ghanaian worldviews and health beliefs. The theme is divided into smaller themes relating to: the beliefs of the participants themselves (mental health professionals), the descriptions of healer belief systems and data relating to descriptions of Ghanaian patient belief systems.

Mental health professionals

The participants were not dismissive of or rejecting the health beliefs associated with traditional African ideas, and demonstrated an understanding that there was truth is an approach that was so different to their training. Most commonly, there was a description of not *believing* in these ideas whilst recognising them as *true*.

The data revealed the significance of religion in Ghanaian culture: the interviewees were happy disclosing their religion. All the participants I met identified themselves as Christian and volunteered the information. Some respondents readily identified themselves as believers in traditional ideas. Some were keen to identify themselves as being more closely aligned to modern approaches. However, those in the 'modern' camp seemed to represent a superficial allegiance, which may be rooted in the social desirability of this position, or the impact of being interviewed by a White British psychologist. This duality was evidenced by claims that participants did not believe in these ideas themselves, which was sometimes attributed to their studies of Western approaches, but they knew them to be true. Not believing in something but accepting it as true felt like a contradiction when viewed from my cultural background.

Christianity has a desirable position in Ghana as it demonstrates embracing Western ideas; participants were less forthcoming describing their own experiences or beliefs in more traditional ideas, although some did. The respondents' language seemed to indicate this parallel belief system: the use of 'us' and 'they' seemed to highlight the internal struggle when worldviews clashed.

There were contradictions in the data in terms of how mental health professionals viewed healers, and many conveyed serious risks associated with aspects of alternative healing practices. However, the data revealed that the participants did not view healing practices negatively: there were positives, too. None of the respondents were dismissive of the efficacy of herbal treatments, although some were able to describe the challenges associated with the treatment approach. The Ghanaian mental health professionals I interviewed had a respect for this branch of alternative healing; none were dismissive of the potential efficacy of herbal medicine. Similarly, spiritual and traditional healers were praised for some of their work.

It was important to understand the historical context of what they were describing. In a world in which Eurocentric ideas are dominant, participants explained that many Ghanaians strive to be identified as 'enlightened', which means superficially identifying with a modern worldview. Respondents reported that whilst traditional ideas are still widespread amongst the population, people are often reluctant to identify themselves as traditional purists as a result of Christianity.

It seemed traditional ideas transpose religions and science as they are firmly rooted in the culture, although traditional healing is often shrouded in secrecy.

Healers

Descriptions of traditional and alternative healing practices revealed a similar parallel belief system to that of the mental health professionals. Some healers were described as purists to their approach, viewing Western treatments with suspicion and resentment (which is understandable in terms of their historical relationship). However, many healers were described to integrate different healing approaches. Indeed, the term 'traditionalism' was revised as in modern Ghana; ideas from Christianity and science have transposed indigenous beliefs in many cases. Therefore, the term 'alternative' better captures the work of healers operating outside mainstream approaches. My first task was to ensure I understood the terms my participants were using and the distinctions between the different types of healers. The table on the next page documents my understanding of the different types of healing approaches. I have separated the definitions into distinct categories of types of healers (purist descriptions); however, the information from the data suggests that healers integrate different approaches, and that the process of integration varies. A traditional healer may emphasise herbalism whilst offering traditional healing, and a Christian faith healer may also employ strategies associated with more traditional African ideas (ideas that predate Christianity in Africa). It was evident in the data extracts that the accounts of healing practices are rarely purist.

Whilst the effort to categorise types of healers implies its distinct approach, descriptions alluded to much overlap between religion and tradition. Respondents described how faith healers practised and accounts generally featured something that sounded magical or supernatural. In addition to understanding that healers often integrate different 'alternative' approaches, it was explained that healers sometimes integrate modern medical approaches. There were descriptions of healers that insisted upon a collaborative relationship with mainstream services, e.g. bonesetters who referred patients for an x-ray before they treated them. Many of the participants described a collaborative relationship between mainstream and alternative healing approaches. Some participants had direct experience of receiving referrals from healers, herbalists and pastors.

Working definitions of the different types of alternative healers (extracts from data).

Alternative healer	Example from the data
Herbalists	*'Somebody who is well versed in using herbs to treat maladies or to treat ailments...'* *'The herbalist are those who use purely herbal treatments to treat.'* *'There is also herbalists. They use natural herbs, tonics and some concoctions. To heal people...'*
Faith healers	*'Those who are purely religious in nature. So I think those who use their spiritual knowledge and gift as they call it to heal people.'* *'We also have faith healers. Those ones usually talk about, um, the more charismatic kind of churches. The newer crop of churches.'* *'There is also the Church. Well we have a strong belief in the Church so that even if the person does seek medical help we believe that the Church, we go to the Church and you pray or the Pastor prays for you or you confess. Your spirit is, is absolved of that sin or whatever is causing this order and when it has taken place within the spirit.'* *'People who use erm their Christian religion, the Pentecostal Holy Spirit powers to heal people again afflicted psychologically or otherwise to address their, their concerns of lack of material erm needs or marital and family erm, erm arrangements or successes and the rest, you know. Or even academic achievements and so on, or generally success by being prayed for by this person who is a powerful Christian spiritualist, you know. Then you also have similar erm Sikh people from within the Muslim sect who are either well versed with the Koran, and, and are believed to have some powers by their, their knowledge of the Koranic verses they can incant to exorcise people and, and, or whatever ailment they are afflicted with..'*
Prayer camps	*'Prayer camps where these patients are sent and then they'll go also so ... ordeal and rituals to as it were exorcise them of the, um, of the bad spirits or to break bonds of or chains of, um ... to deliver them from their bondage as I may say it from sin or from other, um, offences they might have caused that is bringing a curse upon them.'*
Traditional healers/fetish priests	*'Somebody who has some psychological and spiritual erm know how or he can have powers to (...) to help (...) address certain anxieties and, and frustrations somebody may have, that can have any effect on him.'* *'No, I'm told we shouldn't even be calling fetish priests, but those who have their Gods, the smaller Gods, we call them smaller Gods, those who, um, sort of worship the deities and perform rites and stuff to them. Those, those are the ones that come to mind. That would be traditional healers.'* *'So the person could be asked to maybe replace the items he stole or if the person has hurt someone or caused an insult he has to be brought to appease the Gods so that the priest acts as a link between the patient who is suffering from this or that or what he has done, and the spirits. So the person is asked to perform certain acts. The spirits who are harming or causing the disorder, are then appeased after that, they did that the person would be well again. So that is what a traditional healer is.'*

Descriptions of patients' health beliefs

Ghanaian patients' health beliefs also represent multiple worldviews. Throughout the data, spiritual, religious or traditional explanations for psychological suffering were described as the norm. In contradiction to the descriptions of the prevalence of African explanations of mental illness was the idea that the global dominance of Eurocentric thinking had resulted in doctors being viewed with authority. The status of educated individuals, especially doctors, was described. Participants described how they thought their patients viewed them as representatives of the modern world. Due to the authority many Ghanaian patients attribute to medical doctors, the participants felt that a challenge for their work involved encouraging a patient to disclose their health beliefs and help-seeking behaviour. The participants reported that clients modify what they disclose based on how they gauge the attitudes of the person asking them. This is, in part, due to the historical relations between Western and indigenous ideas, and reflects some tension between approaches. Respondents emphasised the need for a therapist to understand the individual's, and family's, understanding of the client's difficulties. Secrecy surrounding many of the alternative healing practices was reported. Respondents suggested that patients were often not forthcoming about alternative healing practices and that some may deliberately conceal their beliefs.

The data suggests that the alignment of the mental health professional would have more importance in determining what the patient discloses than the patient's own worldview. The participants also stressed that when patients are deciding where to seek treatment, allegiance to a particular approach may only be one factor that shapes help-seeking behaviour. The participants explained that if a patient identifies himself or herself as aligned to one particular faith or worldview, it does not always translate to a specific route to treatment. Pathways to treatment reflected Ghanaians' parallel belief systems, and a trial-and-error approach to treatment was described. This process was thought to be shaped by attitudinal and structural factors, although, interestingly, recommendations of friends or family were described as one of the most influential factors of help-seeking behaviour.

The respondents described a small subgroup of patients that they felt would seek help at the hospital as a first port of call; these patients were referred to as 'enlightened' by some respondents. However, participants were unanimous in explaining to me that Ghanaians represent parallel belief systems and an ability to occupy multiple positions in terms of how they interpreted experiences of mental illness, and subsequent help-seeking behaviour.

Theme two: The relationship between Western approaches and alternative approaches

The second theme included data that related to the relationship between the different health care systems (Western/psychological/psychiatric and traditional/spiritual/alternative). This theme is divided into sub-themes relating to: tension between approaches, areas of commonality, collaboration between approaches and negotiating boundaries.

Tension

In contrast to the accounts of collaboration and commonality, the data revealed some tension between the different worldviews. All of the respondents articulated sources of tension between approaches. Whilst the respondents generally demonstrated a respect for *some* alternative health beliefs, a placebo effect was offered as an explanation for the efficacy of some of the healing practices, as were accounts of trickery. These descriptions were more in keeping with my culturally rooted suspicions.

The tension between different treatment approaches can, in part, be contextualised by the historical relationship between the different worldviews. Many felt that the process of demonising indigenous beliefs whilst importing Christianity resulted in healing practices often being shrouded in secrecy and it becoming more underground.

Practices that are shrouded in secrecy are difficult to regulate, which creates tension when viewed from a Eurocentric culture of evidence-based practice and random control trials. This tension can also be understood in terms of fear and concern for their patients, as all of the participants were able to articulate some serious risks associated with some forms of alternative healing. A philosophical clash seemed to stem from the fact that many spiritual or traditional healers view the patient as less than human whilst possessed by spirits, which the mainstream professionals did not agree with. The participants in this study explained the rationale behind some of the forms of physical abuse employed by some of the healers.

The participants seemed able to distinguish between safe and unsafe healers, although the risks associated with delayed presentation at medical facilities related to all alternative healing approaches. Ghanaian mental health professionals expressed concern regarding several practices, including: the use of physical restraints (chains, tree trunks, etc.), the use of flogging and beating, fasting, scarification, burns, sleep deprivation, blood flow restriction, dehydration/starvation and the use of Western medication without proper training or monitoring. Restricted bathing, dirty living conditions and infections resulting from poor hygiene were also described.

Participants also reported that they had heard of cases where vulnerable people were forced to work, had been sexually assaulted or had died in the care of alternative healers. Another source of tension was that participants had heard of healers that were employing mainstream medication without proper training. Whilst participants seemed comfortable with the fact CPNs collaborate with healers to administer medication, offering healers some insight into Western pharmacological approaches was not without its challenges. Western approaches could be viewed as endorsing healing approaches if a patient considers them to be working jointly. Similarly, if the introduction of Western medication into the healer's practice results in healers offering a more effective treatment, patients are more likely to have their belief in the healer reinforced, which results in that healer being recommended to shape others' help-seeking behaviour. Mental health professionals viewed healers using Western medication without consultation with a medical expert as dangerous.

The participants' accounts of physical harm potentially associated with alternative healing practices demonstrated their insight into the practices of various healers operating within their country. The data demonstrates that participants were aware of varied healing approaches, some of which they seemed to hold in high regard. The awareness of potential risks enables clinicians to start a dialogue about alternative places of healing and to assess the risk. If a client discloses that they are attending a place of healing that the clinician fears is harmful, they are able to explore the benefits and disadvantages of the different approaches with the client.

Risk of non-physical harm was another emerging theme from the interviews, and a source of tension between approaches. The notion of psychological harm was raised in conjunction with the fear that families would be disrupted or that vulnerable people could be abused. Risks of financial exploitation were also described.

Another source of tension between approaches resulted from the wider ramifications of the existence of African health beliefs. The implications of a moral or magical explanation of mental illness were discussed in conjunction to: maintaining blame or stigma, causing psychological distress or justifying poor treatment of a sufferer in the community. Respondents thought that healers reaffirm these health beliefs and, therefore, the psychological implications of such beliefs. Similarly, participants felt healers reinforced delusions or paranoid thinking amongst patients.

Commonality

As the data revealed that the participants understood there to be a spectrum of different healing approaches, it seems obvious that there were some areas of overlap between mainstream

approaches and alternative healing. A fundamental similarity seemed to relate to the fact that they recognised that many of the healers are offering primary care. The participants articulated appreciating that many of the healers offered treatment to patients that would otherwise receive no treatment. Many of the participants described similarities in treatment approach. Some participants articulated that areas of commonality related mostly to approaches the Western world would define as counselling.

Counselling was described as a component of alternative healing practices, although it was acknowledged that it might take on a different form to mainstream psychological counselling. The participants suggested the therapeutic relationship may be more directive at sites of alternative healing compared to psychological services, and that specific interventions such as the use of charms and rituals belonged solely to alternative healing approaches. However, there were aspects that were described as being fundamentally similar. The fact that healers offer patients a space to be heard and an experience of someone trying to understand what they are going through, and formulate what they are going though, was described as a powerful component of the approach. Other areas of commonality were described, for example: involving the family to assess the patient's difficulties, listening to the patient and making them feel valued.

Similarly, areas of overlap were identified between approaches of herbal and Western medicines. Whilst participants recognised that herbal medicines often lacked empirical testing and clear prescription guidelines, fundamentally, both Western medicine and indigenous herbalists offer treatment to reduce symptomology, based on knowledge of the way different ingredients interact with physiology.

Collaboration

Respondents described collaboration between medical and alternative approaches on a number of levels. BasicNeeds is an international non-government organisation that aims to improve the lives of people with mental health conditions in developing countries. BasicNeeds is very active in Ghana and many respondents mentioned its work forging relationships between mainstream and alternative services. Many of the respondents were aware of the work BasicNeeds is doing in Ghana and referenced projects that they had either directly been involved in or knew of.

A key lesson from their experience seems to relate to the importance of forging collaborative relationships between mainstream services and healers operating outside these services. Participants described the successes of BasicNeeds: strategies that aimed to identify healers and forge relationships with these healers. BasicNeeds operates internationally and has a wealth of experience of working in cultural centres of traditionalism. Participants described strategies that

alternative healers experienced positively and stressed the importance of not judging the healers they collaborated with.

Another driving force in the process of collaboration was attributed to community psychiatric nurses (CPNs). Respondents reported that community psychiatric nurses work with alternative healers, and due to the distance between much of the population and the three psychiatric facilities in Ghana, are responsible for much of the outreach work on behalf of the hospitals. CPNs were included in this research project as early interviews revealed that they have frequent exposure to traditional healing practices and could offer valuable expertise.

Participants stated that CPNs in Ghana work flexibly and creatively, often involving family members and the community. CPNs that participated in this study suggested a significant part of their work involved educating people, communities, schools and churches about Western models of illness and treatment. Similarly, teaching healers and patients and families alike about potential side effects of medication, relapse indicators and protective factors were important strategies. One form of collaboration described related to the use of Western medication by alternative healers.

The significant structural barriers for patients seeking help at mainstream services, as well as attitudinal ones, necessitate representatives of the hospitals to be in the community. CPNs are a vital way of reaching out to the people the hospital would otherwise not see. They were clear that they did not think what they were doing was teaching them how to act as nurses, but felt it was in the patient's best interest to educate the healers about Western medication, how to administer medicine safely and what side effects, or signs of relapse or deterioration, to look for. The nurses described teaching the healers how to continue administering medication that had been prescribed by mainstream clinicians. The challenges associated with allowing alternative healing approaches to use Western medication are described in a later section, although it seems logical to assume that the fact that alternative healers are able to use Western medication impacts on how the population may view healing practices. The data suggests that the effectiveness of medication was a powerful cue to agent: participants described cases that had begun to believe more firmly in Western approaches after they had responded to pharmacological treatments. If traditional healers are able to incorporate these medicines into their treatment, it seems likely this will increase the recommendations they get. The lending of Western approaches could then be viewed as legitimising these practises, as the boundaries blur regarding what is distinct in belonging to the different disciplines.

Another indicator of collaboration between approaches was conferences organised to encourage information sharing between disciplines. One of the clinicians interviewed reported attending a

conference aimed at sensitising faith healers to issues around human rights and patient well-being.

Respondents reported a current climate of openness towards collaboration with alternative healers. Many reported that they felt collaboration between different approaches to healing was important. All of the clinicians I interviewed suggested that they acknowledge and accept that Ghana is a country with a strong emphasis on spiritual and religious beliefs and that this was something unlikely to change.

Negotiating boundaries

An interesting challenge reported by the respondents was about how to negotiate the relationship between the different disciplines. Ethical considerations were described by some respondents relating to incorporating spirituality into psychological and psychiatric services; whilst a clinician and a patient might share the same faith, being mindful of working within your own area of expertise was emphasised. Although some respondents mentioned that they had heard stories of doctors recommending a prayer camp or faith healer, referring treatment-resistant clients on to alternative healers was described as bad practice. All the participants interviewed felt it was unethical to charge a client for a service that a priest or faith healer was better qualified to do, and that avoiding falling into that trap was sometimes difficult. The participants reflected that with some difficult patients, there is a danger of it being appealing to suggest they seek traditional or alternative healing, as it can be a way of avoiding difficult work or clients that were difficult to work with.

Another boundary to that needed to be carefully negotiated relates to the clash of cultures that can be experienced within the therapy room. Strategies that were described as useful in bridging the gap between a patient that believes firmly in a worldview that clashes with a clinician who has an allegiance to Western models is explored in the next theme; however, negotiating the boundaries between approaches involved carefully handling of the patients belief system. The challenges associated with the balancing act between trying to avoid alienating or disregarding a patient's belief system and avoiding reaffirming beliefs that would shape future help-seeking behaviours were discussed. Rejecting the client's belief system could result in disengagement and subsequent help-seeking being at alternative sites of healing, although reinforcing a client's belief could also result in legitimising a belief system that would also support help-seeking being at alternative sites of healing.

Theme three: Multiple positions, multiple pathways

Due to the plurality of Ghanaians' health beliefs (which were described in the first theme), and as a symptom of the interface between different healing approaches, data relating to 'pathways to treatment' was a significant theme. This section is divided into two sections: data relating to help-seeking behaviour and data relating to how services respond to the challenges the participants described.

Help-seeking behaviour: Who goes where?

Whilst structural barriers (distance to hospitals/ financial considerations, etc.) account for physical obstacles to treatment, attitudinal barriers were significant, too. The clinicians were unanimous in reporting that attitudinal barriers (alternative health beliefs) resulted in many patients presenting at mainstream services as a last resort. The respondents described stigma associated with suffering from a mental illness. Alternative health beliefs were thought to reinforce and maintain stigma surrounding mental illness, and the secrecy that shrouds alternative healing practices is appealing to those fearing the stigma associated with being a patient at the psychiatric hospital.

Many of the interviewees described difficulties engaging patients in psychological and psychiatric services due to differences in health beliefs. Most of the interviewees spoke of the importance of spirituality in Africa, which was reflected by their accounts of clients seeking help with spiritual, traditional or alternative healers as a first port of call. Addressing the spiritual side to an illness or problem was reported to be of great importance to the Ghanaian patient and alternative healing was described as common alongside, preceding or post mainstream treatment. The respondents reported that clients delayed presenting to psychological and psychiatric services because they first sought alternative healing. Respondents suggested that a patient's family or community often served to reinforce an alternative explanation of the mental illness and thereby maintain existing help-seeking patterns.

My understanding of the participants' responses is that the Ghanaian patient embarks on a trial-and-error approach to treatment. Respondents reported that individuals sought treatment from their church or traditional priest, or were likely to trial treatment somewhere else. My understanding of this was that instead of having a firm allegiance to one approach (religious, traditional or Western), the Ghanaian patient was more likely to try what they felt could work. Some respondents described clients trying other people's medication based on a recommendation. The data suggests advice from friends and relatives has a significant impact on where an individual will seek treatment.

Other challenges associated with the interface between systems and health beliefs related to risk of disengagement, non-compliance and future help-seeking being at alternative sites of healing if a patient experiences a relapse. Non-compliance with medication was attributed to a lack of confidence in the explanations of their symptoms by the medical model. Therapy was reported to be ineffective if the patient did not have confidence in what the therapist said and was likely to result in disengagement. Patients can seek multiple sources of treatment and shift between models depending on their results and to whom they attribute the treatment outcomes. Respondents suggested that relapse rates were high because treatment is attributed to alternative healers, which serves to reinforce an idea and dictate future help-seeking patterns. Put simply, patients vote with their feet. Clients that do not experience a service positively, or do not have confidence in the mainstream explanations of symptoms, will disengage. Similarly, even if they get well, as it is unlikely that the patient was solely engaged in mainstream services, an effective treatment outcome does not necessarily predict future help-seeking behaviour, as it depends whom the client attributes the outcome to.

'You have to demystify things. You have to teach people its not a curse...'

Practical strategies to maximise the effectiveness of therapeutic interventions

More in keeping with principles of Community Psychology were strategies relating to addressing public health concerns and longer term strategies aimed at educating the population about Western models of psychological suffering and mental illness. These strategies can be seen as a response to the challenges associated with the help-seeking behaviours described in the last section. Longer term, national strategies were described that attempt to encourage clients to engage with medical and psychological services earlier. These strategies include laws that aim to regulate alternative healing practices, community outreach and education programmes and a Mental Health Bill. As stigma, especially in rural areas, can lead to mistreatment of a sufferer of mental illness, community work that educates families, teachers, priests and faith healers helps to actively challenge some of the misconceptions about mental illness (for example, that it is contagious or due to the fact the person has sinned). Whilst local beliefs will not be changed over a short period of time, this strategy seemed essential in building relationships between the community and mainstream services. Respondents also informed me that education programmes are targeting rural areas to encourage an understanding of psychological and medical explanations of mental illness.

Respondents described community education programmes that were often facilitated by community nurses or organisations like BasicNeeds. Working in the community is vital if attitudinal barriers are to be addressed. The culture clash between Western and local indigenous worldviews can be reduced by gently exposing the population to positive experiences of psychiatric and psychological services. However, at the time of data collection there was no equivalent to the Mental Health Act, and patients were entitled to seek treatment wherever they saw fit.

Respondents described hoping that a mental health bill would be passed soon and it was a few months later. During the interviews, I learned that, at that time, families had a big stake in a patient's treatment and could admit them to the hospital for treatment. Similarly, there were locked wards for people who had a forensic background and were being assessed or treated at the court's request. The lack of clear laws about the treatment of those with severe mental health problems resulted in patients having the freedom to seek treatment wherever they saw fit. The data revealed discrepancies in terms of at what point clinicians felt they should intervene. As with all psychologists, Ghanaian respondents' professional identities reflect individual values. Some felt intervening in the form of normalising and educating was the best strategy, some felt the new law would result in more people being detained under section, and some explained they felt it was most ethical to let a client seek treatment wherever they saw fit.

It will be interesting to observe how much impact the Mental Health Bill will have as it makes it illegal for an alternative healer to hold a person with mental illness for a prolonged period of time. Perhaps the Bill will facilitate stronger links between healers and medical services, as healers are, at least in theory, required to refer patients on to medical services.

Another government strategy to address the risk of harm was described by the participants. In an attempt to regulate traditional/alternative healers, the Traditional Healers' Act was passed in 2000 and requires that healers obtain a licence to practice. In reality this licence has been described as being easy to obtain and that the body that regulates healers is not adequately resourced.

Participants suggested that there was no way of knowing which healers were safe for clients to use. An interesting idea that licences could be viewed as government endorsement was raised. Respondents suggested that the historical context of the relationship between tradition, Christianity and modern medicine meant that traditional healers and traditional beliefs had been devalued and had become more shrouded in secrecy. Respondents suggested that traditional healers feel they perform a service for which they receive no thanks or recognition. Respondents reported a shift over time from attempts to distance the discipline from the approach of traditional healers to a current climate that was more open to collaboration and information

sharing. Respondents believed that both worldviews would continue to exist and that accepting that Ghanaians would always have a place for traditional ideas helped facilitate a position of collaboration. Respondents suggested that the effectiveness of the Traditional Healers' Act was limited due to inadequate resources. However, they felt that strategies that aimed to recognise and support traditional healers operating safely would be gratefully received.

Theme four: Eurocentric interventions in the Ghanaian context - what happens in the therapy room?

The fourth theme explores the specifics of working psychologically in the Ghanaian context. Data that related to *how* Ghanaian psychologists interpret and utilise Eurocentric theory and practise in the Ghanaian context was coded for, as well as specific challenges to psychological work in a cultural centre of African health beliefs. Subthemes consist of: data relating to patient expectations for treatment and how this impacts the therapeutic relationship, challenges associated with formulating client presentations, Ghanaian mental health professionals' specialist knowledge regarding working with these clients, how mental health professionals incorporate spirituality into their therapy and action-orientated strategies that aim to maximise the effectiveness of psychological work in the Ghanaian context.

'So they are not even thinking that it will work in the first place.'
Confidence and expectations for treatment

Many of the interviewees felt that many of their patients did not have much confidence in the treatment being offered by the hospital as it did not fit with their beliefs regarding the cause of the illness. A client's lack of conviction in psychological and psychiatric models of treatment was a recurring theme, and reported to be an obstacle in the delivery of mainstream treatments.

Advice from an alternative healer to mainstream approaches was thought to impact a patient's perception of the efficacy of mainstream approaches. Their advice could impact the attribution of effectiveness as well. Respondents reported that some healers recommend psychiatric treatment, whilst some vehemently warn against it.

Another emerging theme relating to the issue of patient confidence was that many of the participants interviewed thought that some people who could benefit from seeing a psychologist are not aware of the service they offer or what a psychologist does. Attitudinal barriers were described as a major obstacle to patient engagement and confidence in the approach. Part of the

appeal of alternative healers was attributed to the concrete, directive advice they give, offering an *explanation* for a person's suffering and strategies to *remove or undo* the cause in some way. In contrast to this approach, mainstream practitioners are trained towards fostering a collaborative relationship, gently guiding patients towards self-discovery. For many Ghanaian patients, participants explained they thought this approach was experienced as unsatisfactory and resulted in low expectations for treatment. Participants explained that as many Ghanaians are not very socialised to the idea of therapy, they expect a similar relationship to the ones they have with their pastor or healer. Similarly, as psychologists are seen as members of the 'medical' camp, experiences of nurses and doctors that diagnose and treat reinforce an expectation for concrete advice.

The data revealed there were ways in which the therapeutic relationship can differ with clients that have alternative health beliefs. Several respondents described needing to work hard to gain the patient's trust. One respondent explained that entwined with the cultural values of connectedness was a need for some reciprocal conversation. The participants described pre-therapy to develop trust. Participants explained that as many Ghanaians are not very socialised to the idea of therapy, they expect a similar relationship to the ones they have with their pastor or healer or, indeed, medical doctor. The status of an educated clinician is high and it seems logical that for many Ghanaians, a more directive therapeutic relationship feels more comfortable.

The issue of when to disclose the therapist's own belief system was also discussed. Another component of the notion of self-disclosure was how to handle direct questions about the practitioner's belief in traditional ideas. This data seemed to describe therapeutic relationships that were congruent, transparent and respectful. The respondents described being asked directly about whether they believed the health beliefs of their clients. Disclosing the clinician's belief in God seemed to help bridge the gap between the different worldviews: focusing on the positives associated with faith in God facilitates a common ground between clinician and patient.

'Mmm. No they are not delusions, they are really, real because these are beliefs.'

Formulating client presentations

Another emerging theme relating to obstacles to psychological work related to the difficulties in formulating a client's presentation and/or defining what constituted mental illness. Respondents described how delusions are maintained or reinforced by the family or community, or how ideas that sound like delusions may be socially acceptable in the client's local context. For example,

one participant described a client who may have met the diagnostic criteria for psychosis, but after the clinician realised that the client's friends and family also held the bizarre ideas, the clinician described formulating the client's presentation differently. The participants were not unanimous in their descriptions of how they formulate a client's health beliefs.

One explanation of this discrepancy in the data is that Western classifications did not always fit. Respondents were not united in terms of what constituted a delusion, and at what point they believed mainstream medicine should intervene. This point was salient, as Ghana has recently passed a Mental Health Bill, which imposes limits on the length of time a non-mainstream healer can treat someone before referring him or her to a hospital. Some practitioners reported that they felt clients should be free to trial treatment wherever they saw fit; others believed that they should act in the client's best interest and intervene if a client's belief was obstructing appropriate medical treatment. At the time of data collection, a patient's family could admit them against their will.

'Yes, we grow up with these things being said and hear about them and things like that.'

Specialist knowledge/shared culture

Clinicians described several therapeutic strategies for working with this client group. An understanding of traditional African healing practices and beliefs and aspects of a shared culture seemed a major advantage to their work. An understanding of a shared culture seemed advantageous in this clinical work and the participants in this project were able to explain many local ideas in a way that straddled both worldviews. It was interesting that respondents switched between describing these ideas as 'ours' and 'theirs'. However closely they wished to align themselves with these ideas whilst being interviewed by a White British woman, a familiarity with indigenous ideas was beneficial. The participants revealed that operating within a shared culture aided their work with clients. Significant aspects of Ghanaian culture related to the importance of family, community and the importance of spirituality. A shared culture between clinicians and patients enabled interventions from mainstream psychology to be sensitively modified to meet the needs of the Ghanaian population.

Ghanaian psychologists also have the significant advantage of being taught about traditional healing practices as part of their clinical training. Respondents reported that they were encouraged to visit prayer camps and healing centres, and that their training involved lectures on these approaches. Respondents informed me that African psychology is taught on the training alongside dominant Western ideas.

The fact that clinical training recognises the importance of understanding alternative health beliefs is arguably necessitated by the prevalence of traditional healers and alternative beliefs in Ghana; however, it is also humbling to realise that in a country where Western models of psychology are much newer than in the UK, course directors have already identified the need to train clinicians about culturally sensitive work, and responded to this need by providing relevant training.

'But I think that is what is not being addressed from the mainstream Western medical, spirituality.'

Incorporating spirituality in psychological therapy

Many of the participants described trying to incorporate spirituality into their therapy. Many felt that spirituality was not properly addressed by mainstream Western psychology, and that it was difficult to work with African clients without taking a more holistic approach to treatment. The participants described many strategies to incorporate spirituality. Using the bible or other religious texts, especially scriptures that speak of forgiveness and second chances, was reported to be used in treatment sessions by many of the respondents when clients feared their illness resulted from sins they had committed. The participants' ability to occupy multiple positions when integrating their own faith and culture into the treatment is evident.

Engagement in a church was described as a behavioural tool that could be used to help treat mental illness. As with all cognitive-behavioural therapists, the clinicians described behavioural activation assignments that reflected the resources available to the client, and the values that impact the client's motivation to engage with homework tasks. Respondents explained that regular attendance at a church involved socialising, singing and dancing, all of which have benefits to mental health.

Working within a patient's belief system was described as a balancing act between reaffirming the belief and challenging a belief in a way that would alienate the client. Again, the principle of reframing is relevant to any context or country. However, perhaps this process is more salient in the Ghanaian context as *what* the Ghanaian psychologists are trying to reframe is more fundamental.

Participants described encouraging a client to develop a good relationship with God. Building a stronger spirit was thought to help those that believed someone had cursed them, without challenging or reaffirming the belief directly. Respondents described focusing on the positive

aspects of the patient's belief. Helping clients feel more resilient against curses and strengthening their relationship with God were reported to be useful strategies.

Some respondents described telling clients that they felt that God had granted them the ability to practice within mainstream healthcare facilities. Again, the significance of the duality of the psychologist's own belief system is emphasised here. The respondents felt that identifying themselves as a Christian helped develop a therapeutic rapport. Some respondents described asking a patient if they minded if the clinician prayed for them; my understanding of this gesture was that it reflects a shared belief system, which can help build trust. Disclosing the therapist's own faith was reported to be useful with some clients, although some respondents felt this was not good practice unless asked directly by the client.

Harnessing the positive aspect of a belief serves to build a rapport with a client that might otherwise disengage. Avoiding reinforcing the part of the belief that might be causing the client distress or to be acting in an unusual way was reported to be achieved often by finding the common ground between the traditional idea and Christianity.

'...You have to demystify things. You have to teach people its not a curse...'

Practical strategies to maximise effectiveness of therapeutic interventions

The psychologists interviewed for this research described trying to modify Western techniques to suit their clients. Many favoured CBT for the time-limited nature of their therapy, but reported that they modify it to fit the cultural context. Many respondents described doing CBT slightly differently to the purist form they had been taught. Being more transparent with the client was described, often involving self-disclosure about the therapist's own beliefs. The participants described the expectations that their clients had for direct advice, which resulted in the clinicians employing testimonials of other patients with similar complaints they had treated successfully, or a therapeutic relationship that was more directive. Respondents suggested that education was a significant component of their clinical work with clients.

Education was carried out on many levels: on an individual level with the client in the therapy room, with family members, and sometimes in conjunction with faith healers, pastors or traditional healers. Ghanaian colleagues spoke of needing to educate their clients about psychological and biological models of illness. Respondents suggested that psychoeducation was facilitated by the clinician but required a collaborative relationship, which encouraged patients to share their beliefs. An emphasis on involving family members and other individuals in the treatment planned seemed to result from the Ghanaian cultural values of family and

community. Effective therapy was described by maximising the involvement of important stakeholders in the treatment plan. Respondents suggested that psychoeducation also involved in family work, encouraging family members to buy in to the model of treatment. This approach incorporates the patient's support network; respondents noted that people are brought to hospital by their relations who are considered to be directly responsible for the care of this person. A person's level of education was thought to impact the effectiveness of psycho-education. Similarly, it was explained that as education is associated with social status, the most educated member of the family's advice is likely to carry considerable weight.

Information about a client's belief can be obtained from significant figures in their life to help the clinician assess how widely held is this belief. Clinicians noted that family members and members of the community can sometimes reaffirm a client's belief, which can undermine the effectiveness of mainstream treatment. Respondents explained that education also took place with individuals from the community. One of the challenges described in an earlier chapter related to the idea of sticking to the remit of your job description and not being persuaded to take on the role of a spiritual or religious healer because your client attributes their difficulties to those ideas. A way around this challenge was suggested: respondents reported that clinicians could liaise with pastors or healers and try to involve them in the treatment as they already held the client's confidence.

Involving significant members of the community was used as a strategy to reinforce what the professional was saying to the patient, and to increase patient confidence in the treatment plan. This strategy also serves a longer-term function of educating people about Western models of mental illness and healing approaches.

Prompt questions for respondents

Section 1

1. Do the definitions of the types of alternative healers sound like an accurate summary?
2. Is there any information you would like to add to the definition of types of healers?
3. Do you think the results capture accurately the plurality of Ghanaian belief systems?

Section 2

4. Do you think the researcher has understood the relationship between the different systems and healing approaches?
5. Is there anything you feel is inaccurate in this section?

Section 3

6. Do you think the researcher has accurately understood the descriptions of Ghanaian help-seeking behaviour and pathways into treatment?
7. Is there anything you feel is inaccurate in this section?
8. Does the document accurately capture the strategies that aim to enhance pathways to treatment?

Section 4

9. Do you think the researcher has understood the way clinicians describe their work with this client group?
10. Do you think the challenges of working psychologically have been captured adequately?
11. Is there anything you feel is inaccurate in this section?
12. Is there any information you would like to add to the section that summarises the ways clinicians described working with this client group?

Section 5 - Taking part in this project

13. Reflecting on the experience of being interviewed - how did you find the process?
14. Do you think you would have answered differently or more honestly if the researcher had been different? Did being interviewed by a White British woman impact how you answered?
15. How could the interview have been improved?
16. Do you have any other comments about the research design, topic or methodology?
17. How did you find the process of feeding back your reactions to the results?

B.16.9. Explanations of Ghanaian terms used in data

Abosom - Akan word for lesser deities, which can be viewed as representatives of Onyankopong.

Akuapem - Eastern region - the Akuapem are the people of Akyem (pronounced Achem)

Brofunu - is the Ga word for White person

Day names - Names that reveal society/family/tribe and the day on which you were born. Akan/ Twi Kofi – Friday. Kwame – Saturday. Kwesi – Sunday. Kojo – Monday. Kwabena – Tuesday, Kwaku – Wednesday. Yaw – Thursday.

Fante - Central region tribe

Ga - Greater Accra region tribe

Obayi - Akan word for evil

Obayifo - The Akan word for witch, which is suggested to mean 'a person who is of the abode of an evil entity, the Obayi'

Obruni - the Twi word for White person

Onyankopong or Onyame - Akan word for Supreme Being

Rauwolfia - a plant used in herbal medicine, healers use rauwolfia root as a tranquilising agent

B.16.10. Interview 1- transcription

I: **Right my first question is just about the type of service that you work in, the type of clients that you see, so if you could just explain?**

R: Okay, well I er work the XXXXXXXXXX and we have what we call a XXXXX practice so I see patients who come to that practice, erm, and there's a mixed mash, er, and from relatively middle class to very poor, and er and then I also work with the XXXXXX department so I, I go around to them and they, they erm, refer patients to us erm who are going through erm XXXXXX. Erm, they don't do it as often as they should, but we do see some of the patients on the wards and then we get people who've, from emergency who've interestingly not gone through the trauma but have attempted suicide and the very specific things we get referrals for, but for those who walk in or are sent from their offices or er are referred by their churches or, er, by their GPs, we get quite a few of those from GPs, or they come by themselves, and mainly with er anxiety disorders, or er more mood disorders than anxiety disorders, and substance abuse.

I: **And what's your most common sort of model of treatment...?**

R: [interrupts] Cognitive behaviour therapy. But, erm it's almost difficult, almost impossible to practice it in its purest forms, you know... *here.*

I: **What sort of modifications do you make to work here?**

R: Erm, well first of all people don't write their thought diaries as they should, so you, you kind of go with whatever they've written, you know to start off with, to identify the thoughts. So there's a lot more, er remembering of what has happened and what they thought you know by sticking to what the columns ask for, and if they, I mean they're often very sparse when they've written also, so, but it's more a memory kind of thing, but once they get it they, once they get what you're trying to put across, erm they may not be, they're usually not that interested in the different sorts, types of thought distortions. They might say, "Oh I do primarily maybe one two three" and that's it, they don't, they're not really interested in, in the distinctions any more they just, once they get that they're these thought distortions that cause their moods then they're quite happen to challenge them as they go along, they don't care for the different types of thought -

I: **- so roughly, if someone was referred by their GP how many sessions, is it restricted to how many sessions you can offer them or ...?**

R: No, it's erm, because it's a paid service this one erm they come as long as they want to come for, are able to afford it. And so erm, and we deliberately set it as a paid service

because we can't, we wouldn't be able to deal with the numbers. I mean that's all we would do all day, is see patients if it was not a paid service. So because it's a paid service people come according to how they can afford to, you know, and I, we did some research into the average number of sessions a few years ago, and I think on average between four and six sessions they come for, and they feel much better and then they go, and then they might come for a booster here and there as the, the need arises.

I: So you're teaching them the tools...

R: Yes, and it's an education some kind of a psycho-education okay, but this is, this is not er, by the time they've left us they understand that it's not a spiritual illness, that it gets better and it can come back. We also work with psychiatrists, so they can get some medication, er so I think at the end what we achieve is, is a bit of education, a lot of support, some challenging of thoughts you know, never mind if you're not interested in that very much...

I: You mentioned teaching something that's not a spiritual...

R: Yes, Ghanaians are very eclectic in that way you know... in a sense that they can, erm we can accept different views of illness. It's erm, erm you know it's a recognition that mental illness does have a biological component so before you get married you go and check out your beloved's history and if there's a history of mental illness you know you don't get married into that family. I mean there is stigma but ultimately there's a recognition that this can be carried on to your children. You see so there's that biological understanding of mental illness. Then there is the social. I have a problem with you, you curse me... But ultimately it's because you and I have quarrelled okay? And so the social, social illness, er social, the relationship is, is ruptured in some way that's why you can curse me or you have cursed me. So there's social and then there's the spiritual aspects. But the strongest, the strongest beliefs in the spiritual are held by people who are, are less educated. The more educated there's the more the, erm the acceptance of beliefs in, in the biological or the social as the psychological aspects. Erm, or the more exposure to what would you call it, er global...

I: Western ideas?

R: Exactly.

I: Do you think you could explain to me the different types of healers?

R: Sure. We have herbalists, they use traditional medicines to cure, tonics and herbs and plant extracts. We have some great herbalists here. Also there are fetish priests or , er I think its correct to call them 'traditional healers', they worship the deities and the smaller gods, they perform rituals and do sacrifices to the gods.... The churches, the Christian and charismatic churches will also offer healing... with prayer. Holy water and fasting, and all night prayer. They maybe offer advice and counselling too.

I: **You mentioned that churches were referring?**

R: Yes, churches refer their patients, I mean their congregants because they're, especially the, the actually and also the charismatic churches, I think the more educated the population of the church is the more likely they are to see the difference between a spiritual erm underpinning and er one that needs psychologists or psychiatrists, so we are getting, and they'll come with their congregants also. Yeah.

I: **It sounds like a very positive relationship. Is it ever an obstacle if someone is too firmly rooted in a spiritual explanation for their difficulties...?**

R: Yes it can be an obstacle especially where medication is concerned. If they have to take medication then it can be an obstacle. Erm, and having said that about the, about education, you know we have people very well educated especially when it comes to physical illness... say you have a tumour or you need surgery and you don't want surgery you turn to prayer. Okay, and then when you come to see the psychologist you know erm the psychologist says, "Well you know there is a real, there's a physical illness" and so they're like, "Yes but God has taken it away." But then you need to be part of that, you need to have part of that world view to be able to say, "Yes he can take it away." But he doesn't always choose to take it away, you know. Erm, so I'm not challenging your faith but I'm, I'm letting you know that he ultimately decided whether he will do it or not. But if he hasn't done it then he asks you to rely on the likes of us to help, and so he's provided, he's made that avenue also possible for you, you know, but if you don't enter into that world's views and you push that away then the patient is not going to hear you either.

I: **True.**

R: For instance erm, with HIV aids, I, my, I remember Dr XXXX talking about, in the beginning of the epidemic in the '90s, the early '90s, er working with people er who held the belief that it was spiritual so why use a condom, you know? Or erm why protect yourself you're going to get it anyway you know. And, and er, or why take the medicine, and er and they would say to them, "Yes you do what you have to do", erm or that it was a curse and they wouldn't be cursed if, you know if, something about there not being the need for the condom that she would say to them, 'But perhaps it is that condom that shields you from the curse.' So you need to your suggestions more erm acceptable to the client...

I: **I'm interested in sort of the specifics, so if someone comes, say, with an anxiety disorder and they blame a curse that some acquaintance has put some hex on them, how do you, how do you introduce the idea of cognitive behavioural therapy...?**

R: Erm, well the trouble with my XXXXXXXXX is that people don't like to tell me about these beliefs *(laughter)* yeah because they think erm I wont understand or I'll

laugh at it or something so erm if I observe that they're particularly anxious I will right away do erm teach them erm relaxation. And because they feel so much better after that they can begin to accept that what I have to offer will be helpful, you know. So erm after I take the history I'll right away do relaxation training and then I'll find out about that. But if they were really insistent I would ask what they would want to do about that, you know, sometimes I'll bring the whole family in and ask, with er the patient's permission I'll bring the whole family in and ask erm what they think. And sometimes you have to let them go and sort it out.

I: **Do you ever borrow any of the sort of symbolic part of the traditional healing or ...?**

R: No it never comes into that ... I can't do it was well as those guys can.

I: **Do you think that the people that aren't coming to you, if the service was free they would come to see a psychologist?**

R: Oh yeah. Well no, erm, lets see... you know for, for years we practised out of a psychiatric hospital and it was free (short pause) so the service was free and erm people, people came to see the psychiatrists but not to us because they didn't know about the service, they didn't know that...

I: **What psychologists did or ...?**

R: Yes, they didn't even know there was psychologists there, you know. Erm, so erm but I think now, people know about psychology and they will come when they're in distress. What was the question again?

I: **I was asking if you think people would come if it was free?**

R: I think they would come. I think they would come but, er I mean if you're uneducated you just don't know about what a psychologist can do for you or who a psychologist is, you know, so I think we probably begin to see more from the educated people you know. Erm, if it was free more people would come from the educated group.

I: **And do you see people detained at the psychiatric hospital?**

R: I do. But often it gets very bad by that time. Erm, I think when they've gone that far you don't want to send a psychologist, you need a psychiatrist, you know unfortunately, you need the psychiatrist in there first. And then you have the psychologist after that.

I: **Yeah.**

R: You know the point at which you needed a psychologist was way before, you know.

I: **Yeah.**

R: And I have that now, erm one of the calls that I just silenced is a XXXXXXXX who's been going through like for the last four years, four years, psychological distress and so now she's just you know lets rip at work, insults everybody and writes horrible letters, threatening letters to people, four years of you know slowly getting to this

point where they now, have to ask, you know they referred her, she won't of course mind them... they asked me to see her, she didn't show up for work, and she goes to the police to report them to the police. And this is an educated woman, you know.

I: **And why do you think she was so resistant to the idea of your involvement?**

R: She doesn't believe she's ill. And she's, of course almost lost touch with reality. But when she was not so offensive to everybody then would have been the time to bring her in to, before the management team and say, "Something is wrong." You know then at that point the psychologist would have been very helpful. Right now we've gone so far we need to start with medication and she feels already er... threatened. She's totally paranoid.

I: **Have you ever worked with someone who believes in traditional or spiritual explanations for their symptoms?**

R: Yes. It's pretty normal. And it is important to find out what they believe... and what their family and friends believe. Many people believe they have been cursed, or that God is causing it.... Those sorts of things. That is why they go to the healers.

I: **And if someone who believes they are cursed comes to the hospital?**

R: You know if a person thinks it's a hex I've come to the conclusion that that is a paranoid disorder.

I: **Okay.**

R: You, we have these beliefs about the spiritual world... I mean it's there amongst us in our population but to the point where it disturbs your functioning, it's already gone too far, you see it's already gone too far, so at that point it's a delusional disorder or paranoid disorder, you see. And then at that point you really do need medication.

I: **Yeah.**

R: And I, I've come to that point where, because it can lead to death, I've seen it, erm in the case of the tumour that I was talking about, this educated man, with a BSc... teaches biology and chemistry... he has a tumour, the doctors start working with him, he's like, "No I've been, I've been cursed by the people I fight with at home I need to go and sort it out in case it's my step-mother doing this to me." A year later, so he, he, even though the best of medical care in Ghana is available to him, at no cost, you know because the school he teaches at is paying, he takes off for a year and by the time he returns his stomach is huge, his head has shrunk, he dies within three months because his tumour has taken over. And at that point, if we had, if we had been able to say "Now that is a paranoid disorder" you know, we'd put him into hospital and we say, "We need to treat." And whatever our mental health, er law allows us to do we begin to treat whether you know he'd go through the involuntary whatever and treat, he reduces paranoia and then see if he will accept medical treatment. At least we'd have done something. But everybody said, "Oh yeah", and even his wife, his foolish

wife followed him, followed him around the country looking for spiritual healing, and he comes back to die.

Er, so erm, why is it that most of the population will go into hospital, if they are told, "You have a tumour, we need to take it out" they will say, "Okay take it out"?

I: **Would *most* of the population though?**

R: Would they? Yes. Most people who have to have their breasts, and that's a good hypothesis, we can go and find out. We can do some research to find out if most people will accept their, erm, their diagnosis and go through treatment. We can do a very simple study in the next two weeks. Erm, I have nurse that comes for training in counselling - in the surgery department. She needs to break bad news, how to break bad news.

I: **I'm just curious... do you think it makes a difference where they live?**

R: Mmm. It's not as simple as that. Because the clinics are being used for physical illness even with, you know if somebody has malaria and they go to the clinic where there's a clinic ... There is an understanding of what illness you go to the healer with and what illnesses you go the clinic with. So erm there is er a -

I: **- in terms of mental illness?**

R: In terms of mental illness they shuttle back and forth. Lots of these places offer sort of counselling. They will talk about things at church and with healers.... The less serious conditions they can help with I think.

I: **Im trying to understand how people decide to come here?**

R: It depends you know? Some believe it's an illness and see their doctor. Many try other places first. Some come as a last resort, when they are very ill. They do come later, they don't know that you have a psychologist and what services a psychologist can offer. You know, when they are referred they find solace you know and when they come to see their doctors they know this is when we work in the psychiatric hospital if we're talking pure mental illness they will come and see the psychologist, to see the psychiatrist you know and they do use the service you see, but where there, where you don't know that such help is available you don't seek it, would you?

I: **No.**

R: And if they live in a village very far from us here. They do not know to come. And the journey would be hard. They don't look here - why would you? How would you?

I: **Do you ever see someone who has been treated by a healer first?**

R: Erm, yes. And if you go, there are some prayer centres that work with district nurses.

I: **Is that very common?**

R: It is becoming more common, because when the bill gets passed they won't be able to keep people with mental illness for more than three days.

I: **The bill?**

R: The, the Mental Health Bill.

I: Okay.

R: They won't be able to keep people for longer than three days without consultation with the police or without consultation with a health professional. So that's going to change and many prayer camps now therefore will erm accept medication and then they do their, you know, the prayer part of it becomes like a spiritual therapy, a spiritualist comes in. So that there's erm there are pray camps like that using community psychiatric nurses or doctors you know working together... Erm, (medium pause), the question is if somebody has, no they, coming back to the issue of whether erm we can label somebody as having a delusional disorder erm if they think somebody's hexed them to the point where they can't function, I think so. Because the belief is not the same level as it is within the population.

I: Yeah.

R: You know it's kind of like when you are in, in England and somebody says, "There are cameras all around watching us." It's true that there could be security cameras all around, but what is so, why would you label this person delusional? Even us, we didn't flag it up, we didn't flag it up as a mental illness.

I: Did the team discuss whether the man should be forced to stay in hospital?

R: - no I didn't even, I mean I, I was like come on, and I thought okay this is a normal belief within the population, but after he got so sick a year later and he then accepted that he needed medication and help, he knew he was dying, he could feel he wasn't well, you know that was his last course, I mean his last erm... afterwards I thought oh we failed the man, we should have recognised that it was, he still held onto his belief actually, rather than let go *(laughter)*. I felt that we had failed him, that we should have labelled him as such and

I: And have the power to -

R: - yes and have, yes, and then done all we could do to help him.

I: It's a very interesting, I wonder if as a team it's a debate that you've raised more recently?

R: I haven't you know because he didn't come in, you know I knew him because of the school, you know so, and nobody thought it was mental illness. You know we were just simply helping to connect him to the doctors in XXXXXX you know and so it was afterwards, with hindsight that I thought, and then when I'd spoken to my fellow surgeons, my colleagues in the surgery, they, they, they say to me, "Oh we have, we need a psychologist because we're finding people who refuse treatment."

I: But if that happened again, do you think now it would be different?

R: Erm, we haven't done anything different yet. So if you didn't give your consent for treatment they go, the difference is, you see if you say, "I don't want surgery because

I, erm, I don't believe in surgery, I, I want more prayer" okay, you're not saying somebody's doing this to you, you're just saying you believe in the power of God to heal... but if you say, "no no no no no, this cancer is because of my neighbour, it's my neighbour that's doing it" - that's different.

And if it then manifests in suspiciousness and all of that and we begin to close one door, you know that, then you're entering the realm of paranoia.

I: **So if that client had been detained, but maintained this very fixed belief... how would you work with him?**

R: The same way you'd have to work with somebody who thinks the cameras are all set on him and you know the CIA's following him, what do you do? You would test out the belief! Yeah, yeah. It's just as difficult as you're dealing with, well maybe even more, a bit more difficult because of the spiritual part, you know you can, you have to find ingenious ways of testing it out.

Spirituality and faith is important...Er, I find, I find that erm the West is losing it in that respect, you know. You know because, er I find particularly that people are so quick to not give offence... You know that the moment you mention religion you know people kind of step back. But more important if you mention Christianity it's your basic religion now, your commonest religion in Britain, you don't defend it. You let all of us you know Hindus and er Muslims and Pagonists and so forth come in and say, "We love the peace in your country but we want to er, and we want to practice our religion but don't talk about yours", why?

I: **Yeah.**

R: The foundation of your civilisation is that, don't throw it overboard, why would you?

I: **Do you ever use your religion to help your work?**

R: If erm, I mean I've prayed with patients from time to time but I don't do it regularly. I myself would pray silently before I see a patient. Not every patient. When I don't know where to go with my patients I will pray.

I: **And do you ever tall a patient that that's what you do?**

R: Sometimes I will ask the patient, "Can I pray for you" and they'll say, "Yes."

You know I think erm if the client accepts that a psychiatrist or a psychologist can do those things and it is within the psychologist's belief system, or psychiatrist's belief system then that's okay. But erm I think that we would run the risk of being thought of as false prophets or you know or patronising if we begin to ... if we don't believe in these charms and hex and things and we buy into the belief system... I mean then we, we, we say, "Well we'll try this, it might keep the spirits away" kind of thing you know... I think a more authentic service or way of being would be to, because we have to maintain our integrity and our authenticity would be to say, erm, "It sounds like you

would feel better if you saw somebody who knows about hexes and you know, here's a referral, try it and let me know what happens. But I'd like to see you again."

I: **Yeah. And do you do that?**

R: Er, no. I'm thinking about it because they know where to go in Ghana for those kinds of things, I don't need to tell them, they know where to go.

I: **But would you ever see a patient who is also engaged in healing?**

R: I see many people that go to prayer camps and those sorts of places....

I: **And how do those two treatments interact?**

R: Now that you mention it, mmm, erm I had a patient recently, erm an older woman who is very much into the Catholic Church... Erm, she went into the catholic, I mean she was erm, er, a very strict catholic and she erm, she would go for erm Novenas and er I don't know what they call it, but go and visit you know if you go for retreats, and er for days on end in the Catholic Church, you know all of that, so ... and then she'd come in for therapy as well. And erm the two didn't clash, you know because we were, we were dealing with a marital issue and we were dealing with her coping with his relationship with another woman, erm yeah, it was erm, it was a longstanding difficult marriage. He was very unfaithful, had been all their lives and she was a woman in her late 60s now.

I: **Ok.**

R: She was forgetful, she was erm miserable, she was, you know she was depressed and she was, she was afraid she was getting forgetful, erm it happened and she passed out, she was getting weak, felt she was getting weaker and weaker and so we ran all the tests on her, she did an MRI, CAT scan, everything, nothing. So then her priest suggested that she needed therapy. And I think they had tried to help her, it turned out they had er intervened several times with a marital issue and nothing had happened.

I: **Yeah.**

R: And in that case you know they'd bring them in together and the man would listen and he was always the villain, because he was the one going out, but in therapy it turns out she was very closed erm and there were things that she did in the past that also pushed him away, and she wasn't, in therapy it became abundantly clear that she was not a victim.

I: **Yeah.**

R: You know. Yeah, but er from the church's counselling it was so apparent that he had children all over, because he was clearly ...

I: **Yeah the evidence was stacked against him?**

R: *(Laughter)* yeah.

I: **Okay, in that situation the prayer just went alongside quite nicely to the therapy?**

R: **Yes.**

I: **I'm just curious perhaps I've become aware whilst I talk to you, I'm probably more nervous of healers' treatments than you are...**

R: I think when it comes to things that are life threatening like for instance er seizure disorders, and you know that about 40, ooh what's the percentage, about as high a percentage as schizophrenia's, as schizophrenics er... let me back track... the proportion of patients that come to Accra Psychiatric Hospital or all the psychiatric hospitals... we have about 30% with schizophrenia, we have, I think, is it between 10% and 30% coming in with seizure disorders... But I think the number of cases, because I think they would probably come more regularly for their medication and if we count them as cases rather than patients it would be almost equal numbers of schizophrenia as there are.... erm but if we think of them as patients then we can say about 10% of the population. And that's high for seizure disorders. So now if those people began to think of going to spiritual camps I would be very scared for them. There's certainly a whole lot of work that needs to be done with education. And erm my boss goes up to the north sometimes, er Doctor Y a psychiatrist, and whenever he comes down he is so upset with you know what could have been prevented in terms of seizure disorders. So for that they make us nervous... very nervous, because when it comes to er you know in schizophrenia, in schizophrenia and the, the common mental disorder ...

I: **Yeah.**

R: Erm, we're not so nervous, we wish we could offer everybody treatment but obviously we don't have the capacity to do that.

I: **Yeah.**

R: You know so and we, and there are some healers who have access to Rauwolfia and anti-psychotic herbs we just don't know who exactly they are, so, but what you can't, and then we have our community psychiatric nurses in about half the districts of the country, we have basic needs...

I: **Yes. When you, you just mentioned anti-psychotic herbs, what was the name?**

R: *Rauwolfai* is er, an old plant, it's actually one of the, one of the first anti-psychotics to be used in Britain.

I: **I didn't know that.**

R: Yes, and the story is of a, er a young erm, a Nigerian student in the UK who got psychotic and his father was a wealthy Nigerian and brought er a healer, a traditional healer erm who came with his, his medicine bag and treated him and the, and the doctor saw... so they took it, they took the, er the herb in and tested it. The scientists thought it might be a placebo - it's not.

I: **That's very interesting. Do you think mainstream services need to learn something from these practices?**

R: You know (short pause) *absolutely.* But you can't do everything.

I: Yeah.

R: You know, you can't do everything and you have to know where your limits are.

I: Yeah.

R: You know, and what you can't do, you need to source information for your patients, you have to refer them on to someone who's trained in that, are steeped in those beliefs, you know, erm but the boundary between faith and therapy or faith healing and psychotherapy that, that boundary can be a little murky I think. And erm you kind of are constantly watching so that you're not sucked into providing erm a cop out for yourself, you know. Erm... if I'm trained in Cognitive Behavioural Therapy and erm somebody wants er, if I go, if I went through all of my, my steps in, in with Cognitive Behavioural Therapy to challenge beliefs and er, erm, er try and build, help build new schemas and so forth, if I, if that person, if I were to get sucked into the belief that it was simply a curse that needed to be removed why would I bother? You know, every time they came I'd sit down and I'd pray with them and I would you know er listen and, and, and then what?

I: Yeah. And then you're slightly unethical charging a patient to do work outside your expertise...

R: Absolutely. So we have herbalists.... Those that know about the healing qualities of different natural medicines.... Plants and tonics. Some bonafide healers that know their work well... We also have the churches offering some healing - prayers and healing. Using God. Different types of churches - the newer churches do things differently... And we have tradition - those that worship the Abosom, the lesser deities, the old African way... We have bone setters and witch doctors but healers all have their own ways of doing things. We must stick to our own job.

I: Do you think some of these belief systems or values have something to offer psychology without sort of interfering with our theories of personality or mental illness?

R: *Absolutely,* and, and erm, well in, in, when we teach medical students now er theories of personality... We, erm, we teach them, we erm we teach them the theories of personality, Western theories of personality and then we teach them er an African theory of personality based on the Akan belief system, you know and there is very much a spiritual component to how your personality develops. It has the blood which we get from your mother and the, the spiritual which you get from your father, and the two together combine erm in, in some way to help you build your character, but at the same time you're born with this Okra - your spirit, you have your own spirit that you come with, and then your character develops from a mixture of socialisation and the

spiritual, you know day name and you know that's why we have day names, er and all of that and it's quite a nice mix in there.

I: Yeah. So as a cognitive behavioural therapist you would still bring in African-centred ideas?

R: If my patient, yes, if my patient erm believed in these things. You see the, the problem for me is we buy into the concept that erm if you believe somebody has hexed you then that's just a part of the culture, it's not, well a certain, at a certain point you will have to make a determination that you are paranoid, you know. And I think we, we, we take the, the perhaps a romanticism of African beliefs too far. So I, we haven't written enough about it to alert clinicians to say, "Okay when, when you see somebody that's come with this belief treat them as you would the person that is paranoid..." But these beliefs are common, most people recognise that these things can happen. Erm, yes, okay, so sometimes is they have these beliefs and yet they are functioning? Erm... It's murky for us. It's murky for us. Erm but at the same time when you give medication the strength of the, of the belief goes down, you know because it doesn't go away completely but it goes down to the point where people accept alternative explanations, you know at least they will hear them.

I: It's a difficult -

R: - it is a difficult one, and er I think it would be easier to write about er for physical illness like the tumour.

I: Yeah.

R: Er, versus, er and to begin to think about it, versus erm in the case of very you know mental common disorders.

I: Yeah.

R: Erm, yes I think because erm if it, if it's purely a psychological disorder erm (short pause) you know my difficulty actually, I do have a fear also ... because erm they can be very disruptive of families, you see, and, and I guess that's where the problem with er licensing, a lack of licensing traditional healers and faith healers, that's where the problem is because you do have -

I: - how do you mean disruptive to the family, sorry?

R: You do have charlatans, or you do have people who think the families are a problem. And they break the ties with family completely, so that they have, they, they think that if you have a belief that it's the family that's leading to your patient's illness, then the thing to do is to separate your family from... Then you, then the healer becomes the family and they, they can then extort

I: - exploit?

R: Exploit completely.

I: Yeah.

R: Or even if they, let's say they were good people and they didn't exploit, when they're not able to heal the patient is left bereft, you know, with nobody and we don't have a social system, so erm we don't have a, erm how do you call it, 'the dole', we don't have anything like that, so without family support they really very vulnerable, you know.

I: There was a traditional medicines act passed in 2000?

R: Absolutely, and there's a tiny office, I really don't think it has regional branches. It's too small to make a difference. How can they see all those people?

I: Okay. Where is the office?

R: It's in the Ministry of Health.

I: Okay.

R: It's er in the Ministry's complex, there's a low line building opposite the Ministry of Manpower that's where I picture it now, in the Ministry of Youth and Employment, the Ministry of Employment and Youth or Manpower, whatever it's called these days, social welfare. Yes, and just opposite it is, is, is a block and in there somewhere is the traditional healers' office.

I: For me it feels like there is secrecy around these things?

R: Well the mystery is good, in the sense of erm the mystery as to the ...

I: The power?

R: The power, the belief, er the faith a patient has, you know, so, and that's part of the, the active ingredient in there. But I think the, the... some kind of a licensing that allows erm the body to police itself or be policed... and you have to remember that when the country embraced Christianity, the healers had a difficult time, the old beliefs.

I: Yeah.

R: Erm, that's important, erm because we do have some fantastic traditional healers, and erm... who are, purely herbalists for instance and therapists, psychotherapists together and have a spiritual for prayer you know, as a backing for their work, but they really know what they're doing, er herbs have been handed down from generation to generation or they've been apprenticed to erm, er a bonafide healer you know, we do have them, the thing is knowing where they are and who they are and so that you can have that kind of referral.

I: Interesting. Do you know any healers you believe are safe?

R: - I did when I was er much, well when I, before I became a student I went up to er the hills erm, the Akuapem hills and there was a healer there who'd been working with a plant research team in Mampong. And he was already old at the time, but he told me about his training and, as a young man, and his model of psychotherapy which was really quite nice.

I: **What, do you remember any of what he described about his psychotherapy?**

R: Yes, he had, erm well first he was, he was well known for treating agitated mentally ill patients. And so when they'd come and his, his, his erm concoction had cola, it had Roufia and it had I forget something else, the cola was to help keep them awake because of the sedative effects of the Roufia and some other things. And erm, and then he'd give it to them but it would take about two weeks to calm them, so in that time they had to be chained because they were so agitated, they would run away.

I: **Yeah.**

R: And one person from the patient's family would come to stay. And erm once they would come they continued to take their medication, the chains were taken off and they became integrated into his family, he had, at the time I think he had two or three wives, so the patient would join one of his wives, and they'd go to, and his children, and they would go to the farm, they'd come home, they'd cook together, you know go for water and then after about a month you know he would begin to talk to the patient every day to see if they wanted, er what it was that bothered them and then he would call the family and, and they would do a family session. Okay this is what's bothering him, we need to do A B C, and then, then he goes through a rehabilitation phase where he finds out what it is they could do when they go back home. So it might be that they get an apprentice scheme or they give him a piece of land or something and then the patient is discharged.

I: **Yes, so really quite sophisticated treatment?**

R: Very much so. Very much so. And so he told me about this interesting case where erm there was a guy, a young boy whose father had died and his uncle had inherited his father's property. Now the traditional belief is that when you do, you have to take that person's responsibilities, but he'd inherited his brother's wealth and was not looking after the widow or the children and so forth and suddenly he began to hallucinate, to hear voices, thought he saw ghosts, so they brought him to the priest, they brought the uncle to the priest. And, so when he heard, after he heard all of that, he called the family in, "I think he has something to say to you" *(laughter)* so the guy confessed that he hadn't been looking after his nephews and nieces and the widow, he was going to change his ways and you know, then that kind of settled and healed and then -

I: **- without the medication this time or...?**

R: No no with the medication, with a concoction.

I: **It's fascinating...**

R: Yeah, so there, you see so there's, there's, it's just a ... it's just not one belief. It's, I mean the man had a sense of guilt, that he's not doing what he's supposed to be doing, he's probably hearing whispers within the community, "Look at him he has taken everything."

I: **Yeah.**

R: You know. Absolutely. Absolutely.

I: **And to work with this client?**

R: You would have to gain his trust... he would need to believe that your way could work. You could not just reject what he was saying... but it would not be so easy. You would need to understand his situation and the importance of what was going on in his family... systemic work... but the healers already have the people's confidence. That is our challenge. Many do not even know what we do...

I: **The more I learn, the similarities are more apparent, aren't they?**

R: Mmm hmmm. Mmmm hmm. I think that's where the comfort is. You see, but if we could only be able to, so if we had a way of knowing who are the good ... The good, er, traditional healers...

I: **It's very ... so I'm very grateful of your time.**

R: You're welcome. There were some hard questions there!

I: **I will see you on Thursday, wont I?**

R: Yes you will. Is it 10 o' clock already?

I: **Yes it is. Thank you for your time Dr X.**

B.16.11. Interview 2 - transcription

I: **Right, I know we've known each other for a few weeks now, but for the purpose of the tape, can you just explain your job title please?**

R: Well I am a doctor, um, my job title is ... I'm a psychiatrist. I, XXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

I: **Do you have a specific research interest?**

R: Currently, um ... I entered the fellowship programme with the, um, interest in XXXXX. Unfortunately I may have to stick with what the college can offer now because their initial arrangement was that we could plunge straight into our sub-specialities of interest -

I: **OK.**

R: - but due to reasons of lack of expertise because our trainers, um, are basically adult ... general adult psychiatrists, um, maybe with specific skewed interest, but they haven't specialised there, so because of that the ... we are all compelled now ... we are two of us in the programme, we are all compelled to do general adult psychiatry, but of course our research can still be in our skewed interest areas, um, and which I'm ... I'm preparing to do and present my topic. I haven't arrived at one yet, but soon before the ... before the next month is over I should have a proposal to the college. The other thing I heard off record (laughs) is that there is, um, a UK based trust, um, that is running ... I think the XXXXX Trust or something – I'm not too sure. Um, they're running a programme with the XXXXXXX in XXXXX region on, um, medical assistant programme for psychiatry and community mental health psychiatric programme, um, like a one-year programme to train other staff to deal with mental health cases in the districts -

I: **OK**

R: - and I understand that Trust which is supporting this programme in XXXXXXX um, is in talks with the XXXXXXXXX to do something about XXXXXXX psychiatry, so I may be a beneficiary of that if it does happen -

I: **Exciting.**

R: - yeah, because one of the lead people with this programme they had a meeting here and when I brought up the issue about forensics they said, XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX well that's off the records, but officially -

I: **Very exciting -**

R: - what ... yes, quite exciting -

I: **- oh OK, I understand.**

R: - yeah, but the official position is that we do not have that kind of expertise.

I: **Yeah.**

R: Um, it was originally, um, told, um, us that they would partner other schools outside the country for a period of training for say up to a year or six months at least and you would graduate from there and they would, um, look at your work and also, you know, ratify it for the college so that you would finish up as a sub-specialist -

I: **Yeah, OK.**

R: - but that hasn't materialised yet, so for now ...

I: **But you're keeping your ear to the ground.**

R: Exactly. Exactly. Because we do not have a proper XXXXXXX psychiatric practice in Ghana -

I: **Mmm.**

R: - in fact we do not have that kind of perspective so far.

I: **Mmm.**

R: Um, even though in the last year I heard, um, one psychiatrist who returned ... who has returned from abroad – I think in the UK or US, one of them – um, who says he's a XXXXXXX psychiatrist, um, he's doing something on his own, but we do not have a recognised system of XXXXXX psychiatry in this country -

I: **OK.**

R: - to support our XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX. We do not have ... general psychiatrists see everyone... we have a lot of work...

I: **Do people come to you on a Court order -**

R: Yes, so as general psychiatrists we do deal with that, um, but we deal with it as an added responsibility, um, criminal offenders to be brought here for assessment, examination and if possible treatment, um, which we do and then write back to the Courts whether the person is fit to stand trial or not to stand, so basically that's what we do, but we are not involved with the Court system so on and so forth. You may be called to witness -

I: **But if you find someone isn't fit to go to trial, will they be legally obliged to stay with you without the Mental Health Bill ...**

R: Um, we ... we ... we ... we are still operating under the old law which was passed in the '70s, um, which ... the decision is on the doctor whether to send back this patient if he is found to be ill and, um, send back to the Courts or to keep ... most of the time which is the norm we do keep them and treat them and ...

I: Under a locked ...?

R: Yes, yes, there's a ward that is meant for cases from the Courts because, um, we don't want them to run away -

I: Yeah.

R: - we don't also want, um, to be entangled with, um, Court contempt, so, um, we don't have enough security though, but it's a locked ward.

I: OK. You have read the little bit introducing the nature of my study -

R: Yeah.

I: Could you please explain to me the different types of healers in Ghana?

R: Yeah. Before medicine, even before Christianity, we had an African way of helping people. People that use herbs, or spiritual healing, they consult with the gods, the deities, and they tell the person what they must do. The traditional healers, we used to call them fetish priests. The people that believe in the old way. Now we also have herbalists. They use plants and herbs and mixtures and tonics to treat people. We also have the churches, they will use prayer to treat people. They will ask God to remove a person's suffering. Sometimes the person must confess their sins. There are lots of different forms of healers, they mostly use a mixture of things....

I: - Can you think of a case that has attributed their difficulties to traditional explanations?

R: I would say it's mostly the norm rather than the exception - that, um, patients will attribute the cause of their mental illness to spirituality or spiritual reasons -

I: Mm-hm.

R: - and you'll be sure that the majority of the patients you'll be seeing do not choose you as a doctor as a first option. You are, um, actually the last trial and if I don't like an option, but they are just trying to see if it will work because they've been elsewhere and I mean elsewhere it's a ... a Christian-based place they have, um, camps, faith-based healers, they have camps, we call them prayer camps where these patients are sent and then they'll go also so ... ordeal and rituals to as it were exorcise them of the, um, of the bad spirits or to break bonds of or chains of, um ... to deliver them from their bondage as I may say it from sin or from other, um, offences they might have caused that is bringing a curse upon them. Alright? So patients are made to fast, um, they make concoctions that they smear on their bodies or they drink them in potions on a daily basis. They are made to either, um, shave their heads, smear all sorts of

things on their body, um, they actually bring them ... in fact not may, but most of them done a lot of harm to patients.

I: **OK.**

R: Yeah. So you have people give an explanation as to why they're ill. The other thing is that people have a poorer understanding of mental symptomatology ... mental illness symptomatology and because ... because of that they always think ... attribute their symptoms to, um, a spiritual reason. The other thing is that the disease model for mental illness is not fully understood. Even amongst medical practitioners it's not understood. The Ghanaians' understanding of illness is the physical illness model -

I: **Mm-hm.**

R: - but to see someone who is bodily able to walk, to do stuff for themselves and to say the person is ill really doesn't make sense. Now to say that I hear voices that others don't hear. I see visions that others don't see then it ... it must be spiritual because most of the spiritual, um, healers do get their inspiration from a supreme being and the only mode of communication is either in visions or in hearing comments from the unseen God. Therefore if you are exhibiting symptoms like that then it has to be spiritual... so they are not even thinking that it will work in the first place, that this medication I'm going to swallow or this injection I'm going to take is going to treat my spiritual illness - so they would refuse medication -

I: **- yeah.**

R: - partly because they do not agree with your diagnosis and with your explanation of why they are experiencing those symptoms.

I: **Yeah.**

R: And not necessarily because it's a delusion.

I: **So what happens if a person that you believe is a risk to themselves or others wants to seek treatment somewhere else? A prayer camp or...?**

R: We, um, we would rely on the, um, consent of the relations to treat. If the... because in the first place, um ... because of our social network system here people are still brought to hospital by their relations - the mother or the parents or other relatives who are directly responsible for the care of this person - decide that, "Well we think we have to send you to hospital." And usually they... they... a lot of the patients are brought here in any case against their will, so we would agree, um, with the consent of the relations, um, as the practice is now and treat. The other thing is that a lot of them ... a lot of the patients if you explain, um, and give them some bit of insight into... or some say... I will call it a mini insight therapy they may go along with you. We have had people who says, "Well doctor I don't believe this illness is not spiritual, because I believe it is spiritual. I don't even think that you can help me and I don't even believe that the medicine is going to work, but because you are the doctor and you say

I should take something I will try it or I will take it." They ... we have had instances like that. They don't ... they believe strongly that it is spiritual. They believe that their place is not at hospital, but if the doctor says so I will comply with you. Alright? There are those who ... a lot of them after giving them analogies of how these symptoms are experienced by others -

I: **Mm-hm.**

R: - and giving them examples of others who have benefited from your therapy, um, one thing that traditional healers use which I think is very important for orthodox doctors to also employ is the testimonial system, right? Giving testimony of how someone ... or giving examples of people coming forward to say, "Look, I went to this healer and he healed me." So we also try to give ... for example in our usual clinic we would have a mixture of people who are stable and come in for a drug refill and those who are acutely ill. Now if you can, um, relate to the patient, "Look, this person you see sitting out there you came to meet in the queue, um, was maybe worse off than you or had the same kind of ... or similar symptoms, but today look at him or her, he's fine, because he applied himself or herself to our medications." Then you get the person, "OK, let me try it and see."

Because our people are also very used to trying what has worked for somebody, so you'd have, um, um ... one of the reasons for people not even coming to the hospital and trying to self-medicate is that they ... a relative/a friend who got helped by a particular medication would say, "Well when I had similar symptoms I went ... they gave me this medicine" and then they will have a sample to show you, so they go to the pharmacy and in a country where, um, regulation of sale of medication is not as stringent... they can easily get it from ... from over the counter. Some of them do, but particularly in psychiatry you can get our drugs freely from the general pharmacist, so what they do is that, "Alright, when I had similar symptoms I went to this hospital and they ... and I got help, so why don't you try that?" So almost invariably they try the hospital as a last resort. But there are few of our patients who are enlightened already and they come as a first option.

I: **Do you believe that the traditional healers have a role to play? Do aspects of their treatments work?**

R: Yes. There is a place for it as part of traditional healing. I think they implore principles of psychotherapy in a way, especially with counselling. In performing rituals and so on they actually end up should I say making the patient feel valuable -

I: **Yeah.**

R: - or valued and they listen to them and then they offer advice, so in mild to moderate depression, some anxiety disorders they are able to effectively treat them and that is why people still keep going there because there is something

they are doing right and the new Mental Health Bill, if passed, would create that kind of partnership between the orthodox practice and the traditional healers and one, I just attended one workshop, um, organised by the Human Rights Advocacy Centre in Ghana, um, to sensitise faith-based healers on what is right to do as far as human rights of patients are concerned because there are some practices of course that are not good or violate the person's human rights, for example flogging. Flogging the patient. Now why are they doing that? They are doing that on the understanding that they are beating out the spirits that has invaded the body, right? The other thing is starvation which they call, um, fasting. They basically starve the patient. Now we try to tell them the man is ... or the woman is sick. How effectively is this person going to fast and pray when they are sick? OK? So, um, these are workshops organised by of course an NGO like that to sensitise faith-based healers on what to do, right? But the effectively ... the, um, the new Mental Health Bill seeks to regulate the practices of these, um, people and as a first step I think the traditional, um, healers have an ... have a body now set up to ... to regulate them and they've undertaken a drive to register. One way is to know who is practising this kind of ... is in this healing ministry if I would call it. Once you know them you know their sites, they can be regulated, so that is the first step in the ... I think they are doing pretty well so far, but the Bill would make things more clear.

I: **If ... if you were able to know which healers were safe, would you refer patients to them?**

R: As a tradition ... as a trained doctor I ... I don't think so. I don't think I'd be comfortable. Um, it would depend on the specific need of the patient and if I think that our psychological support system, is not as good to support this, um, patient and that we have a faith-based healer within the vicinity of the patient and we must also take note that some of these patients have to travel distances to access our service which is located in a ... in a capital city and far away from a lot of them, so if we have a well regulated centre we can prescribe specific therapy for them to follow, for example counselling and so on, but not other aspects of the patient's management. Currently the community psychiatric medicine system is gaining roots and lots of them are being trained in simple psychotherapeutic principles and I think that over time they will be able to do it better than our faith-based, um, healers. The most important thing is to integrate them to the mainstream health delivery system ... mental health delivery system -

I: **Integrate the traditional ...**

R: - exactly. So that we can regulate them because there are those who still go there. Now the danger is also that under the current practice a lot of the traditional healers are employing orthodox medication alongside all that they do without any knowledge of how to use these drugs just based on the fact that this person had this ailment, went to the psychiatric hospital and was prescribed this medicine, so another person comes and they ... they go out there and try and ... I don't know how they manage to get the drugs, of course they can get it from ... unapproved sources and then they administer it to ... to the patients, right?

I: Yeah.

R: So if you are able to integrate you will be able to regulate these negative practices. I think the aim of integration, one is to safeguard the human rights of the patient and to make sure that they ... they ... they are doing what they are expected to do.

I: Mmm. Mm-hm. Do ... do any traditional healers refer clients to you?

R: Um, currently there are a few that do. Um, they then have agents (laughs) -

I: They have agents?

R: - yeah, they have, um, well patients ... patients who went through them and then finally ended up with us who have gone back to them in their recovered state to help treat people because they still believe ... that's the ... the interesting part. They still believe that even though I am well ... the African always believes that there is always a spiritual side to everything. Even if I cough or I have a cough as a disease symptom and I'm treated ... I'm being treated by the doctor, I must seek the spiritual aspect too, so one, they believe that you've been treated well by the hospital. There is also the spiritual side that they must tackle, so you have these stable patients returning to offer help and they are the ones who serve as a link between the healing camps and the hospital. There are a few like that, so they refer ... they do refer or they do use these agents – let me call them – to select the patients that they want to come to the psychiatric hospital. A lot of them also come in very deplorable states, um, very dehydrated, almost stuporous or going into coma or something, um, emaciated, in very bad medical state, so when then come ... you have the, um, kidneys shutting down, in grave situation and a few times you lose them.

I: It sounds like there's a sort of parallel belief system? Do you think that will change?

R: Yeah, yeah, um, if the current trend continues ... because, um, engrained in our belief system is the spiritual aspect, um, which tends to control more. Um, we had unfortunate situations where even doctors tell patients, "This is spiritual. Go and seek spiritual help." Um ...

I: Is that a rare story to hear? An unusual story?

R: Yes, unusual story. We've had ... not most doctors, but one or two doctors would ... would still argue that there is ... because of their belief and their spirituality, um, so with ... and especially if it is coming from a doctor then it even authenticates the belief, so I don't see it changing rapidly in the future -

I: Yeah.

R: - but what I think would happen eventually is that if the mental health system is proactive, um, with this new Bill and trained people ... eventually people will start seeing the benefits of orthodox treatment and it's going to start diluting the ... or challenging the question of spiritual ... spirituality in disease position over time, but I don't expect it in the next ten years to change. Maybe in the next century, probably.

I: Do you think that an African doctor uses spirituality in this room more than maybe a Western trained?

R: I don't think so. I don't think so. In the consulting room – no.

I: Mmm.

R: I haven't heard of, um, experienced one myself, but one specific doctor that I encountered who is a physician, um, specialist... who believes that, um, spirituality matters in disease and healing, he doesn't implore that in the consulting room, but he would engage you outside of the consulting room or ask you to seek spiritual intervention. He would actually make that recommendation to you, but not ... he will not let that influence his, um, treatment. He will give you what he thinks is medically proven, but he will not as part of therapy engage in spiritual rituals within the consulting room or on the ward – no.

I: Yeah.

R: Um, there is one specific example too I didn't, um, meet him personally or I had not experienced him personally, but listening to other colleagues he used to recommend spirituality and actually would engage a patient outside of the hospital, um, he had a small prayer group or something like that -

I: A doctor?

R: - yes, and then, um, would recommend you to join, but of course he would put you on treatment, yeah.

I: Yeah, so you would have anti-psychotics and ...

R: And spiritual, but like I said they always believe that, OK, there is always something more, um, more to it than we can see, so we deal with what we can see and ... and understand physically and then also deal with it spiritually, so it goes hand-in-hand.

I: Please tell me if I'm too intrusive, but do you believe there is a spiritual component to everything?

R: My person? No. Personally, no. If I do not understand it's because probably we haven't discovered yet. Right. As a Christian I believe there is God and so I worship

him in the way I believe, um, but as far as disease position and symptomatology is concerned I do not believe that, um, there is a spiritual component, at least until now I don't (laugh). I don't believe so.

I: **The ... the cases you mentioned where the doctor would maybe recommend a trip to a prayer camp or ... do you think that's because the doctor believed or because he was working within the beliefs of some of the patients?**

R: I ... I personally would work within the belief system of the patient, alright? Um, because that helps, but I can't speak for others, but for those that believe that there is always a spiritual ... actually work within their own belief system. I think a doctor that recommends traditional treatment has forgotten his job....

I: **How ... how can you do that? Learning how to work within that belief system -**

R: Yeah, OK. Yeah, I think that's quite interesting. The ... you need not to challenge his or her belief system. What you need for the patient is to provide your patient and their relatives, um, I'm sure the African community comes with a significant other – one or two of them or three (laughs) of them – you need to appreciate which angle they are coming from. Um, some of them may prefer the Christian belief and mind you our understanding of Christianity is quite, um, culturally influenced. Um, a lot of Africans transpose our cultural belief system into Christianity and it might be different from the way you in Britain ... you're an English lady in London would understand the influence of Christianity or Christian faith on yourself and your countrymen, so you'd have to understand their perspective, where they're coming from and like I do I want to understand your perspective and integrate my therapy to rhyme or to resonate with your perspective, right?

There are a few, um, black spots ... let me call it, um, where you might not fully understand them. I try to avoid those areas and tell you honestly I ... "I don't have an opinion on it, but for the purposes of our therapy or for the purposes of our interaction I want to concentrate on these areas that we all agree and want to use." When you do that you ... you are better able to get their confidence and your therapy goes well. Yeah.

I: **Can you think - I know it's putting you on the spot – but can you think of an example of a client who believed one and you believed another, but the treatment was successful?**

R: Um, well I ... like I said I do not believe that psychiatric symptomatology are caused by spirits, um, but I ... I ask my clients "what do they think is responsible" for their ... and then they talk about witchcraft and so on. Now they ask me whether I believe in witchcraft. It's always a difficult point to say, "Well I don't believe in witchcraft", in which case a patient will not have trust in me or I will say, "Well I'm a Christian, the Bible talks about witchcraft, yes, but, um, they may be existent, but what I know is

that whether there is witchcraft or not, people like you have presented with these symptoms to me severally and the so-called spirits have left them. They responded to my treatment."

Then I also go onto the issue about, "You are a doctor so you do not ... you are not an anointed of God, it's the pastor who is the anointed of God" and I go like, "Do you think I'm anointed by the devil?" And he'll say, "No." Alright. I said, "I'm a Christian and I believe God put me here as an anointed to aid in the healing ministry just like the pastor does, so if you believe in that why can't we go along?" Eventually they identify. Always I try to get them and myself on the same path. If you do that they believe everything that you are going to do for them.

I: **Sharing a faith ... do you think that's a significant part of the work?**

R: Yeah, it is. It makes things easier. The patients trust me more when they see I am a Christian. The other thing is, um, you might not necessarily have the same belief system with a patient. For example you can have a Muslim patient. Now there is something unique to both the Christian and the Muslim and ... or any other, um, faith system, especially the traditional, um, belief ... the traditional, um, the um, faith ... something ... I'll get the terminology right later on maybe. Traditional religion.

I: **Yeah.**

R: Right. Traditional religion. Is that there is a commonality at the top. Even though our approaches might be different we all worship in the same God, so when you have for example a Muslim patient who believes in Allah and believes in Mohammad and, um, what the teachings are in the Koran you try to break common grounds between the Bible and the Koran and the fact that even though you worship in Allah and we are saying we worship in God, Allah and God are the same and the principles governing your worship and my worship are actually the same if we go back to fundamentals, so when you are able to bridge that gap one of ...

I: **But you have that conversation with clients?**

R: Oh yes, we do and I do personally, and one of the things you do is to eliminate tension. Once you eliminate tension and they know that you are not one, prejudiced against them and you are not going to contempt them because of their different belief or faith system they're going to trust you as friendly, they're going to trust you as tolerance, they're going to trust you as a certain diverse opinion. So the more times I ask them to explain what happens in their faith and then I use it the way it resonates with mine, so that we are on the common ... so I don't necessarily need to believe in what you are saying, but it has to ... it has ...

I: **But you would be transparent.**

R: Exactly, very transparent. It has to also be something that is governed by the principle of orthodox practice, so I am carefully ... um, I'm careful about what areas I get

selected and to ... which part that I talk and there are a lot you would get in common, um, um, if you are a clinical psychologist and you want to use then in line with principles of psychotherapy – the various forms – there are a lot ... if you allow the patient to talk a lot more about what he believes in and what influences their thinking and their lives, you get a lot of common based ... um, common points that actually resonate with the principles of psychotherapy.

I: **Do you think we should facilitate traditional healing for our African patients who believe in that approach, or we should be focusing on educating people about Western models?**

R: I ... I'm at ... I ... I understand the point you're coming from, but I think that one of the things having interacted with, um, Black Africans who've moved back ... back and forth is their belief that the Caucasians don't understand African issues.

I: **Mm-hm.**

R: But if we are able to bridge that gap and acknowledge openly, "Look, I'm Caucasian, yes. I come from a different cultural background, but I believe I have under ... I have studied and understood your culture quite well. I've interacted with a number of Africans and been there myself and I think that I can appreciate where you're coming from. I may not necessarily agree with you because of my background, but that is your way of life and I'll respect it." I think they wouldn't ... they would be more receptive to you, but where you make a strict distinction between their traditional belief and our Western way of doing things, then you build a mistrust and a tension. You're going to get a kind of cooperation. They may just politely – like the Africans always do – they are slow to offend, so they would politely not be rude (laugh), let me put it that way, but behind their mind and, you know, in the back of their mind they are not listening to you, but once they get the impression of this person doesn't know much about me or ... but is willing to learn and to accept my way of thinking and doing things, I'm also prepared to work with that person and not separate this is a Western way of doing it or Western model and your traditional model. I think that by and large there are commonalities.

I: **Which raises a more ... or a bigger question... do African philosophies have something to offer psychological treatment models?**

R: Yeah, yeah. The ... the African philosophy, um, emphasises on empathy, emphasises on the perception that I'm one of you.

I: **Mmm...**

R: Yes, connectedness, yes, put it that way. So ... and they like the personal touch. Um, I understand in some Western cultures this is not ... it's quite offensive to find out, um, how many children do you have, are you married, um, where do you live, um, these are private issues, but an African doesn't see it that way. They see it as you

caring ... you care. If I walked in this morning and you came in here and said, "Oh XXX, good morning, how is your wife and kids? -

I: **Yes.**

R: - Ah. How is home? How did you sleep? Did you have a sound sleep?"

I: **Yeah.**

R: In ... as far as I'm concerned you are not prying privately – I'm talking as an African now – even though (laughs) -

I: **Yeah.**

R: - personally I wouldn't want you to ask that.

I: **Yeah.**

R: (Laughs). But as an African I wouldn't be offended. I would see that, "Oh Rebecca is a very caring person. She would ...", and one of the things that people around will say, "Oh when she greets you she really asks about everything about you, she wants to know that you are OK, she is very interactive." Um, um, um, compliments like, "Oh I like your shirt. Your dress is so nice. You're looking so beautiful. You're pretty today." So all these are compliments that the African sees as caring.

I: **Yeah.**

R: Alright? Which may not exist in the Western culture and it's part of therapy. It is important to gain their trust...

I: **True.**

R: Yeah, so a lot of times I hope that you will have the chance to sit in more sessions of mine that sometimes our history taking does not begin from, "What are your complaints?"

I: **Yeah.**

R: It actually begins with, "Are you married? Do you have kids? Oh, how is your husband? Does he work?" Alright, we start talking about psychosocial issues and you'd be surprised where the problem lies because a huge chunk of stress which provokes mental illness is from psychosocial factors in our part of the world.

I: **Mmm.**

R: So you would have him in ... in the job places a boss who is interested in what happens in your home, how you cope and cope with work, is seen as the best boss.

I: **Yeah, yeah.**

R: So, um, a lot of the things that you deem as private in the West is actually not private and, um, you ... you ... yesterday you remember I commented on somebody's weight.

I: **Mm-hm.**

R: In the African context you can comment. She was getting fat!

I: **Yes.**

R: - but you also ... because of westernisation bits and pieces of Western ways of doing things is creeping into our culture and getting mixed up, so if I were you in London I would try to find out what is appropriate for this African as opposed to tagging every African as accepting, um, A or B. For example, if you meet me in your office and you think asking about whether I'm married or not ... it's acceptable, maybe you have to revise your notes (laughs) ... maybe.

I: Yeah.

R: Yeah, so that's ... that's the ... depends on the enculturation of the person.

I: Are there benefits that you think should be protected as part of your ... your culture that ... that the Western influence is detrimental to?

R: Yeah, what ... what ... what happened in the ... if I quite understand you, what happened in the old practice was to condemn outrightly, "No, this is not spiritual", rather than working within the context of what schizophrenia would mean in a spiritual ... in a spiritual way to the person. I ... I ... like I said earlier on, I told him, "Well it may be spiritual, I don't have the eyes to see, but what I know is that this way works." And one of the things I usually tell them is that, "Why don't you try. If it doesn't work you pull out, but if it works you stick with it." Eventually you'll have yourself a timeline to work to make sure that this person, um, kind of recovers and he'll come and tell you, "Oh I used to think it was spiritual, but now I think the medicine is working", so it does work.

I: Is that the norm? Do you think if your treatment works they *attribute* it to your treatment?

R: Interesting. Interesting. That's the very interesting part. No.

I: No?

R: They won't attribute it to you?

I: Yeah?

R: They attribute it to the power of God.

I: And if they got ill again?

R: It's, um ... ironically if a friend got ill, had something similar, they would recommend the person come here. They would recommend ... I am sure yesterday you saw one or two patients that came in as a recommendation of somebody that, um, had had a ... had benefited from our services or, um, a recommendation that, "Oh, this place if you go I believe you'll be fine." Um, they might believe otherwise, but they will ... the African tends to, um, believe in results.

See if they came here and they didn't get results, then they wouldn't believe in the system, so the same thing happens with the spiritual healers. Alright? They also suffer the same way, even though most of times they are the first choice if they ... and they keep hopping from one spiritual healer or pastor to the other, alright, because the

African believes in immediate fast results. "I went to this pastor, he laid hands on me or sprinkled some holy water on me and therefore, um, the person got healed." That person will get a lot of recommendation. And the funny thing is that you don't have to be ... you know, even within the Christian sects the quite different doctrinal teachings, right, you don't ... you have a Catholic who goes to a Protestant pastor because it has been recommended that this pastor is ... is ... is, um, favoured by God, is very powerful and when he touches your forehead you will be healed. They will not go to the Catholic priest or to the bishop, they will go there.

I: **But they won't change their religion. They won't convert.**

R: They won't change their religion. On Sunday they will go back to the Catholic Church for prayer.

I: **But they get help wherever they think will work?**

R: Exactly, when they need healing they would say, "Well I don't think my pastor is that powerful to heal, I will go there, I got results." So there's the ... the ... the ... the other part of the psychology or the philosophy of the African that I think you can exploit. Even though they ... they might think that orthodox ways ... I don't believe in that as a spiritual ... if it works they would ... they would come to where it works and then still, um, hang onto their belief.

I: **Mmm. And a tough ... tough question maybe, but if there was a free mental health clinic in every village or every town all across the country, would these traditional healers still be as popular?**

R: I don't think ... I ... I ... I ... I ... I ... I don't think that's going to change the fact. What is going to change significantly or shift the, um, the tables is literacy ... education ... formal education. If we get our literacy up, we get our education system good and well, get a lot more people educated, we're going to shift this whole thing. One other thing I think, um, needs to be understood is that if I am in a family home and I'm the only one who is going to school, going to secondary school or high school to, um, college and I tell my illiterate patients ... illiterate in terms that they are not formally educated. I tell them that, "Well this thing that you've been doing is wrong, let's try it another way." They would more believe in what I'm telling them than what they know. Yes.

I: **They would?**

R: They would. The educated children within the family have a greater influence on the belief systems, that's my experience. I don't know what other speakers will say, but that's what I know.

I: **Yeah, yeah.**

R: So that if we make education more accessible, not only at the primary level, but to the higher level, so that people go through to the end or very high extent, we'll be able to influence, um, belief systems, um, as far as even help-seeking behaviour is concerned

I: Yeah.

R: - in their families and in their communities. That is the only way I think that we can have the influence of orthodox mental health service penetrating, um, into the remotest place.

I: Yeah. You mentioned earlier that you don't even normally give them a diagnosis...

R: Yeah, because, um, the majority of them don't even understand your term that you are using or even your explanation, so, um ... but we try to explain it in the way they culturally understand mental ill health, um, and mind you we do not have comparable words -

I: Yeah.

R: - to explain schizophrenia.

I: Yeah, so with schizophrenia, how would you explain ... what would you say?

R: It's a mental illness to them, whether it's bi-polar or it's mania or a severe depression. For them it's a mental illness and we try to let them know that there are categories of mental illness or various diagnoses. For the enlightened ones, yes, you would ... for those who have gone to school, know what they want, are working and so on, you would let them know, even ... they would even ask you, "What is wrong with me? What diagnosis have you made?" But for the very traditional person schizophrenia makes no sense, so you would want to lump all that in as ... "this is as a recognisable mental illness that is treatable."

I: Do you think that that protects a person in a way? If you don't label them...

R: No, it doesn't. Once you're mentally ill, you're mentally ill, irrespective of your diagnosis. It doesn't really make a difference in the community. Um, if you've suffered a depression and you've been seen, treated or receiving treatment from the psychiatric hospital or you've been brought to the psychiatric hospital, as far as they are concerned in the community you are a mental patient. It's ... it's ... it doesn't matter whether it was anxiety or hypochondriasis or -

I: Or schizophrenia...

R: - or ... yes, schizophrenia. They don't care. All they ... they ... they, um, they know is that you were behaving oddly, um, or had a strange behaviour or your behaviour changed and you were being punished by the psychiatric hospital.

I: Yes.

R: So I don't think it makes any difference.

I: **Yeah, very interesting. I know you're, um ... you're short of time. Is there anything else you wanted to say?**

R: The only advice I would say is that when you are dealing with the African community, you just need to be open minded, um, you need to downplay, um ... am I using the right word? You need not to hold onto your own prejudices, um, prejudices or beliefs, but be open. The other thing is that because they also ... they also come in with a certain prejudiced mind and you need to create the impression that you are open. You may not be that open, but you need to create that perception.

I: **Mmm. Mm-hm.**

R: The other thing is that, um, you need not to hold back on what you think is rude or not rude. You need to understand it from their perspective before you can label it as rude or not rude. Um, the other thing is that in order not for you to lose your autonomy you also need to, at some point in time, let them be sensitive towards you. When you are sensitive to them they will also turn around to be sensitive to your -

I: **What do you mean by that? Sensitive to ... do you mean conversationally?**

R: - yeah, for example in conversation, because they may say certain things that in the African context we say without a blink or we don't think that it offends the next person or it doesn't offend the next person, but you may take it in a different way, alright? So whilst you create an open and ... and perception that you are willing to learn and to apply what you have learned in your therapy, you will find them also being very sensitive towards you.

I: **Is that sort of information sharing you talked about, saying -**

R: Yes. Yes. Yes.

I: **- "Yes, my drive in was fine." The information that -**

R: Yeah.

I: **Thank you very much for your time.**

R: You're welcome.

I: **It was very interesting for me.**

R: I've enjoyed talking to you.

B.16.12. Interview 3- transcription

I: Okay thank you. Okay so for the purpose of the tape, pretending I know nothing about your organisation. Could you just explain a little bit more about the project in Ghana that you run?

R: Yes. It is NGO, a non-government department organisation which is focusing on mental health and development. Actually such an NGO is trying to bring issues of mental health into mainstream development and has been the case. Erm compared to issues like gender, HIV, aids, children, child labour and the rest. And the basic reason for that is in all development processes, people with mental illness seem to be the most neglected. We have talked about issues of disability, women's empowerment and the rest, but there has always been this neglect, intentional or unintentional, of people who have mental illness. And who would on their own, not be included because of obvious reasons, because of the illness they suffer and because of the misconceptions and the ignorance associated with mental illness. To the extent that they would happily be talked about when it comes to how best improve the quality of life for human beings. And this can only happen if we consciously and actively include these people who are probably the most neglected and the most marginalised in our communities. So that we can hear from them and positively address their concerns. Because if you are looking at the whole scale of opportunity, they are probably the least that will have and grab opportunities. So somebody needs to look at actively look out at ways of addressing these. And this can even be best done if they are the ones who are at the centre of all we do. So XXXXX whole premise is that mental illness is not something that leads to the discrimination of human beings, who like their own way of life and being human beings equally need some level of dignity in their lives, need to realise their own potential and the rest. So the founder of XXXXX thought about this good for his XXXX, basic rights. And the whole thing is we want to work to see to it that people who have mental illness satisfy their basic needs and exercise their basic rights. It may look like a simple statement, but it is a lot of work that is looking at issues of treatment, issues of a erm a means to a secure livelihood, issues of people being able to determine what is good for them in any development activity and so being able to influence public opinion and public policy and decision-making, that can address the needs of people with mental illness. So that in brief is what XXXX stands for. Now in Ghana you will realise that right from the 2000s, the WHO dedicated one of its health reports to mental health and that revealed a lot of erm information and evidence about the situation of people with mental illness.

I: Umm.

R: That was preceded. Yes. And that was preceded by various epidemiological studies that went down about the conditions, treatments available and the rest and they found out there was a huge treatment gap. And it was even more serious in the developing countries. Low and middle income countries, where issues of human resources for treating mental conditions or generally interventions for mental health were really inadequate. There was poor knowledge or inadequate knowledge which is seen in the erm statement associated with erm conditions of mental illness you know. And the whole lot of where people could go for treatment because of erm such stigma, people would usually use a traditional healer as their first port of call you know. Erm because they would define it either being spiritual or sort of a spell or a curse or whatever. They do not see it more in the erm organic sense of it and probably accept there is some medication that can remedy the situation and enable them peaceful lives. So XXXXXX came in to promote and facilitate this idea of encouraging more treatment support, more involvement of people and families that have people with mental illness. In development processes that can address their needs because there is a whole lot of public poverty alleviation, erm programmes mental and in poor families and communities improve basic education, but there is still nothing involving people with mental illness. So coming to actively promote the need to include and the need to ensure that all projects and programmes of government tend to address this neglected group of people, who for a long time have not been factored into, into those things. So our approach when we came was to look at the issues of treatment, which was woefully inadequate, that a light proportion of people who really need treatment, don't have it. And to make that effective without being... to promote the idea of community based care that is integrated into primary care. Because there is just three psychiatric hospitals in Ghana all situated along the costal belt of Ghana. With the rest of the interland left on its own. And there were very few people who would have the opportunity or the means to come down to get assessment. So we started with what we can give you, come in psychiatric nurses that are there. And luckily government around that time or for a long time has embraced this idea of primary health care and also embraced the idea, the policy of promoting community-based mental health services where they train community psychiatric nurses to offer care in the various district and regional hospitals. So building on, on that policy, that was actually not carried out successfully. To promote erm availability of treatment to encourage families to come forward and do that mainly to get well, and help them to get back to life. And being able to contribute to their families and their own wellbeing. So that is the whole thing that has got XXXXXXX this far and for the last erm close to a decade now, with just one year to ten years since XXXXX was in Ghana. Erm to working with local organisations and the Ghana Health Service with funding from various

resources like Comic Relief and the British government, DFID, European Union have implemented programmes ranging from treatment services, group formation, encouraging erm policy, erm formation that addresses issues of mental illness. Particularly the Mental Health Bill encouraging district assemblies to plan for mental health issues, erm retraining of community psychiatric nurses, encouraging community involvement and a lot of community education to increase awareness. Yes.

I: **You mentioned that a lot of the people especially ones that that are out of Accra, their first port of call or their only treatment option are the traditional healers... could you please explain what you mean by traditional healers?**

R: Well from what I have come to learn, a traditional healer is probably one of (...) these three people, somebody who is well versed in using herbs to treat maladies or to treat ailments... And somebody who has some psychological and spiritual erm know how or he can have powers to (...) to help (...) address certain anxieties and, and frustrations somebody may have, that can have any effect on him. And finally and more recently, people who use erm their Christian religion, the Pentecostal Holy Spirit powers to heal people again afflicted psychologically or otherwise to address their, their concerns of lack of material erm needs or marital and family erm, erm arrangements or successes and the rest, you know. Or even academic achievements and so on, or generally success by being prayed for by this person who is a powerful Christian spiritualist, you know. Then you also have similar erm Sikh people from within the Muslim sect who are either well versed with the Koran, and, and are believed to have some powers by their, their knowledge of the Koranic verses they can incant to exercise people and, and, or whatever ailment they are afflicted with... So that is what I know a traditional healer to be. Erm, recently or I would say for quite some time from what I know, you would tend to see that even herbalists also combine some amount of the spiritual way. They may get the right herbs but they might pray over the herbs or they have go to through some rituals to turn those herbs into certain powerful potions that can address the ailment or a case or can prevent it even occurring to you. So those are traditional healers and, and they are the most common health practitioners you would find in any typical community. And probably that is understandable because that is what this society erm has been associated with until Western medicine came in.

I: **What do you think works about the traditional healing?**

R: I don't know... what works about traditional healing is the fact that traditional healing is grounded in the social cultural context or setting of the people. That it almost... it is almost synonymous with a way of life or most part of the population in which they are found. So erm they are able to understand the nuances around everyday living, around understanding of illness or ill health or being well or not being well. And are able to address their issues including the spirituality of the people yes.

I: **So do you think that the traditional healers offer a service which is important to somehow incorporate into government policies of health care?**

R: My view around that is that erm yes. I think there is an opportunity to incorporate traditional healing into well call it, mainstream care now because it is like the most accepted model of care is the Western-based care, which as you have likely have seen to be exclusive of erm existing ways of treatment before introduction of these. I might add that seems quite recent, it dates back to several years back and not being able to marry with what existed before. And I think there are opportunities for that. And I said so because if you look at the traditional healing practice as I said, it is grounded in or to a light extent, the way of life of the people, what they believe in and how they see the cause and effects of ailment or what has caused the causality of the conditions and the rest. And so traditional healing sometimes is able to erm look at those aspects that influence the way somebody describes his or her illness. Especially if it is not related to erm virus or bacteria cause, bacteria causing conditions. Which you say it is because of this bacteria you have the malaria, or it is because of this virus you have contracted HIV Aids. Most of them also have light, to a light extent a psychological aspect of it and somehow traditional healers are able to look at or identify those things and deal with the, the population in which they are. And, and so even if somebody has malaria, he wants to think beyond how could I have had, how could I have had malaria? This could not be normal, something must have caused it. And I want to find out what is the cause of it. Because of certain beliefs they have, you know. There are certain areas they say, well I have been made ill because they think that I was working too hard and I may get a promotion so they made sure I look ill. It is not looking like either lack of rest or whatever that has brought it about or exposure to mosquito bite and the rest. But he is looking at it he made a friend in a different context. So because of tradition healers' understanding of, to a light extent their belief systems way of life of people, they are able to prove immediate erm interventions. And as I said, with emphasis on those psychological aspects of illnesses that may be it is not just the cause of the malaria erm whatever, plasmodium virus, costing them and all that. So that is where I probably think they remain relevant. But of course society is not static, as people progress they get to have new knowledge, people are moving into Christianity into whatever, some belief systems... But to a light extent, you still find people who are highly educated still having certain perceptions and beliefs that they wouldn't mind going back to a traditional healer for the remedy. So that is why they would continue to be around and should be used as much as they remain effective, yes.

I: **Okay so you mentioned your own research interest in this area. And your job involves visiting many healing sites. For me there is a sense of mystery as to what happens when you visit a traditional healer...**

R: *(Coughs)* Sometimes I think the best word for what they do is counselling... The least harmful aspect of what they do... Erm I don't know whether traditional healers understand it as counselling. But they would say that it is their treatment they are giving you. You know I tend to define what their practices are in the context of Western practices. As we may see them as providing erm counselling services and that is where it seems best. For the others erm they also work to an extent, because some of them are able to or they're, I don't have the scientific proof, but there are some scientists or health professionals that say, oh yes some of them are able to find some herbs that really have some chemical components that treat some of these. So yes to some extent, those herbs may work. But they cannot talk in terms of erm the prescriptions what doses you should take, the chemical combination, it is not put into packs of tablets where you, to take over a number of days. They can say drink this number of cups of a herbal potion or preparation over this number of days. And that is very difficult for Western traditional healers to quantify you know. But yes, where they are seen most to be effective is the fact that they are able, I don't know whether to say it, read into the person, know what your psychological needs are. And again because some of them are based in their communities, they are also should I say, representatives of history of almost most of the families. To the extent that they can be able to say in your family you have your condition, that is a traditional healer. And it has come now. So if in later life somebody from that family has a condition, they can trace it to say of course. Even though they may, I would say the client may not know, they are able to know that quite a long time ago, this condition existed in this family. And they are able to see how they can guide you and whatever it is they do, because they are living in the communities, they know the people, they know what family does. They also see who engaging in what kind of lifestyle, and when they begin to say I see this, I see this is happening to you. Then you begin to say how does this man know? And it is true all these things they are said, are true. They have, they are all also very, very observant. You can see that they have intelligence, that they get the information about everybody because they know at some point you may come and they will reveal things to you, you probably thought nobody knew you know.

I: **Yes.**

R: And that already settles you. He is able to tell you I have certain powers over you because I know all these things about, about you and so if you know, decides to talk and make some prescriptions that he knows will help you -

I: **You already have confidence.**

R: Exactly! You already have confidence and that allays whatever anxiety or fears surround you. And you can go through whatever he is talking to you. So he may just to make dramatise it add some preparation that may have no effect, say in relation to this, take this. And go and take it and after three days come back and let's see how it is you know. So that is where they are most effective at. Where there is a problem is in situations they decide to overdramatise this, to add some draconian practices like physical abuse and, and all that, they say "Well, I think there are spirits in you and because of that you who are sitting in front of me now, you are not really human, but you are spirit and best I can do is to beat the spirit out of you." Inflicting physical pain... is really some of those practices that are negative. For the fact that it is very difficult to appreciate because it is shrouded in, should I say, secrecy and the rest. I think that is what is going to let them thrive with their practices. And I tend to go into that is what they guard against very, very much. So there are issues about it being difficult to see the practices. It is probably because of how they can protect their practice. And it seems to be across the board... all professionals have certain secrets that they will never, just watch a computer erm scientist who comes to work on your laptop or whatever. He will never let you see what he is doing. Or if he sees a problem, he will do something to distract your attention and fix it so that you can always get back to call him. So erm, then it is a level to with we can push them to reveal. (*laughing*)

I: **I understand what you are saying, but I think you made a really important point that the client needs to have confidence in the treatment that's offered...**

R: Yes.

I: **And this element of mystery -**

R: Effect. Absolutely, absolutely. Absolutely. And that is on what they thrive.

I: **Mmm.**

R: If it works, so be it, you should go for it (*laughing*) so long as it is not erm, erm I don't know. So long as it is not erm beyond abuse, I don't see anything wrong with that. And that is why in our work with XXXXX, I mean traditionally our work in XXXXXX with traditional healers, one thing we have always said is, we are not coming to question how you are able to treat this person. We are coming to let you understand that there are certain things in your dealings with a client which you shouldn't do because they infringe on the right of the person. And these as much as possible, you should avoid. And also to let you know there are other remedies. Should your line of remedies fail, this is also there for you, and it is even good if you make an early, early referral. So that the person can get that other remedy whilst you administer whatever you have to part so that at least it helps in a faster stabilisation and recovery

of a patient. So yes, we will like you to let the person bath in the herbal preparations you have made, but it is wrong to let him or her bath in very hot when the person can suffer scolding. You know. It is wrong to use infected sharp edges to put incisions on a person to administer your herbal potions, you should think about a clean blade and the rest. And do remember that Western medicine has also produced certain remedies, medications that are good and if you make a referral, the person will get the needed support early enough, at least to convince the person to accept to refer when he finds that it may be difficult. Or even refer for the combination of treatment. Because the client himself, the country will go to that traditional healer and still go to the hospital. Yes.

I: **I understand that Ghana passed a traditional healing, healers' act a few years ago.**

R: Yes.

I: **Has the act improved things?**

R: Erm, healers get licences now.. I think the, the licence is also another level of confidence that has been provided to traditional healers. And I can give you a story. When XXXXXXXX started engaging with some of these, we printed t-shirts to give them, just to promote the relationship of collaboration. And those people held those t-shirts in high esteem. Because one they were seen to have been recognised by an NGO that has given them more legitimacy. And don't forget that some years back, or in as a result of religion, Christianity and the rest the traditional healers have been more or less demonised. That they are evil, erm they are hidden and they have nothing good to offer. So they have either protested quietly or recoiled erm into the background. So anything that will recognise them is very, very important in boost their confidence, you know. So that is why they would gladly flash out their licences to say "Look I have a licence." Because there are a few instances where traditional healers have been arrested for certain bad practices they have perpetrated on people. And they, they, they are common, I mean they do happen. For example things like erm having, there are instances where people who have gone for healing services with traditional healers especially women, later report that they have been either raped or who have had sexual affairs with people. Or people have been told to go and work, have been used on farms of traditional healers as labour, cheap labour and the rest. They have often come up. Or some remedies to treat people go wrong and the person dies. And traditional healers have been arrested for, for that. So some of them also have had that kind of fear. So if they can sort, if they can get (...) recognition from government by the licences it will help. But again to answer a part of your question does it mean much? I would say it doesn't. Erm they are happy to have a licence they can flash around to anybody that I have got a recognition. When I, in addition to the licences,

they get services from government or they get any other recognition from government, for me, it seems not to be there. Once you get the licences you probably will never get a visit from the Ghana Health Service or Minister of Health or any inspector to say we are coming to see where you operate, your conditions, what kind of training do you need that we can, we can help you enhance your training and the rest. Oh, there is this package available that can enhance your infrastructure and the rest, it is not there. And it is like, it is not like, oh in this hospital you have a unit that you can come in and do your practices. So it remains as that. However I do know that recently there have been attempts to establish the traditional healer council within the Ministry of Health erm to take responsibility of erm alternative medicine, erm medical practices.

I: **And has that happened, the council?**

R: I think it is about ready... I think so, the last time I read in the papers. Plans are far advanced for an establishment of the council.

I: **Do you think traditional healers are regulated?**

R: No. not yet. There is much to do. Some are much better. And one might be very worse! Yes. That is it. And again coming back to our own little work that we have done, that is what we have tried to do. To, not to force but to encourage some level of synchronisation of practice or sharing of best practices. This guy, he's been good at doing this and once he is willing to share the success people should take a cue from that you know.

I: **But the air of mystery is the business....**

R: Is the business. Exactly .

I: **But if you share your secrets -**

R: Then you lose out (*laughs*).

I: **And it is big business.**

R: Yes and you want your clientele, you want to record he is the best healer around.

I: **And the traditional healers I have met argue that because they, their customers or clients come through word of mouth, that their work must be good if their business is successful.**

R: Yes. And again you can look at it positively that because of that you have to perfect your work. You have to make your, your services really good for the immediate patronage you want, you know, so. So if you can advertise, even these people advertise, I don't know whether you are aware of it, they advertise. And some traditional, a few traditional healers have been able to package their medications either in forms of lotions or ointments or erm, preparations you know.

I: **I've seen some of the tonics and herbs...**

R: All those tonics, yes. But when you talk to some of the healers they tell you that that is not healing. If you advertise your healing then it is not the best. You should let clients

talk about you and people will come to you. So some people don't believe in advertising. My work will advertise for itself and the rest. So (...) erm (...) the point about erm there are practices being shrouded in secrecy so they can guard against it and have more business is one thing. But again you are able to, once the more you bring them together and introduce issues about human rights which everyone can accept it is wrong to chain somebody in the sun, it is wrong to let somebody fast unnecessarily because fasting is part of your remedy. You are rather wearing the person who is already ill down, and before you know it can have grave consequences on the person. It is good to keep certain utensils clean for hygienic purposes or for hygiene purposes. Issues of use of... as I mentioned... razors that have the potential of introducing tetanus and the rest, it is making your environment clean and, and giving the dignity of the client. Recognising and giving the dignity of the client to him, or her, it is important and it can help. Those ones of course we are ready to really learn and go back to practice you know. So there are communities where they can really share what should be good to make things work.

I: **And I am interested in your experience of working or meeting traditional healers... they are providing a service which needs to be provided...**

R: By government yes.

I: **How do you gauge the attitudes of these healers?**

R: I think (...) from our work with those healers that we have dealt with, they are very open to, I would say to a large extent ,they are very open to erm being involved in mainstream care and giving the needed recognition to deliver it. If there are any doubts or any reservations, it is as a result of their, what is a proper term to use? Their, I won't say lack of respect but lack of recognition -

I: **Hmm the relation....**

R: And denigration yes. They have been in most public announcement for until recently, denigrated. They have been given all sort of unpalatable describing. Or as I mentioned earlier, they are evil, they are tricksters, they are fraudsters, their medications don't even work, we can't prove it scientifically and the rest. Rather than trying to understand how best to do it. So they have always been on the defensive in the quiet. That if you cannot even give me a minute or some little bit of recognition, how can I even come forward and say I am ready to cooperate and work with you. So it needs to start from a point of giving respect and recognition and I believe they will open up to it. Some of erm the traditional healers who I have worked with said I am ready any time, especially bone setters. I am ready anytime to set up my facility within the clinic, if only they recognise me. And I also know bones setters who go and tell you to go and do an x-ray and come back before they can set, and then they can set your wound for you. There are men who can tell that, doctors and what the bone setters do,

your bone will be set faster than the doctor's way. Even though it may be erm, even sometimes, shall I say informally, people can refer you to bone setters from within the hospital you know. For certain exemplary compound fractures and the rest and so on. So they will be very open but government, being government as it is now, because we are now all being ruled by rules and regulations. You cannot, a chief cannot make certain... government will have to take the active route to do it. And I believe that once they get that recognition and set the rules for them this sort of abuse would go down because it is like you are now signing a contract with government that you provide these services and that they follow in parameters. There will be no chaining, there will be no flogging of the person as part of exorcism. There will be no unnecessary fasting, if you agree and still think that absent these, your remedies will still work, come on let's work together. And I think a lot of them will take that literally. Because it also, it is a source of livelihood. So if, as I said, if they can get the needed recognition to work, I am sure they are willing to make trade-offs.

And again whether you recognise them or not, their clientele is there and probably will be there for a very long time to come. So what is best? If we are talking of bringing about universal care or the best possible care for people, what is best? Erm recognise these people and bring them into the setting where you can, not control, but regulate their practices. I think the latter is better, it is sort of forgetting about them because they will continue to do their own thing with the excesses that are there.

I: **I am really interested because XXXXXXX is coming up to ten years in Ghana; it seems as if there is a model that is working as far as building a relationship between different approaches...**

R: Yes, in erm, I think I have described the remodel of working with traditional healers with, one is to identify them. And one of the things we have done is to say, alright we want to work with people who are treating mental illness.

I: **Umm umm.**

R: Now it will be interesting for you to know that while in some areas we did get people who came out to say, "Yes we work in mental health." The other area who said "But there is no condition I don't treat, I treat all conditions... so when you say mental ill, even I treat mental illness because they also have some" erm (...) you can probably say they also have some form of cognitive behaviour therapy they do (*laughs*). So one thing was to purposely ask for those who treat mental illness, that is one thing. So that you don't then jumble up all sorts of people who say we are healers and the rest. And then begin to develop a rapport between them and the Ghana Health Service, especially the community psychiatry unit.

I: **Mmm.**

R: Build a relationship between the community psychiatry nurse and the group of traditional healers within the setting. And then encouraging periodic experience sharing and, and, and introducing Western remedies of mental illnesses to them. To either agree or disprove to say, no this doesn't work and you should see the bits they have when they are saying things about depression, about psychosis, about drug abuse and the rest and, and what possible remedies are there within the Western medical practice that traditional healers give. And then see to ask the question, how do you think this can fit into your practices. And they tell you their opinion. So there is erm a beginning of (...) a sense of sharing ideas about each other's practices and the rest. And also I mean I should say finally, making it a regular affair for interactions among themselves and among the traditional healers. And introducing issues about human rights and the rest, patient safety and all that, so that we are aware of these and how they can help with them running their practices. We cannot say with all these attitude and practices change overnight. But it is a process to, to build in. So that is our approach. And I did mention that we don't go to question how effective is your remedy and can you prove that when you combine this and that you get that and so that will help in the recovery of stabilisation of that patient. But we will say, okay well if you think that what you are doing works, how can we enhance it to work from the point of view of human rights, from the point of view of other effective remedies that are there and you can could fall on in the event that you have to. Yes.

I: **What about the issue from the Western model? Is there more resistance or less resistance?**

R: I think that there, I am not speaking for traditional healers, but even though there is mutual suspicion from both sides, I think the resistance is from Western medicine. I think so. They feel superior, they feel they are more scientific and they are more rigorous... They feel they are cleaner, erm they feel they have learnt it formally, and, and only them can prove it. Traditional healers cannot do that you know. And so erm, it is also an element as I said, this whole thing is a status, status issue sorry, I wear a white coat, you always in tatted clothes, you can't even read and write. You know so I think some of, but I also know there are some traditional healers who vehemently say that there is nothing Western that works. And they will not go and work with the Western, there are also traditional healers who will vehemently tell you: "Western medicine-forget it! They are criminal, they are hiding under education to rob people and the rest." (*laughing*)

I: **What about the future? You talked about these ideas of spirituality being so, such a fundamental philosophy of a lot of African beliefs.**

R: Yes. Well if I have to look into that crystal ball (*laughing*) –

- and see that (...) what is likely to happen from my understanding and view of things is, what is likely to happen will be, what I will say, the really, real traditional healers, herbalists, are likely to give way to these Christian, Muslim, spiritualists, Pentecostal practitioners who have spiritual answers to every need of a person. The prophets and they over see us, who use the bible, and holy water and incense and even to some extent, their own traditional outlook of things to heal and pray, pray and heal people. And you will see more and more of those who use herbs, who are using tree leaves, who are using animal bones, who are using roots, who are using nature's products to treat giving way. And I say this because increasingly we are shying away from traditional religion, you know. We are shying away from traditional religion but I doubt whether we are moving away with our own socialisation and culture backgrounds, that is yet to be debated. You know. So you will find a balance probably giving way because they may not get the clientele and the spiritualists who are cloaked in Christianity or Muslim come into the fore, the prophets and the rest. And for me it would be basically the same thing, it would be for those for the same anxieties, just that now they won't go into the bush for the herbs...they won't dress traditionally but they would be in churches with alters with the cross, with the bible, with holy water, with the incense. Doing basically the same thing that the herbalist would have been doing, that is what I see it to be. So they will transform into Christian prophets or Muslim sheiks because if you ask me today, I would say I am Christian, I am showing my children the way to be Christians. They would not be later growing up saying I am going back to be a traditional healer you know. So we are getting erm to a stage where traditional worship is going to be at the background, and more and more people identified as Christian or Muslim. And who like the remedies they would have sought from traditional healers, seeking them within those settings but basically with the same resources as the traditional healer would have given. But it is different in different regions and in different tribes. The Akuapem, Fante, Ga. And in different villages... some villages will continue the old way for much longer. And the old way finds its way into the new...

I: **But I'm curious if that, if I understand you correctly, spirituality is the part of a person that the Western models are neglecting, is that fair to say do you think?**

R: Yes I think so to a large extent. Erm and the spirituality I don't know whether you can divulge what is it from the psychology camp or the psychosocial, I don't know, I don't have the answer. But I think that is what is not being addressed from the mainstream Western medical, spirituality. Yes the spirituality that he understands. And again I, I can imagine the African immigrant in Europe will not go to a European church but will look out for the African church because there are certain practices that are from Africa that way.

I: **Okay.**

R: So it is not straightforward.

I: **Can I ask you just before we finish, when we talk about this, are there any examples that come to mind of someone with a psychological difficulty that you have seen treated by a traditional healer?**

R: Umm. It would be very difficult for me to openly say... But we have had several testimonies of people saying, I went to this traditional healer and it worked. I went to hospital and there was, and it worked. We also had an overwhelming majority who said until I got in contact with psychotropic medicines, I went from one healer to the other. And it is only with psychotropic medicines that I have become stabilised. You know, and they are the majority. But we have had people that have said it is true this healer, I got well, it is working. So I don't have the straightforward answer. Sometimes I may be wrong, but sometimes, probably if people get to know where you are living, where you discouraged traditional healing, they will tell you it is hospital medicine that worked for him. But they say that probably you have an open mind. They will say it is the combination or the healer also did his part so I am sure there would be differences in what the patient or person tells you. Yes.

I: **Okay thank you very much for your time.**

R: You are welcome.

B.16.13. Interview 4- transcription

I: **It's only two recorders just in case. Right so just for the benefit of the tape, can you explain your job title for me?**

R: Okay I am a clinical psychologist and what I do basically here at the XXXXXXXXXXXX is counselling, psychotherapy, treatment and assessment and diagnosis and that aspect. My talent is for this, in psychology and psychotherapy for psychological problems.

I: **And have you ever worked with a client that attributes their difficulties to traditional explanations? By that I mean non-psychological?**

R: Yes. Quite a number of them. It's quite normal here. Erm initially when coming for the intake and some of them do explain that what they are going through, their belief that someone else in the society has probably done something to them spiritually. And I don't know how to put it, that somebody is responsible for what they are going through spiritually.

I: **And how would you work with that client? How would you work with that belief?**

R: Yes sometimes (...) I had one particular case, I think it was the Dr XXXXX that saw that person, initially erm the person came in with the fact that he was seeing things, having delusions and hallucinations. And he felt that it had something to do with Satan. This was a person who strongly believes in God, he is a Christian, he used to pray for them all day. So he felt that all that he was going through was as a result of his enemies doing that to him. I think at that point I need not to waste my time trying to explain what is going on to him and so he was given medication by Dr XXXXX. And later he came to his senses, was responding to medication then I began the therapy with him to some level, whereupon he was getting better. At that point he was able to reason that yes all that he was going through was not Satan and he laughed about it. So this is somebody who knew that because of his spirituality, and his belief system something abnormal is happening to him, he quickly attributed to supernatural forces that he has no explanation for. And when the person takes appropriate treatment, he is able to recognise the demons were delusions basically.

I: **Do you think there are any advantages of working with a client group who have a belief in more spiritual explanations to their illness?**

R: Yes. Erm most of the people we see here are Christians and they belief strongly they get you in God, they believe God is seeking them. They also believe that when they pray, they get results. So all you have to do is you go through the psychotherapy with

them and the cognitive or whatever appropriate with them and encourage them to hold onto that belief, that positive belief it does help them. And of course I stress the word positive, a positive belief.

I: Great. Do you have to modify interventions?

R: Yes a typical African is very spiritual and you can't do without the spiritual component sometimes. You know we clinicians often talk about connectedness, as a source of healing. That sounds appealing be with you with your family unit, your environment. And spirituality actually plays that role here in our country. The person may go to church, see people, sing, do all sort of things, that relieves him of his stress at that particular moment. So if he is doing this regularly every Sunday he comes home refreshed, dancing some form of exercise and he forgets about his troubles for a while. At least for a week he goes back and renews that okay? Okay so basically this person thinks God is hearing his prayers, which to some extent could be very true okay. And if he is coming to you and you want to condemn what he truly believes in. Remember that beliefs are strong and you, it is probably inculcated since his childhood, so you can't take a minute or an hour and take it out on the person. But the positive aspect of this is that he holds his belief that he is going to get well or that there is a supernatural being that is going to heal him. Aside him coming to you and that just hastens the process of healing. Basically it is process, I would say it does have an effect yes.

I: You described sort of protective factors like activity and distraction... positive factors...

R: It can yes.

I: What about when someone believes maybe someone is wishing them harm?

R: No it doesn't have an advantage to my work, it makes my work difficult. Okay when most of the time the person may be a Christian so as soon as you refer to him, someone is trying to do harm to you where does your god tell you? Does he tell you he is going to protect you, does he tell you he is going to reach out for you? Does he listen to your prayers? You use that compliment to counteract that bad aspect. But as a clinician I am not a reverend, a minister or something, so my concentration is not really on the belief system but I try to explain the person's issues psychologically to them okay? And sometimes they have to go back to their pastors to work with them. For example a person comes to you and he says erm he thinks the problem he is going through is because he thinks he is committed. I don't have that skill to deal with that. It is the pastor or their spiritual leader who has that skill, so I am going to do my part as a clinician and he has to go back to that spiritual leader to work on that aspect. Personally I wouldn't want to deal with that, then to have somebody who has that skill to deal with it.

I: **If I stay with that example, if someone came to you with maybe an anxiety disorder and they felt it was because of a sin that they had committed, would you first send them, would you suggest they talk to their pastor first?**

R: Umm umm. Yes I will do my part as a clinician, I will do that. And sometimes after a number of sessions (...) and they are getting better, I can maybe know what they are thinking. But when it becomes too difficult for them to ignore, that is when you recommend that they see their pastor to work on that. And sometimes we communicate, the pastor or maybe the marriage counsellor or somebody call you ask you what exactly you think is going on with this person. And we can communicate back and forth.

I: **So the church might refer people to you?**

R: They hardly do but some do. When they have the client for quite a long time and they are not getting any feedback, positive feedback.

I: **Yes.**

R: And they have some if you are lucky to have a person who has some exposure to the role of a clinician or a clinical psychologist, then they will refer, okay? There are groups I would say of spiritual bodies and what they are looking for. There are 13 groups which promotes their members to be internalises. Okay? And there are some churches that promotes their members to be externalises. If you are understanding me? Now the externalises group are those who would quickly attribute their problems to the external process, they are engineers. And they can be difficult to work with. But those who are interlisers will be quite straightforward people to work with.

I: **It's an interesting distinction...**

R: It depends on the level of the person's belief. Erm before a person comes to you for long treatment, he is ready somehow to listen to you for treatment. Why you even get them to come if he is not on that level, you will find them, they will be in the church, or they will be at the shrine. Or where they think that can be removed, that is where they will be at. Hardly wouldn't even walk the street with a psychologist, they don't even know who it is and what he does. Probably even think of one other person who knows about psychology. Or an extremely schizophrenic person whose brain is shrinking. That is when the psychologist has come too late anyway, if people knew to look to us, they would come early. But they don't know. There is ignorance about our job role. Therefore he doesn't look that way so why would he come.

I: **Okay. I am interested in the roles of the two, traditional healing alongside psychotherapy...**

R: **The traditional healers?** It was before, before psychology came to our country. Psychology is quite still new in our country. Those who are doing the role or playing the roles of psychologists were the spiritual healers. And the, the clergy. Okay. So

there are some people who have been there to be spiritual healers several times and if builds or strengthens their faith when that occurs, they get results. And there are those who are also strengthened, their faith in their clergy because they get results. Psychology it is more or less something new, now coming. It does sometimes make our work difficult but now we do understand who we are okay? We are very different from the Western world, we Africans, we Africans are very spiritual, feel, erm I believe this, if you look around you find a whole lot of church buildings around. If you go to England you can hardly find one church.

I: **I got woken up by six churches this morning (*laughs*).**

R: So that tells you that this is something that is our culture, it is part of us and it is engraved in us. Whether you like it or not, right from the scratch. So you cannot heal the African from mind prospective, we cannot heal the African completely, when we are talking about holistic healing approach, completely without the spiritual conflict, you understand?

I: **Yes.**

R: Before then you look at the bio medical model, they were doing these physicians, they were writing the medications and doing all these sorts of things and you realise that those things were not working alone. The psychological aspect had to come in because some of the symptoms that are presented are psychological coming in physical. So that is how the psychological component comes into give you a better approach to treatment. Therefore if you have realised, it just follows logical, if you have realised it is a spiritual component of the people, that really makes them they are. Then of course if you are talking about our setting, you cannot do a holistic treatment when you don't include a person's spirituality, that aspect of them. So that is where we came by this bio-psycho-social approach so basically that answers your question.

I: **Yes. I think that makes perfect sense. I think it would be useful if you could explain to me the different types of healers that you know of....**

R: Well traditional healers are those that follow traditionalism... the old religion. The smaller gods and the rituals.... They are healers. We have witches... Obayifo. Those that manipulate the power of Obayi, evil, they can cause harm. But now there are also those that use plant materials.... These people use herbs and plants to make medicine. The herbalists... although healers mix and match... We also have the new churches, the Pentecostal and the charismatic churches... even the Muslims... I'm sure healing happens everywhere.... We also have prayer camps.... Places people go to get treatment.... When you say traditional healing, I would like you to personally define that. What would you say is traditional healing?

I: **Okay. Over my time so far, I have learnt about traditional healers, and other types of healers, religious or spiritual or herbal approaches... newer approaches that seem to include some older African beliefs too....**

R: Yes. The African way has transposed many different religions....we are a spiritual people. I understand that in your culture, there is not much talk of God? Okay. Okay. Okay. Erm I should think that as a professional, I am lost, how can I put this? I am not judgmental I mean as a professional I am not supposed to be judgment. And I personally I am a Christian so I would personally not involve erm the traditional healing as you are saying, in to the mind-set of treatment plan. Okay? Personally. But professionally if that is what would help them, why not? It depends on the client before you, that particular client before you. And as a Christian, I would promote Christian principles if I have the opportunity but I don't necessarily do that. I strictly act as a professional. So whether you are Muslim or you are a Christian, I just encourage you to strengthen that part of you, to facilitate your treatment. Therefore why would I ignore the traditional healer? Professionally I don't think it is right. Are you following me?

I: **Yes I do.**

R: So it doesn't matter what the religion is or what your faith is, what we need is your spirituality that boosts the positive aspect of you. That's what the emphasis is, so I won't say I would include the traditional healer whether you are Muslim aspect of the healer blah, blah blah.

I: **If your client tells you they are Christian, would you use prayer in a session?**

R: I think that I don't use prayer in a session unless it comes necessary and that is what the client is comfortable with, yes we can do that. If the client is comfortable and it becomes necessary, but other than that he has come in here for some sort of consultation rather than -

I: **Yes.**

R: - the spiritual aspect of it. So that is what I focus on yes.

I: **Do you ever, you said that some churches will refer people to you and you will share information with the people that refer them -**

R: Yes some information yes, yes.

I: **Do you ever refer the other way?**

R: Erm, I have not had such an encounter with any client who I have asked go and find out from a healer or, who have an actual curse.

I: **Because we have been having some discussions with some (*somebody knocks at door*) (...). Is that your next patient, is your patient waiting?**

R: **No, no, no. Just go ahead.**

I: **We have been having some debate about what constitutes a delusion if an idea is culturally accepted -**

R: If an idea is culturally accepted?

I: **Yes if an idea is shared by a whole class or a whole family...**

R: No, no. It depends on the neighbourhood. You know maybe the Ghanaian setting some years back. It depends on where you are living, your exposure and your level of spirituality. You may go to certain areas, like the rural areas where that is really erm of importance, that somebody cursed you for some reason and that curse is going to follow you and it is really going to happen. Yes it does happen. Okay? And as soon as you make amendment or you re-consult with that person and the person truly forgives and lifts that curse off you, you are free. That is there, it is real, it works. But in certain areas like urban areas like where you are now, you would hardly find such issues.

I: **Okay.**

R: Okay. Where you are likely to find those who believe in the old ways only? Most people today can have many beliefs... most people will know a little of physical illness and will think to talk to God too. Those who have such a deep belief into their spiritual belief as Christians and they believe that this is just a kind of test or this is something we are going through and we do our prayers it will be fine... we are the psychologists, those are the people you will find, the people that do not solely believe in tradition - they would not come here. Here we rarely see those people... until they get very sick... but then they are in hospital, they would get medication first mostly but of course there are some others responsible who would believe so much in these curses and these traditional, and it works for them. The fact is, if you believe in it, it works for you. Okay. But maybe it is forgetting a person might have problems. They come to you, you work and try to work with them and they believe this, they are society or someone, some sort of enemy or external process, I am truly into your family and causing problems for the family. When you as the psychologist assess the issue that they probably have is marital differences. So you work with them on those lines, they get to a set and know each other better. And things begin to move smoothly. So where are the enemies? You must show them another way. But there are true issues when no matter how you the clinician works with that person on those levels if indeed, the cause of the problem is spiritual it has to sort that out. If indeed it is.

I: **So what impacts how a person interprets their experience...?**

R: Erm civilization and the influence of the Western world. Erm higher level of education and I don't necessarily rule those things out. A person can have a PhD but hey, when he is really faced with something, he will go back to his village and find the cause of it. So he does not always cut that off but it does help. Erm sometimes you

realise that there is so much stress around and stress is a cause of these beliefs and it is something to somebody else. It just makes sense that you look at those stresses that causes and solve them and you are free. Rather than just say that you are going through this suffering because somebody else is doing something. And again because most of us are Christians, Christians strongly believe that erm our Lord doesn't forsake us, he is there for us and no matter where he is, he is only important to the person and is ruling everything, so there is no way that the enemy would get charge over you when you have God. That is positive feedback. And spirituality helps us deal with some of these problems, to treat some of these problems.

I: **Yes.**

R: Because it is a positive mind. It only becomes a problem when he goes and wait and then you focus on much of the negative. So what I would do as a clinician when you come to me, I would move you from the negative part and look at the other sides of it, at the positive sides of it. And that just becomes looking at a brighter part of it, doing what you can and see if that will work.

I: **Yes...**

R: Umm umm. Yes it is our culture.

I: **I am curious why, how do you feel about CBT for this client group?**

R: Yes, yes. You see the Western model and the European life to some extent more individualistic. We are more of a group living. If it is so much stress for you to have family members at loggerheads with you. Because what we do, we always do it in a group, that is how we are brought up. We always have some family gatherings to go to. We always have some family members to take care of because we were taken care of by others. We have this way of doing things. We say one person gives birth to a child but the whole community raises that child. So in that sense we live as a group and if you live in insolation, you have so much problems. Why? This is very simple. If you live in a group, you have so many people you are connected to. Immediately you have a problem with your child, you may talk over it with one person, talk over it with another person. You have these issues, you discuss it, you have marital problems, you go to your family, your parents or your uncle to discuss it. He will call your partner and help you discuss it, can play the psychologist role in the connected life okay? Now when you believe to live an individualistic life, you disconnect more often. You disconnect from the social aspect and life becomes a bore. If you understand? Life becomes a problem. If a person is depressed he begins to withdraw from things of interest. So if your things of interest or your culture of interest is being connected and your social life is taken away from you, then somehow you become lonely and that is not going to help you psychologically. So if you have so much stress you have no one to pour out with even discuss it with your family members or your friends or the

community members. So we are talk therapy, you pour it out and they are gone. We don't see it, we don't level it, that is what you have just done, they are gone. But the more you build your life out in your car or you drive to work and getting back there, you are lonely. Every day you are angry if you are certain you have issues it is all down what is in there. It goes up then it comes up, poof, just like that. So it is a psychological wellbeing.

I: Yes.

R: Which we already have it in our culture so you don't have to disconnect. Only those like have it a bit different each day. Things are changing so we do not have all the people you used to know, you don't do all the things you used to do. And indeed it is important for the African to keep connected, not just African, everybody, to be connected to other people. But of course when, let's say in your culture, raises you as an individual and you are used to it, you are fine. They didn't raise me as such. Now if I come to England which is difficult, I will get to lead an individualistic life. When I, when I am here in Ghana I see friends, I see family members, I go for family gatherings, when I come to England I stay in the house. If I go to my family there, he is the only person there we communicate. You know find people visiting, they tell us that there is more lonely. Everyone is busy, I understand the lifestyle, but that is not why I am coming for. I am coming for the group kind of living. So if you are there working which can be stressful you have no people you are talking to. The family is far away, separated, you are going to have so many psychological problems. And then if you don't take care we sometimes have this belief system that somebody is causing us harm... which are not fair. Because he is jealous of you or because he is a bad person. So when things are not going well and you are not reasoning on the level, but when you are feeling stressed you look to these beliefs to explain it. I have these issues I need to sort out, you might be tempted to go back and say, who might be causing this back home? Because I know here in the UK they don't do any of those things. So who back home is causing that problem. And that is maybe when we are having these problems treating these people because you don't understand why they should believe that, but yes they do.

I: But (...) everything you said makes perfect sense to me. It sounds like you think Ghanaian culture helps people stay well? They look after each other...

R: Yes some part of it. You see I am a multicultural counsellor. I deal with your culture and your background. Say if I am having an Asian person before me, I know which lines I will take her. And if I have a Ghanaian before me, I know which lines they have. A British I know which lines to take her. All doctors they say this. You must be multiculturally competent to identify the person's culture. Which is indeed a pattern

for a person you can't take away or you can't change over time. There are parts of Ghanaian culture I encourage…

I: **So how do we better improve the way we support Africans in England?**

R: You have to ask the person what their culture is, what is his belief system. What does he believe is causing his problem? When he attributes what is going on to a belief system, you ask questions for him to teach you more (…) about it. Try to understand it, you may not really understand it but it is real, the patient is not crazy, it is coming from somewhere that holds strong belief in that okay? And that cuts across every culture, there is some strange, as is being told to a different person, that it is that person's culture, it is that person's belief so you listen to them. And then you ask the person how that can be solved through his belief system. And how sensible that is, he needs to go out there and if it is not real, he needs to calm down. If it is a Christian for example he doesn't need to travel anywhere to meet God, he can meet God right in his room. So you do your part as a clinician with your CBT or whatever model you use, and you don't just ignore that part of him, you try to give him the opportunity to discuss that part of him okay? And work along those lines with him when healing. Okay so what do you think you can do now about it giving where you are coming from?

I: **Yes.**

R: And then you ask them. Do you think we should go through CBT? You want them to have confidence for it to work with you now here, I hope you are following me?

I: **Yes.**

R: So basically what I am saying is, you use a client to educate you because you have different types of Africans coming from different parts of Africa with different belief systems. So that client can educate you on what his theology of the problem is and how he thinks that can be solved. Then you can also help him with what you have and explain it in the positive part of you. For example I just asked a client, a client said he, I think he suffered from severe anxiety and he feels that the whole world is unfortunate for him, he is not going to cross path, this is a person who was a GP, he graduated with the second degree okay? Which is not easy to come by in Ghana. So I said, okay so if you feel your future is not worth believing for. Are you a Christian or what spiritual affirmation do you belong to? He said he was a Christian. What does Christianity teach about your future? What does Christianity say about being protected? So I asked him, suppose I am not a Christian and he quoted part of the bible in a second. I can't remember which part, it was about forgiveness or something and I wrote it in my report. He quoted some word for me which talks about erm God not forsaking anybody or blah, blah, blah. So right there he gave it to me, I didn't want to give it to him, he gave it to me. And I said explained that I don't understand that.

And he tries to really explain it to me. Then what happens, he gave insight in what he is saying and then he begin to rethink about the catastrophic statement that he is making you know.

I: **Yes. Yes.**

R: So basically that person has that positive aspect of his spirituality. Take it from him, he will give it to you, he will tell you. In a serious traditional practice one which says, or which believes in immediate punishment and immediate reward, it works. If you stole the spade and you were taking it to that shrine and something unfortunate would happen to you, it will happen. And of course if you are not the person that is expecting to have stolen that thing, if you are sent there, nothing will happen to you. So all our belief system has a positive and a negative and they are working for us okay? So basically you can't condemn any of them just like that. The Christian will not really buy the traditional healing but they might do although I do not think it is very Christian at all. I can't say the true gods but ultimately there is only one god every religion is trying to serve and through different mediums as you know.

I: **Yes. Yes. I'm wondering though, people who do believe in traditional healing... how do you...**

R: It depends on what is going on with the person. If the person is quite delusional, but how can you tell? You have to find ways to telling this person is delusional and he is not, he doesn't know what he is talking about until he takes some medications and he is okay. Okay? But some of the issues they are not sick, as in traditional or they are not behaving, they are behaving like schizophrenic but they are not schizophrenic. They are screaming, they are doing stuff inappropriately, but it is because of where they are coming from sometimes. It is because of what is going on and it is because of what they believe might be causing that problem. I am not really sure even if I am answering the question you are asking, but your question is not like should you talk irrespective of what the person is saying to treat him, you need to provide the services, should you detain him and give him the treatment.

I: **Umm umm.**

R: There must be evidence as to why you think this person needs... your treatment plan should help him find the positive part...

I: **Actually -**

R: With counselling you can't really have meaningful counselling if your person is not responding to you.

I: **Yes. No I do understand. We had an interesting debate at another hospital that if a patient had a cancer, had a tumour that needed to be surgically removed and they said they wanted to go to a traditional healing place to try an alternative, some doctors thought that under the new Mental Health Bill they should keep the**

patient and treat them and others thought that they should let him go... to have the choice to seek help where he chooses.

R: You see when a person has cancer, prayer alone, cannot heal it. That is what I believe. You as a physician or a clinician know that, this is something that has to be treated by a medical model or treatment. Without that the person will lose his life. So I personally would think that even if the person has some sort of rights, when we know the dangers of this, especially when the person is young. You know when you are 18 and above you are an adult, you have the right to whether you want it or whether you don't. But when your belief system overrides your chance of life. This child has cancer, if not treated he will die and mother stays and belong to this church who does not allow the blood transfusion or blah, blah, blah, I am not going to allow that. I think that we have to treat that child, you know. (...) I understand your rights, if you are out and you strongly don't want the treatment but you want to go the other way which you think may help you, that becomes a little bit dicey, we have to try to convince you. But to take your rights and treat you, and treat that as a delusion erm (...) that cannot be appropriate all the time. Because there are some church bodies who don't take blood transfusion because of the beliefs. And these are a bit difficult to erm you know just take or ignore for a person, I don't think that is right to just ignore somebody's belief, but there might be ways of working it out with the person, talking to the person to see if there is something. But if it is a child I think the treatment will normally be done, it is done, the child is taken from the parents and treated. And if parents understood it to be okay well fine she is an adult, she will deal with it. It's, it's not as straightforward, you can get, I mean it has to be something that we have to really debate about. But for the Mental Health Bill, I don't know about that. Maybe we will see more patients who don't trust us because the healers are not allowed to hold them... I cannot see yet.

I: **Yes it is a grey area...**

R: Mmm it is. Maybe you are thinking all of these ideas are delusions? Because they sound strange to you? No they are not delusions, they are really, real because these are beliefs. But of course you know that when the person is ill sometimes, they, they get back to some beliefs when it comes a delusion and they stay there, they, they belong it, that is an illness. We should be able to distinguish between that.

I: **So it sounds like it is more clear for you...**

R: I don't know how I want to put this. You see I see clients that when you talk about belief system I just, you know what this guy is sick, treat him, that is different. But there are some when you do and he is talking about a belief system and keeping the opportunity and maybe you use that to treat him. But that is how we realise that this person is psychotic. I don't need time to affirm that he is psychotic, but you need to be

treated. After treatment you got this (...) erm stuck, beliefs will just erase. You don't get it?

I: **I do, I'm just still curious as to *how* you do that...**

R: You see a client who is psychotic then you know. I have seen a person who is beating around the bush, you ask him what he is doing, I mean he is telling you he has some, (...) he has something on his key, you don't see anything on his key.

It is different if a whole class believe there is a hex or something... we had some cases where the beliefs were real and the whole school shared them. That boy was not psychotic. He was very anxious...Yes the person may not have the symptoms of the diagnosis that is given but does talk about some sort of belief system and that is a person who is able to talk about their beliefs, who you can reason and talk to them, is different from someone who is psychotic. It is not someone who is ill, I can tell quickly when I meet them. If someone is sure that they are being caused harm and they will not listen you would diagnose that person as a schizophrenic or bipolar or whatever ... maybe. It is not that simple. It shows you it is important to gather information from lots of people too.

I: **Yes.**

R: - and he has this thought belief system. He believes that enemies are chasing him, he believes that, you can tell that this person is sick.

I: **Yes.**

R: They maybe know where they are. They have, they have they have lost touch with the environment. Easily you can tell this person is sick.

I: **Yes. Yes. Okay so my concluding question is about how you perceive the role of psychology... do you think it will replace healing or that both are needed?**

R: The traditional healer typically they shift the focus of your problem.

I: **Shift the focus?**

R: Of your problem. Let's say you think that (...) XXXX has put your, it is this article that was written by one of my colleagues... XXXX has put your ... No, no I am just thinking of her name, XXXX has put your testicles in a box, that is why you are impotent.

I: **Okay.**

R: So the traditional healer shifts the focus of impotency to finding that box, it reduces the anxiety, you keep on looking for the box blah, blah, blah. And somehow you find the box and you feel okay I found the box I take my testicles, I am free.

I: **But how does the patient find the box? Just, you mean as a distraction.**

R: As a distraction.

I: **The anxiety is removed -**

R: Yes.

I: **- and they are able to perform so the box must have been back.**

R: Right.

I: **Okay.**

R: The spiritual healers have their own way of shifting your focus towards something else, finding the cause for dealing with a curse. And somehow releases your symptoms. Or he tells you any time you feel this way, kick the bucket.

I: **Yes.**

R: And you believe it. So every time you kick the bucket, psychologically you feel better. But I have not been to a traditional healer before, these are the kind of things that really goes on as you know and the psychologist typically will work with you through some problems a different way and you will sort it out. And suddenly the reality of the issue is helping you gain insight on how to treat it blah, blah, blah, blah. These other people are also doing the same thing but in a different way. Our way helps you in the longer term... with the healers you must keep going back.

I: **Umm umm.**

R: They encourage you will also shift the focus from the problem to waiting on the Lord to answer your prayers to believing that this thing will change to blah, blah, blah, blah. Why you start saying this sentence. (...) they begin to see the size of your prayers, it will work. So psychologically you are happy.

I: **Yes.**

R: Because before psychology came into existence, this is how we were healing, this is how we were solving our problems. And this connected issues socialistic or collude even help with us. So typically erm we can't necessarily do without the spiritual aspect especially if that is what the person seriously believes in. And if the person is very flexible then, then that is fine. And if he is strongly opposed to that he will be -

I: **But as far as the roles of the two disciplines, do you hope they move closer together or they must stay true to their own disciplines?**

R: I think they have to work erm as a team. (... ...) Just a second. [Someone enters the room]

(Respondent speaking to colleague)

I: **Sorry I know you are busy, last, last bit I just really was interested to hear your take on the future as far as to the two disciplines, or the several disciplines erm are concerned.**

R: Yes I believe we have to work as a team erm basically what that means is when you see and first meet the person be the clergy, by the spiritualist, be the psychologist, be the physician or psychiatrist. As parents, all people are the same. When you realise that other compliments that is in play is something of a speciality by another person or another professional which is interfering or has a bigger take on the treatment, of

course if it is just minor something that is fine, but if it is something major, you don't have to ignore it. You have to erm refer the person to the appropriate quotas and work as a team to be helping the person. I find, that is my strong stand. And that is where we try to educate the clergy on that look, you are doing a good job, you are helping out and helping people, but sometimes these things are also difficult to do. The spirituality is important, an aspect to the person, they are psychological and they are spiritual. So we are not doubting your capabilities, we are not doubting erm the result of what you are doing, we are finding that you are doing a good job but the other aspect that is missing, do that person a favour by referring the person to a psychologist to go through what their elements, of psychology, those parts that are psychology of the person. And if the person comes back to see you and you work with the person on the spiritual aspect and the person gets an holistic approach. It is just like if I realise that erm I am suffering from malaria or (...) what can I use? (...) Or cancer okay? As a physician, I will welcome what I think I can do to help this person suffering from this particular illness. But also suffering from cancer or HIV Aids all of a sudden, you do need some counselling to help you cope with it. And that is the work of a psychologist most of the time. So why don't you let them see a psychologist to work on that. So the same, the spiritual aspect is such a big deal for the person's understanding of the illness, causes and treatment then you have to ignore that aspect of the person's life. I think it just makes sense to work with some people as a team.

I: **Yes. Okay that is perfect.**

R: It is. But I think it is important. Yes.

I: **Thank you very much for your time.**

R: My pleasure. I enjoyed thinking about these things.

B.16.14. Interview 5- transcription

I: **Right so just for the benefit of the tape, can you explain your job title for me?**

R: Okay. I am a former nurse, working in psychiatry. Now I am the XXXXXXXXXXX for community psychiatry. My work sees patients from the 3 psychiatric hospitals for various reasons... then you continue with their treatment and educate their families in the community. How to follow the treatment, how to look for side effects, how to integrate them into the family, to involve them in their house jobs, farming, organising funerals, everything. Watch out for that side effect and report back. In the regions somewhere, we have some volunteers who come from the vicinity that the patients are staying, so they contact the patients, continue their observation and inform us and give us the report whether they are doing well or not.

And apart from that, during our visits, we see new patients in the area. We hold clinics and take care of them. Sometimes, well most of the time, we go to schools to give health talks on mental health and the contributing factors leading to mental health. And we will go to societies like church groups, Muslims groups, talk to them about good mental health and what they should do. We tell them if they get sick they should come to hospital.

Then, in fact, the reason we integrate into the main er health service, so we are under the regional director, we are delivering public health... we go around and we work, where we cannot take care of you or it is above us, we take you to one of the hospitals.

I: **The area you cover is very big...**

R: Okay. We must travel. The patients cannot all reach our hospitals. It is important that we are out in the villages too. We talk to the relatives, educate them and if we have to bring them down for admission...

I: **I see. And sometimes the psychiatrist will not need to see the patient?**

R: Most of the time... we don't bring many patients. Most of the time we just talk to the psychiatrist so he can suggest to us what to do.

I: **One of your nurses will cover an area?**

R: Oooohhhh. We have districts. We have sub districts. We have communities, small small communities.... so she covers all. The catchment area is larger in the other regions apart from Accra. Accra - they have the advantage of the hospital so it's easier. But look at this extreme end (gestures to map of Ghana) it's a long way coming to Accra, the nurse will have to bring them, normally under sedation...

I: **I see.**

R: Its only in extreme cases... we try to treat people in their community.

I: **That sounds like a big job...**

R: It is a very big job. We have regional coordinators. I am XXXXXXXXX. Once a year we meet, all the regions will bring their report. I will put them into a national report... so we

meet at annual conferences and discuss discuss discuss and put them together as one national report...

I: **I see...**

R: The nurses do a lot of the work in mental health care... yes

I: **I am interested if you see clients, patients, who believe their mental illness is not a medical or psychological illness... that they are not 'mentally ill' but maybe they think they have a curse?**

R: Yes. Yes! We see a lot of them... I remember one man... he was cordially dressed in his regalias, he said he was a chief, he wasn't sick. So we said "We know you are not sick but we wanted to talk to him." He started insulting. And when we asked him to enter the room he started walking backwards, he was entering the room but walking backwards.... he went with his back... so you could imagine. He didn't believe in what we do. He would talk to his gods to give him extra power, he would have to do some rituals, but then we gave him tranquillisers. In two weeks' time he came back and said ,"Oh, I was sick", so he accepted us. Initially, he would not accept, but with the drugs, he would settle and accept.

Then, in the northern region, because of the vicinity, I mean the distance between the psychiatric facilities and where they stay, the first place for treatment is the traditional healer or churches, because they believe in it. So what we did in the northern region was that we trained some of the traditional healers who were coming to us for tranquillisers and anti-consultants and they gave us reports. It happened in the northern region, if you could go there you would be very interested...

I: **Is this with BasicNeeds?**

R: Yes. In the northern region, the traditional healer is there... but he does it with us, we work together.

I: **When we talk about 'healers' - what types of healers do you think you have in Ghana? Are there different types?**

R: Yes. You see. Traditional healers, they are the fetish priests, they worship the traditional religion. They use powers and potions, they teach people to honour their ancesteors and make peace with the spirits causing harm... they will do something supernatural... they call it a gift. We have, have witches - some can use their powers to cause harm... Black magic. People will go to them when they are desperate... we also have herbalists - that use the plants and natural ingredients to heal. They know about the different healing properties of plants... we also have the newer churches - they will call what they do healing. They use prayer and the power of God. Some prayer camps are here too. There are many different types of healers, the old way and the new. We are a spiritual people. We are trying to work more with the healers... to teach them about the medical way... modern medicine...

I: **I see... so you would train the traditional healer in nursing?**

R: Not nursing... we give them an orientation in what we are doing. And we tell them what to look for and where to refer and how to continue the treatment....

I: **So are they trained to administer your medication?**

R: They administer Western medication with our consent...

I: **So you would prescribe...**

R: Yes. And they would carry on...

I: **And you would teach them the signs of something serious?**

R: Exactly. The signs and symptoms... for example, if they see someone who is dripping saliva, it means they are reacting to the drug, the anti-convulsants. Or if somebody becomes stiff, with their hands like this (gestures) he is reacting to one of the tranquillisers.

I: **And so, this one project in the northern region, where you work with the traditional healer and BasicNeeds, is that a new incentive or is that the norm? Is that how you work everywhere?**

R: We progress as we work. We did this with the assistance of BasicNeeds. They came and trained us together with the traditional healers and some of the churches, we were working as a team. You are the traditional healer, you are seeing your patients, you are in your corner... if he is restless, come to the hospital, get tranquillisers, go back, he will respond to the tranquilliser, but then if he believes in what the traditional healer tells him, he will accept the treatment. I think I asked this question before at a national meeting, I said no "such a person, if the patient gets well, who takes the credit? Is it the traditional healer or the medication?" The thing is, that our goal is to treat the patients and nothing else.

I: **And from this scheme... how do you think healers feel about working with you?**

R: They liked working with us very well because the patients were getting well rapidly. BasicNeeds helped them build up their buildings, from a small room they opened up to an airy place, sometimes they would have a party eating and dancing, it helped them. We tried to organise some recreation together. It helped...

I: **It sounds like, I don't want to put words into your mouth, but it sounds like you think there is a place for traditional healers? What should the role of traditional healers be?**

R: The healers have something different... they believe in rituals. But our problem is say if the patient is very restless, they cannot calm him, all they can do is pin him down with ropes, I wish you could go to the northern region and see it...

I: **I saw the BasicNeed images... they were using tree trunks too.**

R: Exactly, tree trunks, that is just to pin the man down. We say "No - we don't have to do this, it would help to give him some tranquillisers, they will come down and then there is

space for you to do your rituals." Whatever rituals they do, we are not interested, all we are interested in is that the patient gets well, seeing them come back to normal and comes back to the family.

I: **Working alongside traditional healers, do you think you have seen something that is good?**

R: What they do is good, because they are the first place people can go... let me put it this way - if I am sick, and you come to visit me, even if you just touch me, I feel relief because somebody cares... somebody cares and somebody is ready to talk to you, somebody is ready to try to help you, even if it means beating... somebody is beating you to remove the devils in you, what do you do? At that time you have nothing else, you just succumbed to whatever they are doing... so that is why we appreciate them - for being the first place - for reaching out to these patients that we cannot see...

Okay. [another woman enters the room] I would like this woman to add to our discussion, she is a XXXXXX nurse and would have something to offer you...

I: **Hello. I am Rebecca, I am taping an interview. I would be very happy to hear your comments but I will need you to understand why I am taping the conversation and get your permission to use your recording...**

R2: Okay. No problem at all obruny (Akan word for white person). I will sign it.

I wanted to add - I wanted to say in Ghana and in the whole of Africa, we believe in spirituality. So no matter what you do in a hospital, even if you bring them to the hospital, you still go to either the spiritual churches or the traditionalists to find answers. "Why me, why should I get mad?" They believe there are answers only the spiritual places can see. They believe they need answers because it is not normal, it is not natural. So they go.

R: The traditional healers... they will go there.

I: **You make an interesting point... if the patients believe that a traditional healer is the right person to help him, how do you work?**

R: Okay. So I work mainly in the hospital now.... she works in the community. We have to talk to them... I think the medication helps them believe.... when they settle down.

R2: In the course of treatment they start to believe more.... we have to talk to the family. Sometimes when they wake in hospital they don't remember "Who brought me here? What happened?" and then you go, you tell them why they are here and what you will do for them. We tell them, "If you take the drug and follow instructions, you will get better." And happens in, in psychiatric illness what we have realised is, the rate of relapse is very high, so if someone goes way with the belief that the hospital made them better, they will come back. But if they go away and see a traditional healer too, they have the belief that the healer was the one to help them, and they go back there. They go to find out why they got unwell, to be mad is not something people accept. People around you will treat you

differently. The healer will tell them something to explain why it has happened. They are eager to do what they say to keep it away... then they feel confident and they stop taking the drugs and they get ill again. They come back. But they go to the healer first... they should come to us first. They relapse and come back. It's a vicious circle.

I: **I see. I am interested in more of your examples that explain how you work with people that believe they are cursed or possessed?**

R: Okay. Let me start this one. If for instance you have been married for some time, and you didn't have children, normally they would take you to the traditional healer. If you are lucky and you become pregnant, then he is a winner. So if something happens you will refer - you will say - this man helped me - you should see him. That child is seen as resulting from the traditional healer. Nothing can change their mind. If anything happens - they will say - well maybe you didn't do the rituals they told you - maybe you didn't pacify the gods - so this is the consequence... And in Ghana - we believe the ancestors have power. Your own grandmother...

R2: They will say your own grandmother is a witch... there is someone who hates you and has gone to a witch...

R: It's true. And you believe them. Because you cannot explain why one person got mad. They see it as something the healer can explain and then keep away. But then you will be stuck to him. You will look up to him...

I: **Do you think there are some 'less serious' illnesses that are treated by the healer? I mean the patients that are not psychotic...**

R: If you are anxious and you are relaxed the next time - he has treated you! Yes. He will take the credit. And he will do so happily.

R2: Last week Sunday I was reading the paper and there was this man that said... a woman had married 3 husbands. The first husband she says she didn't know him very well. He died 4 years after they married. The second husband - they were going to a funeral. They had an accident, both of them, many people were injured on the bus, some died on the spot, they were both unconscious, and later she regained consciousness and the husband died. Then she phoned her mother and said she would not marry again, after the death of the second husband, people started pointing fingers at her...

R: That she was a witch!

R2: Exactly - they said she was a witch. So she decided not to marry again. But she said the finger pointing became too much that she had to migrate to Accra. So she came to Accra here. She had the fortune to marry again. She did not tell him of her past. They married, 2 years, and then the man died. 3 husbands. She said the third husband died because he was diabetic... how can one woman bury 3 husbands within 9 or 10 years? So now the stigma is such that no one will marry her. Everyone sees her as a witch who kills her husband... she had written to the psychologist in the newspaper. She says she her family tell her not

to marry because she is a witch and the man will surely die. They believe people get ill if they get near her... she doesn't know what to do. But you can see that because of how others see her, she must seek traditional healers' help, doctors would not change anything for her, the people wouldn't listen.

R: She is not the only one. In Ghana, when husbands start dying people start asking questions. No matter what, they point fingers at you.

R2: This woman had only one friend who hadn't abandoned her. Even family members had abandoned her... her friend could see the first man had been ill, the next man had had an accident, she was lucky to be alive, the third man had bad diabetes... she was the only person who could see it was not her fault.

R: She could have committed suicide without her friend... it is very hard when everybody you know points the finger and abandons you. They are scared of you...

I: Do you think a psychologist could help this woman?

R: It would not be enough, but they would do their best...

R2: If the psychologist sees her... she would point out the evidence... she would help the woman cope... she would help her see that the medical conditions were not her fault... she would give her anti-anxiety medication...

I: If you two were here nurses, would you advise her?

R: Okay. Of course I would not advise her to see a traditionalist! I would advise her to go to the hospital. I would tell her to see the psychologist... but she would not believe it. The people that have abandoned her would not change. Like me, as I sit here, if a traditional healer was telling me something, I would not believe it. I would never believe a traditional healer.

You see it works like this. If they told me "Hey - your mother is this" I would say "No - my mother is not that" then they would say "Your sister is this" and I would say "No my sister is not that" he would say "Ok - your brother is this" and I would say "I do not have a brother" but the moment is coincides - people believe. People say "Yes - I see." You see because of the psychiatry I have read - I don't believe - but people who are not educated see it as being true.

R2: They believe in it and the rituals. They collect everything they are told to do. "Bring goats, bring sheep, bring corn, bring corn, bring yam." And rather they collect everything of yours and make you poorer!

R: hhhmmmm....

R2: Let me give you an example, my son became sick. And there... all of a sudden he became unconscious. They went to the hospital and they could not trace what was causing it but he was given medication... then when I brought him to my mother she said there was someone who could treat such conditions... they took him there. Tied his limbs together. Told them he could help remove the devils and that the boy should not bath. Fortunately I

arrived that day and said "What is this? Remove everything and go and bath him! those bandages are going to restrict his blood flow. And if he doesn't bath there will be more bacteria." So my mother said, "You have gone to school, you don't believe in these things." Do you know what? One year later those who saw that man - their limbs started falling off. But my boy is well.

R: Praise God.

R2: Bandages! Restricting the blood flow... most of them lost limbs. They believe that yes - they are carrying the devils... it is our belief in Africa. We have been born into it. Whatever. Unless of course you decide not to believe in it.

I: And in a village if everyone else believes in something....

R: Yes yes yes yes yes!

I: How do you make the village decide not to believe in something they were born into?

R: Slowly slowly. We go to villages, churches, schools.... educating the young ones is good. We tell them whatever. And they see from what we do. But we cannot change their minds... not to entirely forget about traditional ideas - no! You see this man is wearing beads - the moment you see him - if you are a Ghanaian you see he is a traditionalist. We have certain memorabilia - you wear and it makes you big - we believe in it - even if he is a Christian, they will have to do certain things in order to to do a ritual... as an African we cannot run away from these ideas. We can't. We can't run away from them. Even if you go to a church, you come home and someone will say your grandfather will say "Hey - this man was helped by a healer - why don't you go to him?" So we tend to combine. It would be difficult for us to dissociate from them... I'm telling you the bare facts.

I: If you had unlimited money to build a great psychiatric hospital, would you employ a traditional healer to work with some of your clients?

R: Yes I will. I will.

I: What type of patients would you refer to him?

R: All kinds of patients. Especially the hypermanics, the schizophrenics, the epileptics... I would like because... why I am saying so is it depends on where the clinic would be... if it is somewhere where they believe very strongly - it would be good to have a central point for them to go to see a traditional healer - because they have that confidence and I believe that that faith will help you recover - once you have faith in traditional healer you take it without questioning... we would work together. I would want to see the patients first. I would want to check them... but I don't mind who gives the patients the medicine - if they will take it from them then let them...

I: So you would do the physical checks and prescribe the medication?

R: Exactly! The traditional healer would then observe the patient and encourage him... even with feeding... he would tell them to eat their food. They will listen to them. Together we could give the medication but the healer would be trained to watch out for side effects...

they would listen to the patient. Talk to them. The language is different in different villages - maybe the healer can understand him better (laughs).

I: And what about the rituals and symbols?

R: I would not allow those in the hospital, no. You can't run away from it. They will be giving it to people in the house... let me give you an example... somebody was brought to the hospital to one of the special wards... the people went and did this concoction - I don't know the contents of it but they gave it to them (shows me a cola bottle full of murky dark brown liquid)

R2: They wash in the water. They write on the slates, Islamic writing, they believe it has some powers...

R: She gave it to me and I educated her. I said, "No - let us try with the hospital and when we have finished with the hospital, you can try somewhere else." Even now she has been discharged but I didn't give it!

I: And you still have the potion?

R: ha-ha! (laughs) I didn't give it!

I: Do you think if the Mental Health Bill is passed you will have more patients brought here against their will? Patients who do not believe that the hospital can help them?

R: Yeah. But they almost always do - they come against their will, in that state. Their family bring them. They do not want to come. But by the time they have the tranquillisers they will settle. They will accept. They will accept they are ill and it is ok. Let me tell you. There was a man, I met in Tamale, who was working in the hospital but it was alleged he was smoking marijuana. He became high and walked the streets. People were lying with him - he was throwing stones to them. So when I was in Tamale I told him to come to the market together. He would carry my bag for me. We would go together. People would look. We would go to the taxi rank. We would take the taxi - I would give him one cedi. So I convinced him like that - I brought him to the unit - the psychiatric unit. Then he also showed me his house. I educated the people in his house. He would come to see me every day and at the end of the day I would give him a tablet of laracel. One day I told him I would just inject him. I had arranged to take him to Patang Hospital. We took him to Patang to have the depot. This man is now well. He travelled. He came back married.

I: So you had to build up your relationship slowly...

R: Yes! You know you need to convince the relatives to understand what is happening to him... you need to spend a lot of time with them so they trust you. It's not supernatural. It's sickness. If there is someone in the family who doesn't believe you - it will not work. You continue to convince them. They then see the dramatic progress of the patient. Now when I go to that area they bow down to me. They think I have done a very good job.

I: Wow.

R2: There was one of our XXXXXX [JOB TITLE]. The brother was in Europe and became mentally ill and then he was in the house. So this minister rang Dr XXXXXXXXX (the XXXXXX psychiatrist then) to say he had a brother that was sick. He was told that I was there, they said I would know what to do. This man had insight into his condition. He would not consent to treatment. So I talked to my team: "Let's tell him some lies that we are having a mass immunisation and we need to give him some jabs." He said he wouldn't take it. We forced him. We injected him with tranquillisers through his clothes. I wasn't there and I was worried that the man would take us to court. I travelled to him. When I saw him I said to him, "I am sorry" he said, "That's ok you have brought me to hospital" I said "Would you please write it that it's ok" (laughs). He wrote and he signed. I told his Dr I didn't want to be taken to court after all this time.

I: **First you tried to trick him?**

R2: Oh yes. We knew what was best for him.

R: The point is no mental, nobody can say they won't take medicine, it's the relatives that sign... sometimes the police help bring people in here.

I: **But it sounds like what is powerful about changing people's attitudes is experiencing the drugs themselves?**

R: Or somebody in the family... people listen to what works for people. What worked for their friends or family.

R2: So slowly things are changing... there was a chief in Tamale. He was very agitated. He beat his whole village. They took him to the fetish priest. He wouldn't calm down. They tied him. And then somebody said, "Why don't you call sister X -I saw her help my brother." So they took me. I said: "Oh - my husband! Don't mind them. I didn't see you- why? Don't mind them - they didn't do well bringing you here without you knowing!" Then I said to the fetish priest: "Oh - you haven't treated him nicely - is there any food? Put some yam on the fire and pound fufu - I am going to eat with my husband!" And then I told him to bath, that when he finished bathing the food would be ready. He sat down and ate the fufu. I said, "I will see that these people are sent to court." He said – "yes - I was telling them that." So after that I said, "Please turn yourself so I will give you the injection so you relax and I can help you get home." He turned and I injected him. The whole town said I was using supernatural powers: "How?! A man they couldn't concur and I have come and he is willingly taking the injection." They saw it!

I: **You have lots of experience communicating with these people...**

R2: Yes. You have to come down to their level. In the community, show him love, show how you care. Show you are not with the people who are mistreating him, show him you do not think of him badly. You care for him and he will open up. [laughs]

I: **When you go into a school or a church, what is the reaction to your education?**

R2: The churches, the pastors believe that they use God to treat them. We are sad because we all believe in God. But we go to educate them. Even if God is causing it - if a man cannot sleep, let us give him sleeping tablets to rest, because he needs rest.

I: But you would be gentle?

R: No no no. You don't refuse or reject what they are saying. You have to be with them at their level in order to gain access to do what you want to do. You say, "God has caused this - ok - you help him through prayer but let me help him with my medicine too."

R2: When I was working in the ward there was a man who had been at a church. He was very restless. He had been kept in there for a week and he wasn't calming down. So we brought him in. He was very restless. We said, "You haven't slept well for several days- we have something that can help you relax" he wouldn't take it, after some time he did. The next day the pastor of that church came to see him, he asked us to give him the drug that had made him sleep, so he could give it to other people, he had other patients that needed his help...

R: Even we have other pastors like that. We help them know what to look for. They come to us and we give them the drugs. They perform miracles!

I: Miracles! [laugh]

R: But we are happy if our goal is to get the patient well. If you want to say, "No, no, no, no, no - why should I bring my tablets to you" but then the patients are suffering...

I: You want to build bridges...

R: Exactly!

I: So it sounds like your focus is stopping the harmful parts of their practice...

R: Yeah- teaching them not to chain them, not to cane them, not to burn them, not to starve them... just talk to them and give them the tablets - they will be ok. You have your way, we also have our way... because sometimes when a restless person is removed from the chain and is well - we are happy!

I: Even if you don't get the credit... [laughs]

R: [Laughs] exactly. We never get the credit! I feel happy when a depressed person who has not come out of home for 8 years, they smile. It's so satisfying. I am very happy. I achieve those objectives. I am proud. An epileptic, very beautiful girl, somebody wanted to marry her, they came to me and said, "Madam- how do I help this girl get better? Can it be the devil" I said just have time for her. I taught him about epilepsy. How to care for her. How to give her her drugs. And to always show her some love. And to let her know God. They are married with two children! How much happiness is that!

I: That is great.

R: And that is a big change. People do not understand epilepsy. They think it's contagious, that the moment you touch her you have it. I had to teach them. I sit back and I am happy!

I: And you mentioned that you told him to let her know God?

R: Yeesss! God created us. Where will you have come from?! If Adam hadn't come... or you don't believe that? You don't believe that?

[the two women talk in Gha together- the word 'Brofunu' can be heard]

I: er...

R: We know that we have come in to the world because someone created us. We should worship the man. We should worship God.

I: I am a Christian, I was christened as a child but my faith is not something that I would ever talk about with a patient... I suppose I consider it to be private...

R: But how long have you been in Ghana? Have you been to church here?

I: I have been...

R: Where do you go?

I: I stay in Chokor... I have been to some around there, and to some in Korle-Gonno...

[inaudible- talking in Gha]

R: You stay in Chokor? This is not your first time to Ghana?

I: No I have been coming for 10 years...

R: That is good. You are a Ghanaian! We Ghanaians believe there is a god and we worship him. So if you are sick, he has made you sick, you pray to God to make you better...

R2: No! That is wrong. God doesn't make you sick. We believe in the devil... so God will heal us.

R: But the Muslims believe everything is by God... if God doesn't allow it, it won't happen. I am not disputing what she is saying, because it is true, but I am saying that as Ghanaians, we have Christians, we have Muslims... we all give thanks to God. For everything: happiness, sadness, ugliness, beauty, because he knows why... he knows why things happen at a particular time... if you believe in him, in the long run you come out the victor. That is the Christian belief...

I: And this helps you with your work?

R: Yes... You have to intensify your education. You have to demystify things. You have to teach people it's not a cures, it's not by the devil, it's a condition... that is why it happened... I believe in tradition but I believe in medicine... like my niece, who has been brought up in UK, and there she is a psychologist, when she comes to Africa, she will find it difficult to work with them because they believe in these rituals, traditionalism whathaveyou. In time she will realise she is an African. She will go the African way.

R2: You can't change that perception. You must work together, you cannot build walls between us. We must find ways of working together. The patient must be our goal. And it is the same goal. We have different ways of doing things. But the same goal means we can work together.

I: **Thank you very much for your time.**

R: oh. No problem- when are you going back?

I: **I am here for another month...**

R: Oh excellent. You must meet my son. He is not married. He would like you! You are a Ghanaian! And you know XXXX is my nephew?

B.16.15. Interview 6- transcription

I: **Erm I know we have chatted before, but just for the purpose of the tape can you explain your role here and the kind of patients you see.**

R: Okay. I am here as a clinical psychologist. I have XXXXXXX XXXXXX XXXXXX XXXXXXXX. And over here you see all kinds of cases, mostly alcohol, drug related. And then we see depression cases, we see schizophrenia and we see assessment cases, people who come in to erm, they come for assessment report. And some parents also bring their children in when they think that there is something wrong with their children and they want to find it is not mentally related. And we also see relationship, relationship issues, violence you know, abuse, domestic violence etc. And children sometimes related issues.

I: **And generally do people self-refer to psychology or the psychiatrist will refer to you or a bit of both?**

R: Both of them yes. Sometimes the psychiatrist refers, sometimes they come by themselves. But most of those who come by themselves are, you know mostly educated and most of them come in when they have been referred from the school. You know, and most of those cases come for assessment report for their children.

I: **Okay. Thank you. And how would you describe your main model of practice or the main, your, your approach?**

R: Erm it is mostly cognitive behavioural. And with erm sometimes religious, you know, aspects.

I: **Okay. Can you expand on that?**

R: Erm oh well culturally Ghanaians are mostly religious and we don't just, well I don't just start with the religious aspect, I start generally cognitive behaviour. And if the client is, the client is a client who has religious beliefs, then we can incorporate that here so.

I: **And how would you do that?**

R: How would I do that? How?

I: **Can you think of an example that you saw recently that came who was, you had the same religion and the religion was useful to you in a -**

R: Okay. This client who presented, well she was referred from the psychiatrist and she was diagnosed with depression. And she thought that erm she had sinned against her God so, and God is punishing her for what she has done. So I used the, she was a Christian, so I used the bible and I went into the bible to explain how God, God asks us to acknowledge our sins and we should, when we know that we have sinned we should come to him and confess and he is faithful enough to forgive us. So if the bible

or God is saying this and you have done something and you know you have sinned and you go to him for forgiveness. Why are you guilty about it again and you are letting it bother you? So that is how and it worked.

I: **Okay. Maybe it's useful to go back a step. Can I ask you to explain to me the different types of healers your patients might go to?**

R: Ok. Well fetish priests believe in traditionalism.... They believe in traditional African ways. Traditionalists. Er, the African way. We also have faith healers who are Christian - the charismatic churches more... they combine both approaches I suppose. A mixture. We have herbalists too that use special knowledge about the medicine in plants.... There are the herbalists and, and, and there are the faith healers (...) and yes, well those are the two main groups. Those are the two main groups I would identify and the herbalists are those who use purely herbal treatments to treat. And most of those who use herbal treatment, they have this religious aspect to it. And they know, and those who are purely religious in nature. So I think those who use their spiritual knowledge and gift as they call it to heal people and those who do treatment by herbal treatment. So these are the two groups that I know of.

I: **Alright. Have you had any clients like that? That would see a healer?**

R: No. Well mostly clients like that are schizophrenic. I had one recently. And then he was thinking that erm, you know he went to school and because he was so intelligent, one day somebody put something in his food and so it was a curse by someone in the school. But obviously he was diagnosed with schizophrenia, so I had one.

I: **So then how do you, what sense do you make of that, is that a cultural expression of a delusion, of a paranoid delusion?**

R: It could be.

I: **Do you believe someone put something in his food to curse him?**

R: No. I don't believe it.

I: **Can you remember the treatment plan for this man?**

R: Medication and psychotherapy.

I: **Did you work with him?**

R: Yes.

I: **And so how did you work with that belief?**

R: Erm I, when I worked with him he had so much belief in, I wouldn't say he had so much belief. He was very much attached to the mother who also had a similar belief so -

I: **She had a similar belief?**

R: Yes she also believed that the son was cursed by somebody, someone actually put something. So I start by psycho-educating the mother. And I believe that in the mother I am a stranger in the person's life, so the mother whom the clients believe, is able to

understand my point of view and is able to transfer the knowledge to their son, it is going to work better than me just telling you that I don't think what they are saying is true. And one thing that I, I also did was, I psycho-educated him on schizophrenia then I asked him to go and read more. The good thing was he was educated, so I asked him to go and read more on it as one of his assignments. So when I saw him the next week we discussed what he found and I was trying to find out if he still believed that, you know he was being cursed and he was like, well based on what he read, he doesn't think that. It could be one of those things, one of the symptoms so, and then the mother was also helpful in this situation. So I try to use people that are familiar with the client to kind of transfer his knowledge. I have done that with three clients or so... he was educated so that was helpful. And his mother was too. I think this way can work so...

I: **Okay. And you make a distinction that because he was quite educated and the mother was supportive -**

R: Yes.

I: **- that intervention was successful.**

R: Yes.

I: **Okay. And what about if, if a client was less flexible with that belief -**

R: Okay.

I: **- would you ever borrow any kind of symbolism or ritual from a traditional healing prospective?**

R: Okay there's erm this belief in erm, in erm the culture that if your soul or your spirit is weak, it is easier for somebody to put a curse on you. So if somebody believes that yes, she has been cursed, one way that I would go is "What makes you think that you have been cursed?" And if the person was able to curse you it would mean that maybe your spirit is weak. So what do you believe in? Do you believe in God, because maybe this is a time to ask for more strength from God to kind of, you know so your spirit becomes stronger and somebody doesn't erm put more curse on you. And so the person, I believe, would get to others start working for himself to build a stronger relationship with God, to build a stronger spirit. Than he just trying to believe that somebody has put a curse on me and rather waiting the anxiety and you know the depression etc related to it. So if I am working on myself to build a stronger spirit so that somebody isn't able to put more curse on me, I guess it is better than just going along in that way... it's empowering.

I: **That you would, you are kind of not challenging their beliefs -**

R: No. But I would focus on their relationship with, with God. So why don't you build that relationship to kind of. So here it is not that you are either putting your hopes on a stronger, I mean stronger power to help you than you trying to fight it and you, you

realise that some of them trying to fight it, they end up in erm religious centres that, where they do more harm to them than you know, just coming for psychotherapy and also working on your personal relationship with your God. You know, I think it does work better than trying to work it on their own, because they will try anything to kind of erm break free from the curse. And then, when, if most of them end up in religious centres, it gets worsened because then their belief of you know someone putting a curse on you is more intense you know. So it is rather worsening the problem than saying okay why don't we try this, build more relationship with God and let's try A, B and C to, to, to try to see if it will work better than you doing it on your own.
You need to be able to see what will work for each client. Some are more ready than others. One of what I do is erm, one of the ways I make the decision is whether the person is educated or not. If that person is education I would more go towards the psycho-education with you as somebody to find out more. If the person is not educated, then I would rather use them here.

I: **Is there anything that gives you clues? Are there differences depending on their route into psychology?**

R: Those who self, most of those who self-refer are people with you know, especially relationship issues and depression and stress. But, and some of, most of those who are referred from the psychiatrist and erm you know, their schools, they mostly come for assessment. And especially those with assessments, some of them have their belief that they have been cursed, especially children children with mental problems, mental intervention and autism they believe that, that the child was cursed. I had a case where the woman believed that erm he, she when she was pregnant she touched a boy with mental retardation, that is how she came to give birth to a child with mental retardation. So it depends on why they are coming in, that is one and also erm yes the reason for their coming in.

I: **Okay yes, it's too interesting. Do you think you being a Christian benefits your clinical practice?**

R: I don't think being a Christian per se. Because being a Christian sometimes you are, you may be judgemental, especially if somebody comes to me and says, I have had sex and I did abortion. You know my belief tells me it is wrong, I am more likely to say well that is so wrong so don't do something like that. I think it is more of the education that I have as a psychologist. But they believe that you, you know follow the lead of your client and try to understand them more than you imposing your beliefs on them. So it is not that I, I am coming to you with a Christian knowledge... I am trying to identify with you before I am going to about, you think what you have done is wrong. Well I will not even tell you that based on Christianity or based on my belief what I think what you have done is wrong or, I am trying to identify with you if you

are Christian, I will identify with you as a Christian. If you are educated, I will identify with you as an educated person. If you are not educated and you are a Muslim or a traditionalist, I will try to identify with you as that. So it is more trying to come to the level of the, the client. I believe that is what works better. Because I am sure they, they believe in Catholics they have Christians and whatever people who are also in the same beliefs with them and are being judgemental based on the bible, based on their beliefs. But when they come to you and you are trying to approach from a different angle by more trying to understand them, I guess it works better than coming from the religious aspect straight away.

I: **And as a psychologist, how do you feel about those treatment options? Would you be happy for a client to also be seeing a faith healer or a herbalist at the same time?**

R: If they believe in that, one thing that I do is to try to make them understand why the two is important. And the role that each of them play. And why they should not forget what I say to them for example, choose, the, the (... ...) a, a faith healer alone to psychological treatment. And I try to use the bible as a Christian, because the knowledge erm faith healers, wherever they get their spirit from, their power is coming from God. And the knowledge I have as a psychologist, I believe is also coming from God. So if you believe that God, I mean give both knowledge why don't you use both? And one method is always better than two, that is my idea. So I won't discourage you from going to the faith healer, but make sure the faith healers are doing the right thing. I will not erm prescribe a centre to you but whatever centre you have chosen, let's talk about it, what do they do? Is it helpful etc? There was a client who before he was brought here he was at the prayer camp. And according to him they beat them all the time, they don't give them food, they have to fast. So I was like okay comparing your treatment here today to faith healers, which one do you prefer? And the person was like here. Then why? And he was telling me both experiences and how this place has been more helpful than those groups. So I will not discourage you, but I will make you see and understand the advantages and disadvantages of both centre and to make sure you are choosing a good centre. Because there are some faith healers who make sure you have seen a psychologist and a psychiatrist as well as. So I would prefer you go to such a place than just anyone. So you try to combine all of them.

I: **You have experience of faith healing camps referring people?**

R: **Yes.**

I: **How do you know which ones are the safe ones and which ones are not safe?**

R: **Well you, I think erm one of the things I will do is, and we are being encouraged to do is to try and visit those centres to find out what they do, yes. And you can also get information from the client.**

I: **Okay.**

R: They will be able to tell me this is what they do or not.

I: **When you say you are encouraged to visit...**

R: Encouraged, our professors who train us.

I: **Wow.**

R: Because you can't escape from - you know, all the religious aspects so make sure you know what goes on there so if your client wants to go, you can say well these centres are the options, choose for yourself, make them see the good and the bad aspect.

I: **Yes and is that in conjunction with the BasicNeeds project?**

R: Yes. Yes. So one of the things, I have not done that before but I know one of my professors did with BasicNeeds is to go and give them education. Educate those centres the need for the two you know ideas coming together and one depending on the other. Because some of the cases, erm the faith healers cannot solve, so why don't you do your part but make sure other, you know what the client or patient actually needs is done. Such as medication and psychotherapy. We all believe in God and God is powerful so yes, treat God but make sure you take the medication and come for therapy.

I: **Yes. Do you think the faith healers ever offer psychotherapy?**

R: Yes. But not psychotherapy per se, it is more counselling. Some of them do, yes. They advise them, you know talk to them and some of them try to sometimes bond the family, tell them why, especially even though they are cause of the problem. For example if it is by drugs and try to advise them not to take the drugs because it is contributing to the problems. So some of them do talk to them.

I: **It's just I, I am interested in how you view these healers and it sounds like there is a big spectrum... it's confusing for me.**

R: Hmm hmm.

I: **Do some traditional healers treat mental health problems? Does it happen?**

R: It does happen but the problem is the comfort you gain. So then they end up going there all the time. It does sometimes but I believe that erm (... ...) it will come back again, it will come back.

I: **Yes. Because you mentioned earlier if this, if this attribution to their problem is reaffirmed, if they go to a healing camp that says oh yes I can definitely take this curse away, that is kind of strengthening that conviction.?**

R: Yes. Yes. Yes I think so. Because it will kind of erm you know relieve the person of the problem for the time being. And then, maybe the problem is still there, it has not been treated so it is going to make it worse. Because if I believe that yes, I came here and I was told, I, my belief was confirmed that it was a curse then it has been taken

away. If you go back and it happens again, you will believe that that curse is coming back or somebody is cursing you the more and so it is helpful and bad.

I: **Yes.**

R: Some of them.

I: **Is there anything easier about working with those clients than...?**

R: Erm it becomes easy if they are ready to accept what we are also offering to them. And if they don't buy into what we are offering to them and their sole belief is in their, their religious belief then you won't achieve anything good. So to me the advantage is when they buy into what you are giving to them. And...

I: **Yes.**

R: And one also good thing is if you are able to get someone in the client's family to buy into what you are offering them. It is easier for them to also help in the process. So I use that a lot, I always try to involve -

I: **It sounds like, and correct me if I am wrong, but it sounds like a lot of your clients will first go and try a healing camp or try another way of solving their problems and then they will come. So they have already had that experience, a kind of evidence to say, oh that didn't work so maybe I will buy into your way of -**

R: Yes it is not most of them but some do. Yes, some of them are like that. Let me see and try. (...) I have not seen anybody who think that the hospital is not able to help them but some will go to other places too, well in the case of a, especially with drugs, the thing that I have being a psychologist you have nothing to fall, not all of them, some of them. Some they believe that you don't have anything to offer them yes. And they don't see how a hospital could help them stop using drugs.

I: **And what do you think erm the future is as far as the roles of psychology and Western medicine and traditional healing? How do you see the future of the disciplines?**

R: I see that erm, (...) I think that education will be a good thing if all of them understand their role - the healers understand that, understand the roles they can play knowing that well if this is a true curse it is my field and if it is not a true case then I have to refer to this, these group of professionals.

So knowing, having that knowledge and that certainty that it is not everything they can do. It is not everything their power can solve, and willing to refer to the appropriate place would be a good thing for, for mental health. So if we were able to get to that point then I believe that we are helping them to a positive direction. But if it is not and you know, that I mean problems also because currently even the psychiatrist don't see the role the psychologists play and the faith healers think that it is, it is spiritual in solving the problem you know with prayers and fasting so -

I: **You said even the psychiatrists are still learning about psychology?**

R: Yes.

I: **A new exciting time for psychology.**

R: Yes.

I: **But you said if it is a curse, let the healers help them.**

R: Yes. Yes.

I: **Can you expand on when it is appropriate for the healers to help the client instead of us?**

R: Okay.

I: **I know it is a very difficult -**

R: I know. You see, this is Africa and I don't believe in witches and I don't believe in curse. But I know it exists. There are cases where (... ...) erm it does happen, well I don't believe in it but I know - as a Christian and as, with my level of education I don't believe it is possible. But I know it exists. So if it is a true, it is true that the person has been really cursed, the rituals can solve the problem. Fine. But I wouldn't be able to erm to know when this is spiritual because I don't have that skill okay but I believe that I know that it does exist. Yes.

I: **So to go back to the idea of the future or the ideal situation...**

R: Okay hmm hmm.

I: **Do you think Ghana will always need, (...) have a need for spiritual or magical interventions that only the healers can meet?**

R: I think so. I think so because people's beliefs and their faith has a role to play in recovery yes, when it comes to mental health. Even if erm the problem is purely organic. They believe that erm it is spiritual and that there is a pastor in the team and a psychologist in the team and a psychiatrist in their team, that alone has an impact, so I believe they have a role to play. So long as religiosity and faith is in our culture, that is what we can give.

I: **Okay. And that is kind of my next question is that. Is there something that psychotherapy neglects?**

R: I think that erm religiosity could be accompanied, could be incorporated into CBT for a culture like this. So incorporating both would be the ideal and learning from tradition more than in Western CBT. So for example in, in erm a restructuring, how we say restructuring, you could use religion to help in the process.

I: **What about for the non-Christians, or the traditionalists? Is there anything that should be included or integrated into our, into our way of working with clients?**

R: It depends on what, I would say it depends on their belief. If they believe that there is a superior power, they all believe that the God we serve is, well I think that every God will serve, though especially some of the traditionalists are (... ...) towards the

negative aspects in cursing people etc. But I believe that God and higher powers up to be more you know, positive and erm yes I believe should be more towards the positive angle than the negative. So bringing the positive aspect in it will be more helpful in that sense.

I: **If you were in charge of the hospital, would you employ traditional healers?**

R: I won't do.

I: **You wouldn't?**

R: I would do.

I: **You would?**

R: Yes. So that the clients who believe that that is what will help the person. If it was me, so I would, I would incorporate it. In a way that we keep our disciplines separate. Yes. Yes. In a way that every professional knows their role so that if, and it is more often, a multidisciplinary approach, it is a multidisciplinary approach so that this professional is playing their role and that professional is playing theirs at the same time. So it is like they are tackling a problem from a different aspect. I would do that.

I: **Interesting.**

R: Yes. Yes.

I: **You mentioned that your professors encouraged you to go and visit these places and, what do you think or how do you perceive the attitudes of the traditional healers?**

R: Some of them are welcoming, others believe that you don't have a place you know. You don't know what they do and you have no knowledge. So if you, it depends on the centre and their ideas and, I think their motives. If you get those who believe that you know science and religion can work together like this. You get centres like that, you get others who think that is only towards the spiritual aspect, so, and they are not welcoming. But those that believe in the two are more welcoming. So personally, I would want to know more about those because obviously I am coming from the scientific background (laughs) so I would more want to know more about those who combine the two so that I will not have to maybe help, that is what is going to be helpful for that client. Yes so erm it's, it's hard to know the difference if you have not actually gone in to find out what is actually going on there. So I would suggest that or I think the appropriate way is that erm the professional, the psychologist find out what it does those centres and find out what is actually going on. And maybe you collaborate with them to work together and, but those people who think that they are doing their job, they are doing the same thing, I think they should be brought into the picture.

I: **Okay. My, my last questions are really about the situation in the UK because we have a kind of melting pot of different cultures and religions and belief systems.**

R: Okay.

I: Do you have advice for working with an African client whose beliefs might seem more foreign to an English colleague?

R: Erm may be you can learn about them and try to erm learn about the beliefs of the person. Sometimes you can learn it from them if they are willing to share it with you or you can go and learn it on your own. So I think trying to learn from them, trying to like, how do we put it? (...) Trying to understand them because most of the time people don't like it when you impose your beliefs on them. So okay I want to know about you, are you, why do you believe in this? Why do you believe in that? It is easier for the person to also listen to you, yes so I think that you should start trying to learn from them and trying to understand them and their, and then it is for them to give you what they know or what they believe in.

I: I am just curious why you think African-centred therapy is not more popular over here...

R: I think it is our training. We are trained towards, you know to all this foreign ideas that Afro African experience and their issues. We are taught to practice and to be, even though we try to bring in people with their traditional beliefs and ideas. I think it is because of the training we receive because well, our professors will tell you that you should try to understand the belief system, just like a part of it, but not the main thing. The main thing, the main ideas that is important to use more of the foreign ideas. Everything we read about is foreign. So it is the training.

I: Okay. Do you think it is beneficial to pair psychologist and client in terms of their religion?

R: No. I think it is unethical.

I: It's unethical.

R: Learn to work with everybody just... If someone is a Christian I will only disclose that I myself am a Christian if I want to use that as a tool, as a part of my you know intervention. Otherwise, then it doesn't come in.

I: Yes. Have you ever prayed with a client?

R: No. If that is what you want, then I will do my part but you have to go to a pastor to do that. I also encourage them. God listens to everybody so if you believe in that, you can pray, you know you can come together, draw a timetable, you can come here at this time, you can do that at that time. But I wouldn't pray with them.

I: Thank you. Are there any other examples you would like to share with me? Or anything you would like to say at this point?

R: Hmm. Well I had a client who, yes it was a cancer and one of the leukaemias, and she needed blood transfusion and she was a Jehovah witness and they don't receive blood. So and I was called in, it depends on the client, you see. And I was called in so I sat

with the client and we went through why she wouldn't take the drug, the blood and then she gave me her reasons and I was kind of going through the situation with her. And the next day she received it. So I think that first of all you should try to well, talk to the client and (...) kind of do some counselling. And I had another one who was sure she wanted to see a healer to remove her sickness, she didn't want to have an operation... so we had to let her go for it. So I think it all depends on the client. You do your job as you should do, well, and then still the person wants to go to prayer camp it's, it's their choice.

I: **Yes. Okay. But it sounds like you are saying the main focus for us should be that building the bridges with these other sources.**

R: Yes. Trying to grow it, to work together. So that if the person goes to the prayer camp and we have an alliance with the prayer camp, and the prayer camp knows that the cancer cannot be treated with prayers alone, he will be able to pray, let the person understand that prayers is good but you need to go and take your drug or you need to go and have your surgery. It is going to work better than saying that , surgery and you don't allow the person or you restrain the person, I don't believe in that. So I believe in you know collaboration, everybody coming in, knowing their role, it is going to work better.

I: **Thank you very much.**

R: You are welcome. Am I done here?

I: **You are done.**

R: Great.

I: **Thank you.**

R: You are welcome.

I: **Was that okay, are you ok? Have you got any questions?**

R: It was cool, it was cool. I don't normally think about it that way...

B.16.16. Interview 7- transcription

I: **Thank you very much for giving me some of your time. Just for the purpose of the tape, can you explain your role here and the type of clients you work with?**

R: Um, well, I'm a clinical psychologist so that's what I really do here. Now we see cases, a few walk-in cases, self-referrals, people who come in who know that there's a such a fac, er, facility available. We also see children who have been referred from the XXXXXXXXXXXXXXX, for us to assess the children for placement in school, and then we see cases from the wards within this hospital.

I: **And what's the sort of presenting problem, the ranges of clients?**

R: Okay, we see a lot from the wards, especially, a lot of substance use disorders. We see a lot of children with special needs from autism to mental retardation. Those ones generally require assessments for placement in schools and some of them require further, er, assistance, maybe with behaviour modification or some other skills training or something. Those are really the cases, we see a few cases of marital discord, but those are not too many.

I: **Yes, okay. And what's your, how would you describe your model of working, your approach?**

R: (Laughter). For me, CBT works, er, it works really well for me, because I found that it usually involves, easier, sorry, to explain some of these emotional or cognitive things and how they manifest in behaviour or in other physical ways to some of our clients, because if we keep it abstract, we keep it, yes, abstract—

I: **Yes.**

R: - then it's difficult for them to see how it applies to their lives, so when we are able to, to show them the, the, to conceptualise their problem for them, it helps them that, in their treatment. Yes.

I: **Mm-hm, alright. What I am interested in, as you probably read a little bit, is the clients who attribute their difficulties to non-psychological explanations.**

R: Yes.

I: **Have you ever worked with a client...?**

R: Yes. Yes, we get quite a number of cases like that as well. Um, a few cases where people, people hear voices, or their auditory or visual hallucinations, they attribute it to a revelation from God or some other spirits or, um, it's almost always spiritual. It's not, if the person is not Christian, they still believe it is some god that is communicating with them. And sometimes you find that

the families also think the same, so sometimes by the time they get to you they, it has been going on for some time. It's when they start getting destructive, or harming themselves, then they come in, but most of the time they believe it's not a, er, er, a health, a mental health thing, it's a spiritual thing, so their first stop would be the church or the shrine or wherever.

I: **Church or shrine... They are different healing approaches?**

R: Yes. Yes and no. The shrines - that is traditional healing. The fetish priests, the many gods and ancestors that have power. The church - they talk of God and his powers to heal. But they can be similar. The newer churches are still African...

I: **So the main types of healing approaches...**

R: There are the traditional. They are the first type. The way of healing in Africa for a long time... there are bonesetters and fetish priests and juju. Then there are those that use purely herbal medicines, tonics and plants. Those herbalists. But there are those in churches too that say they can heal. They call upon their gift from God to help. They talk and pray and sometimes they offer healing... so those are the main types but there is a sort of mixture. The people will see many healers, they do not just go to their one church.... It depends on what they believe will help...

I: **And so then how do you work with those clients?**

R: Sometimes it's difficult. Not sometimes, a lot of the time it's difficult, because, um, we, we need to, we usually work with them, their beliefs. If, er, just a random example, if you have a client saying for instance he believes people, someone in his family is attacking him spiritually, trying to harm him or preventing him something, feeding or something, changing that belief sometimes is difficult, so in a case like that sometimes what you could do is help them to work within that belief. Now they would do that by say, by for instance saying, "Well, fine, somebody you, somebody is trying to do this to you, but what can you do for yourself, to, to guard yourself against the person's attack working?" So if it means going to church more often, you encourage them to do that. If it means meditating more often, you work with them to do that. You know, things like that within that belief, so that they don't feel quite so helpless.

I: **Okay, sorry, is that to keep the power of the curse reduced, you mean?**

R: Exactly, so that if they believe that this curse is what is, someone is zapping them in some way, you can't, you can't, er, we, you try and show them - you can't really affect what someone else is doing, someone else's behaviour. You can change your behaviour to, to, to shield yourself from, from these powers, or

these curses, that they are bringing your way. And then we found out sometimes it helps, it helps to reduce their anxiety or their worry.

I: **Okay.**

R: Mm-hm.

I: **Can you think of an example of a client that attributed their difficulties to a curse or a vengeful god or bad blood, that you were able to work with?**

R: Yes. Yes. Er, there was one – can I give details? Not too many details.

I: **Yes. No identifying...**

R: Yes. There were, there was a case of a young man, a young boy actually, who finished secondary school and apparently in his school, what he believed was that there were (...) cults they were inducted into when you enter the school.

I: **Mm.**

R: And that when you were leaving, your job is to, um, recruit more people. So you go and spread the word, so to speak, about what they do, in the cult, and he believed that he was at risk because almost all his friends apparently had joined that cult, and he was worried, so he, he couldn't study, he wasn't eating, wasn't sleeping, you know. So someone like that, we started working with him about what to do. He, he was a Christian, and believed that he could be guarded by God and the Holy Spirit, so we explored what things would he need to do to ensure that he, you know, he's working right with God, for him to know that God's presence is around, what, how can he utilise the Holy Spirit's presence within him, things like that. So we worked with him on those things and, yes, and so he believed in speaking in tongues and rebuking things and you know, things like that, so we worked with him in that area. Um, sometimes—

I: **Sorry, can I just ask you—**

R: Yes?

I: **Was that really happening with the cults?**

R: Er... As someone were able to find out, there was such a group. I don't know if it could be called a cult as such, but there was a group in, within the school. When the new students come in, they sort of get—

I: **Like a gang?**

R: It was something like a gang, exactly, but given the way our society is, they do, they do some funny stuff that they think is spiritual, pour libation and they have this figure that they leave food for, thinking that it's a god and he would eat it and things like that. So it was, that was happening within the school, and they, we knew they recruited new people as well. We weren't able to determine whether he himself was being recruited because it's really done underground. It's very hush-hush. So yes, from all indications, he was, he was right, so to

speak. He was put on medication, anyway, by the psychiatrist. Antipsychotic medication. But for some time he didn't get well and they didn't think it was helping as much, which was why they referred him to the psychologist.

I: **Okay.**

R: His mother brought him - well, the heads of the school called his parents because he wasn't eating, he wasn't sleeping, he was really jittery and, er, talking in class, you know, and things like that, so they called his parents, and then the parents brought him here. So for some time he was being managed solely on medication by the psychiatrists, and then eventually they referred him here.

I: **And as a psychologist, your role was to increase his perceived resilience?**

R: Exactly.

I: **To these—**

R: Attacks. Yes.

I: **Spiritualist gang or whatever they were.**

R: Yes. Because if you were, apparently if you were recruited or they tried to recruit you and you resist, you go mad. That was their belief. You, they, they believe you lose your mind and you can't study and you eventually have to leave the school and things like that, so he was really worried about that.

I: **But that sounds like a belief that his whole class shared with him.**

R: Er, yes. How strongly they all believed in it, that would be difficult, that was difficult, because the others (0:10:11) they have a problem with it. We don't know who had joined this group, we don't know who was scared of ever joining, because nobody, nobody talks about it.

I: **Yes.**

R: Yes. Nobody talks about it.

I: **And how did you work with this client?**

R: I think in his childhood, um, that their, the family was a bit dysfunctional. The mother was, I think, the third wife of his father. He had two other, um, wives, they had as well a whole lot of siblings, father was abusive, an alcoholic, um, he always felt worthless, like he wasn't good enough to do anything, and so he felt he couldn't on his own resist these attacks, or, yes. To some extent we could say, we could see it as psychosis, we could see it that way, but at the same time, it was a person with low self worth and there was some evidence to support his fear... how do I even put this, er, because we don't have all the information on what's really going on in the school, what we, all we had to work with was what the boy presented with and the little bit of information I was able to get from some of the others in the school, even though it wasn't as

detailed. I didn't think he was psychotic... Um, I did believe - because there was no other incident like that, no other history of any psychotic incidents.

I: **Mm.**

R: No... there didn't seem to be anything else that would lead me to suspect it could be, was schizophrenia or it could be any other psychosis. It was just the isolated - not isolated maybe, but that particular incident, that brought up these things, and they sometimes seemed to all be related to this group or gang or whatever it was. So, um, even though initially I was thinking, yeah, it could be, he could be a paranoid schizophrenic or whatever, I don't think that was the case because of the other, because of his beliefs, the other things that came in, what he believed could be done to him and what he believed was actually happening, you know. Given that five other people, um, they had testified to the fellow, this group or this cult did this and that and like, the libation and the, all the other spiritual stuff.

I: **Yes.**

R: It may be a sort of mind-play, but it was what they believed.

I: **So that's interesting, but just on your own, you were able to increase the power he felt he had against them.**

R: Yes. Yes. Um, not just me, we had to work with his pastor as well. His mum worked with the pastor. Um, for them to, to make him feel like he had more of a spiritual strength.

I: **God's protection?**

R: Exactly. And that their Holy Spirit was giving him the power of, what was the word that he used? Not, you know, the, this kind of resilience, that was his special gift, that it had been revealed to this pastor that that was his gift. So he could do anything, he could declare anything and it would come to being, and you know, that kind of thing.

I: **Okay.**

R: Yes.

I: **But you said "We worked together" - How did that come about?**

R: I'm not sure I understand.

I: **You mentioned that you were working -**

R: Mm-hm.

I: **- with the boy, increasing, challenging his beliefs.**

R: Yes

I: **But also the pastor -**

R: Yes.

I: **- and his mother?**

R: Now, what happened is, if I understand you correctly, I, I started trying to help get him to challenge these beliefs, but he didn't trust me as much as he trusted his spiritual leader.

I: Mm-hm.

R: So then I had to bring his mum in and get her to work with the pastor. Er, I met the pastor in one session, but the mum was working more with the pastor to, you know, let the pastor work directly with him to show him what kind of, what kind of strength he had to resist.

I: Great. So you suggested the mother and pastor come -

R: Yes.

I: - and meet you. With the patient there, or...?

R: No. We saw them without the patient. Yes.

I: And what did you tell the pastor?

R: Yes well... I had to explain to the pastor that this was the situation. Those ones were a little tricky because the pastor himself believes the spiritual, you know, but here was a case, in this case we were fortunate because this pastor was a little more enlightened and willing to ad, what's the word, acknowledge that other things could contribute.

I: Mm.

R: And so he realised that even though there is a spiritual aspect, it was manifesting in physical ways, and so he was willing to work with us to help him get, at least to stabilise him a little, before they move forward from there. The pastor was willing to work with us, that was the thing, so I had to get him to remember that even though he might see it as lying, he should think about the boy's welfare, and that if he does believe that, and if there's something that can happen, they do believe that the Holy Spirit can give you this kind of strength, so he should get the boy to, to see himself as possessing that kind of strength, and then...

I: Wow.

R: Actually at that point it was sort of a trial and error, because we weren't sure it would work. He was really, really, really terrified. You know. So, er, there were a few bumps along the way, but eventually we got, we got him to calm down. Yes.

I: And was that something that was quite a brave thing for you to do?

R: Yes and no. I discussed the case with colleagues. But it is, it is sort of normal to bring in other people. We, we sometimes speak to, if they won't come in, we go there to speak to their bosses or class teachers or, you know, something, if they

can't come in we will go to them. So it's quite normal, depending on the situation.

I: **Okay.**

R: Yes.

I: **And in this situation you described, being with a Christian pastor, what about cases where it's more magical or traditional in the...**

R: Mm...

I: **Have you had cases like that?**

R: No. Um... sometimes what happens is, even when it comes out as spiritual, er, Christian - excuse me - even if it comes out as Christian, er, you realise that they ha - some of them have been to some of these shrines and traditional places. So it's kind of both. Um, when, when they come to you, at least the ones I have seen, at that point, they're telling you it's all about God and Christianity and all of that, but in talking to them you realise that they have tried other things. They've tried to get charms and amulets, and you know, concoctions and stuff.

I: **Mm-hm.**

R: And then when that didn't work they went back to the Christianity. When that (coughs) didn't work then they came here.

I: **A last resort?**

R: (Laughter). It always is. Sometimes you find that even though the person is Christian, professing to be Christian, they have been to some of those other places. I personally haven't seen one that was strictly traditional religion.

I: **But a Christian who's first been to a shrine, or to a prayer camp, or...**

R: Mm. That is more common. People do not just believe in one thing here...

I: **Are there positives aspects of them having had that experience before they come?**

R: More often than not it is an obstacle, because sometimes, ah, a lot of the time, they get here worse than they would have been if they had come before. Because I'm told at least some of these prayer camps, some of these shrines, they are, they are tied up and they're beaten and they, sometimes there are cuts, and things like that. So the person comes in with so many other symptoms than the core thing. But, um, there are a few times when (...) they could, they may help because they, they, how do I put it, um, especially with anxiety problems, especially GAD, ah, it helps to pinpoint... it, it gives a specific direction to the worry.

I: **Okay.**

R: GAD where they can't figure what it is what it's bothering them, they're just anxious about everything, and you go to a prayer camp, go to a priest or a shrine or wherever, the person tells you it's your aunt in the village who is zapping you and then all of a sudden, the, the worry is focused. You know, on getting that person to stop what they are doing.

I: **Yes.**

R: So sometimes it helps because it reduces the anxiety, but then it brings up the whole new set of problems because now all of a sudden they are doing things to either avoid their aunt or to harm their aunt or, you know, things like that. So sometimes, once in a while, it may have helped, but a lot of the time, it causes more harm than good, in my opinion anyway. (Laughter)

I: **It's a very interesting point you make though, that if you believe something is a removable curse, versus, "You have a condition of generalised anxiety" -**

R: Yes, exactly. There are different implications...

I: **But there's a small positive there.**

R: Mm-hm.

I: **That means that can be taken away.**

R: Away, yes.

I: **But if you've, on your own, decided, "Someone's put a curse on me and this is why things are going wrong", I imagine that can be reaffirmed, if you go to a healer and say, "Yes, that's right, that's a curse."**

R: Exactly, exactly.

I: **And then they come to you much later.**

R: Yes, and then by that... And sometimes when they come, they don't come of their own free will. A lot of the time, those cases, they are brought here by family or the police or sometimes their church, a church that is, is, that has a good conscience. Some of the churches, when it gets to a point, they'll tell you they can't help you any more so you should go get help. So the person comes, not really believing that you can do anything for them, but by now my other avenues have been exhausted, so here I am. And then you're talking and you're trying to get them to, I don't know, challenge their thoughts or their beliefs or what they - they sometimes, they just stare at you. And you know full well that maybe this person won't return if you let them go, you know, so...

I: **Yes.**

R: **Sometimes it's difficult.**

I: **It's very interesting, isn't that, that it sounds like some of your patients, and correct me if I'm wrong, need to go through those other experiences before they will listen to you...?**

R: Yes. Exactly. They haven't been helped anywhere else, so they will try our approach...

I: **"Alright, go on, you can have a go, teach me the CBT, and give me your medicine."**

R: Yes. Yes. Yes! To be able to be willing to come, some need to see other centres fail... Yes, and most of the time that's the situation. Um, if you go to those places and they tell you they can't do anything for you, they come here, they, they some of them, and they, they've reached the point where they just want some relief, you know, so whatever I tell them to do they'll do. Those who still believe that, "Maybe I can try another prayer camp, or another pastor", they are the ones who won't work with you, but a lot of the time those ones, if they go, keep going round, and they're still not getting solutions, it's likely when they come, they'll be, they'll have a little more faith in us. (Laughter). Yes.

I: **But then I'm curious... what do you think would happen if they didn't get the opportunity...?**

R: To go to these camps...? Yes. I, hm. I, I wonder myself, because (...) like I said, sometimes we have to work within the belief, so possibly one, one solution may be to tackle it from the point of the religious leaders. If you tell this person, and you are the pastor, that you believe you can heal them, you tell the person, "I believe it, fine, I do think it's a spiritual thing, but there's a physical aspect, so do both. Go see the psychologist once a week, twice a week, whatever, and come, we will continue praying." If their religious leader's able to do that, I think there will be a lot of improvement. I think so. Because if we detain them and they still think that what you're doing is not what they need, I don't know how much we're able to do with them, or at least how quickly we'll be able to help them. Maybe when the Bill is passed we will find out...

I: **Okay. Do you mind if we go back a step? Could you please explain to me... the Bill will regulate all healers?**

R: Hm. There, I'm thinking of the, er... No, I'm told we shouldn't even be calling fetish priests, but those who have their gods, the smaller gods, we call them smaller gods, those who, um, sort of worship the deities and perform rites and stuff to them. Those, those are the ones that come to mind. That would be traditional healers, but we also have faith healers. Those ones usually talk about, um, the more charismatic kind of churches. The newer crop of churches. They, they are -

I: **The charismatic churches?**

R: Exactly. (Laughter). Yes, those are the faith healers. Um...

I: **And how would you feel about a patient seeing a fetish priest as well as yourself?**

R: Mm... Well... See, now I, my first answer would have been, I would prefer the faith healer. But these days, we're getting a whole lot of them who are (...) not very (...) what's like the, the correct term to use? They are not very concerned about the people they are working with. One of the main things about these traditional healers, the fetish priests, is that, um, they are bound by morals, a lot. You can't - they believe in karma. So what, a lot they do, isn't really to harm you, the person, but it's, they believe it would help you. Some of our faith healers these days don't really believe. They don't care, you know.

I: **Exploitative?**

R: Exactly, that's the word, yes. It's very exploitative. Yes. Very, very much. They care only about getting the money, or you to believe in them or something like that. The fetish people believe that if they do a wrong intentionally, it will come back to haunt them. So you know, they, they are bound by more strict morals than some of these faith healers these days. You would expect the other way around, actually, but...

I: **Yes.**

R: Unfortunately that's not the case nowadays.

I: **And what about the fetish priests that are putting these curses on people? My understanding is that if I have enough money, I can ask someone to punish someone.**

R: Yes. Those are really not the healers. Yes, those are...Juju men? Yes. What do they call them? They'd be called sorcerers and be juju men, yes. Um... But there's a difference between the two. The, the, the traditionalist shrine priests, and then these juju men. These juju men are the, oh, I've forgotten their name. It's an English word, so...

I: **Voodoo?**

R: No. Argh... It may come to me later. But their job is just to cause harm.

I: **Okay.**

R: Er, you pay them money.

I: **Yes.**

R: And then they, they give you charms or spells or whatever, but then the shrine priests are healers, and they are, they are sort of like spiritual heads, traditionally, of communities.

I: **Okay.**

R: So their role is to do good for people.

I: And do they work? Can they do...?

R: I don't... For our client group, I guess, depending on how much they believe. Sometimes they don't, they are not really required to drink any potion or anything like that, but they've given you a charm which would protect you from road accidents and things like that, and so you realise for the past ten years or so, you haven't been involved in any accidents, those kinds of things, they believe those things.

I: Okay.

R: Er... on the other hand you could say maybe because they are more careful, you could say it's because, I don't know, it could, you could find another explanation.

I: If someone had generalised anxiety disorder and they believed that a bracelet would keep this curse away from them, is that ever something that you would use in your therapy, or refer them to...

R: To someone...

I: To someone that would...?

R: I don't think so. Um... no. I would say no. 'Cause, unless... no, it still comes back to no. Because I can't verify whether this person is ethical, whether they really know what - I don't believe in these things, so I wouldn't be able to tell whether they really would be able to help you or, you know, things like that. I wouldn't refer somebody... If the person believes in it and already has someone that they feel they can go to get this thing, this bracelet or charm or whatever which will protect them, and they are determined that that is the only way, um, they can get better, I may, um, suggest that they go ahead and then we review. But I wouldn't, I would try other things first. That would probably be my last resort.

I: But it sounds like again, if they had the opportunity to gather that evidence for themselves, test out treatment options themselves before they can have confidence in -

R: In what we are doing, yes. That's the unfortunate thing, but... I'm not sure but maybe things will change with education... I don't know - we still have some very educated people that will go back to the old way if they feel they need to- doctors, teachers, educated people...

I: Traditional healers - herbalists, juju, fetish priests... Will they always have a place?

R: I think so. I think so, given that the way our society is, as, in as much as we are, we are at least trying to be more modern, to be more technology-based,

scientific and all of that, the, our, we are still holding on to a lot of our traditional beliefs and I don't think that is ever going to change, because you find that, um, people who do believe in, in science, in medicine, whatever, actually you get doctors, I had a few cases of people telling me they went to doctor upon doctor and nothing was happening, the doctor told them from the looks of things it's a spiritual thing, so they should forget about the medicine and go look for spiritual assistance. And so, even those professionals believe in those things, you see, so I don't think it would, it would ever change. However, I do think that with more enlightenment and more education and things like that, people would come to see at least to some extent, the use of psychology, such that some things can clearly be seen to be psychological. That you would need the help of, or a mental health professional, even if not a psychologist particularly, but still some aspects of it will be seen to be spiritual. They may be able to work, we may be able to work hand in hand with them at that point, but they, I think they will definitely be traditional healers for a long long time. I think so. (Laughter).

I: **Interesting that doctors have the same parallel belief systems... Do you think Psychology in Ghana will focus more on spirituality in the future? Or would you, do you think the future should be that we do what we do and allow...?**

R: Them to do what they... Oh, no. I think, um, it would be better if there's a merging of those two areas, or those two roles, because it's, it would be more effective or efficient for a client to see you and get the complete, er, treatment he needs or help he needs, if it's physical or spiritual or whatever. But having said that, um, I don't see us being spiritual, zapping kind of people! (Laughter). I don't know about some of my other colleagues, but personally I don't see myself doing that! At the same time, I think that, um, we could, we may be able to incorporate some of this within methods like CBT, um, if you, if people believe that some of the thoughts that they're having and things like that are revelations from God, or, um, the Holy Spirit or something like that, you could work with them, that it is in your head, but where's it coming from?

I: **Yes.**

R: It's coming from a spiritual source and things like that, so we could w - we may be able to incorporate some of these things in, in our treatments.

I: **What about religion?**

R: Yes. I am a Christian. I believe God helps me serve my patients.

I: **Is that ever something that comes up in the therapy room?**

R: Um... Rarely. If ever. I have brought up religion sometimes, when I realise that the person is, also is a Christian and, um, they are believing that - well, one case, somebody believing that he, he was asked by God to do something. He wasn't able to do it at all, or, well, no, he wasn't able to do it properly. So he thought he was going to hell, because what he had been asked to do wasn't working enough. I've used religion scriptures that I know, which talk about forgiveness and a second chance and things like that. Um, to help. I've had one Muslim as well. I don't know the Koran at all, but then I do know a little bit about Islam, so one Muslim person who came in and believed something, um, to do with his religion, and I was able to, again, give evidence to show that, er, he wasn't completely right in the way he was thinking. So in those cases even though I used the religion I had rarely disclosed my religion. I just use it to help me get to them. But personally, I, I, I think that, um, it's, its better if you don't cloud the session with your views. I always try to get it to be the, the patient or the client's beliefs, or his opinions or whatever, so that it isn't like I am telling them to do something, but I help them to realise it themselves, so I rarely talk about myself, anything to do with myself, in a session. Yes.

I: What's the future as far as these quite different disciplines?

R: Yes. I'm not sure I understand you.

I: What do you think the relationship between traditional healers and psychology will look like in the future?

R: Mm... yes. I think more people might come to psychology earlier as more people learn about what it is we do... and that the relationship between healers and ourselves will somehow get stronger. We need to think about the patient. Actually, I think both. Now the, the more education people get, um, they are likely, they are more likely to come see me, us first. On the other hand, if, if the what do you call, the traditional healers or practice, those who practice the, are also educated a little better, their services could also improve so that they work better with us. So I'm thinking that the future should be one where we are both working together, because we can't change the, their belief systems. Not as easily, but if we're able to work together so that the person gets complete care, then, er, then there's a more positive future ahead. So we definitely have to find a way to work with them, and them with us, without disregarding each other.

I: Yes.

R: Mm-hm, but, I, I don't know. A lot of them are very sceptical! (Laughter). They call it the white man's treatment, or system, and say this is our African way, the local, the black man's way, you know, so you should do it like this, or... But then a lot of people are now seeing, it, are seeing things differently. So they

would probably try both or at least come to you as a last resort, something like that, yes, so I think I definitely would have to work together at some point.

I: **Does your training involve learning anything about traditional and alternative healing? Do you have to visit a healing camp or learn anything about them?**

R: Yes, um, we were supposed to... It's what is usually done. You visit, you have one camp to see what they do. And a healer comes to the class some years...

I: **Oh, okay.**

R: But our year weren't able to do so. I don't know if the people that were after us were able to, but we do have a class on, a couple of classes maybe, on traditional healing and what, what they do, what you expect and someone who has been there, to present with, um, things like that, how you can work within their system. Yes, I don't know, maybe it's been changed, I don't know what the reason was, why we, for some reason we couldn't get that person. But we still had the classes with the professor on these things.

I: **And how was that?**

R: Yes, it was, I think a lot of these things, we kind of know -

I: **You already know.**

R: Yes, we grow up with these things being said and hear about them and things like that. A few things were included that I didn't know about, but what was really, what really struck me was the fact that they mentioned that most of the time, the only way you can get results is when you work within their belief system, otherwise you'd be hitting your head against a wall. You would be telling them one thing and they're doing something else, so if you work within their belief system, you could at least get them to a state where they are more receptive of the other things you are saying.

I: **Yes.**

R: Well that, that really helped, actually. Yes.

I: **Wow, I'm quite jealous of that, that sounds very helpful... Have you ever visited a, a traditional...?**

R: I haven't been to the shrines or whatever. I've been to a prayer camp. Er, actually, where I went wasn't, it wasn't as bad as some of the stories I have heard. They don't chain them or whip them or anything, so I've been there, but it's too...

I: **And that was just, um, for your learning?**

R: Yes, yes. I was considering doing a thesis on them, on some of the morbidity rates and things like, I was considering doing that, but... I had a number of areas in mind and I decided to stick to, yes, another area, but... So I went there

to see what they did there, I spent a day with them to see what they... This one I'm told was a little tamer, but some of the places, where the person, they are required to be up all night, they are required to be fasting all the time, they don't give them food, they are chained to trees, and some of them are really bad, I'm told. But this one wasn't bad, it wasn't as bad. It's, it's sometimes horrific, you know, because they, I'm told some of the places they, they believe that, um, they call it scarification. They cut you up and put some stuff under your skin and sometimes you are whipped, and pour boiling water or oil and stuff, all sorts of - they try to rid the person of the spirits... That's what they believe, so... mm-hm.

I: **(Sighs). Right, my last few questions are about the situation in the UK.**

R: Mm-hm.

I: **I was just curious, given your experience and training regarding working with clients that believe their mental health problems are explained by traditional African explanations - what's your advice to your English colleagues?**

R: Hm. To be - I think it would be difficult, because it's like a whole different culture, and sometimes even we can't explain, even though we, we sort of know, because we've grown up with these things happening around, so we don't have the words to explain. It would be difficult, unless you're able to get them, or a family, or someone close to them or explain, or to, yes, to, to verbalise what it is that they're experiencing, or what they believe is going on, because otherwise the person would say stuff that you are not relating to, at all, and then it must be like, you're saying one thing, he's also saying another thing, I don't see how it would work anyway.

I: **Yes.**

R: Unless the person, um, is, believes that even though we are coming from different cultures, what you are saying, I'm going to take that and use it. I don't know. (Laughter). I don't know. Um, on the other hand, there is this thing that we believe, some people believe, er, a foreigner can do things better than Ghanaians. So they may take what you're saying, um, even though it's not quite, doesn't quite fit in with their, their beliefs, they may at least try.

I: **Yes.**

R: I don't know how well it would work, because it's not what is really causing or what they believe is underlying the problem.

I: **Yes.**

R: So maybe getting, getting them to verbalise what they believe and maybe going back a little bit further to see what - not from the client all the time. From

family, from relatives or friends or whoever, who have the same beliefs. It's going back to see where it's developed from, or why they think it's so and things like that. I don't know, this is just off the top off my head because I don't know the situation.

I: **I was just really struck by your point that an important part of the process might be that they have the opportunity to come to us last, in a way, in some cases.**

R: Yes, yes, that's right.

I: **Maybe that's something that it's, it's quite powerful...**

R: Yes. Yes. Yes, that's true, that's true. So, um, in your practice there's no religion, or you don't work within those frameworks at all?

I: **I would ask a client about their belief system... But I personally don't think we learn enough about different health beliefs in our training.... We don't know what to ask...**

R: I am sure I agree with you. You should learn about different ways of doing things... you must know to ask so you know if they are willing to hear you... you can ask about risk... It couldn't, it wouldn't hurt, seriously (laughter). Yes. You might want to consider the, you could visit healers and ask, I do, and I'm sure you have those religious leaders there as well.

I: **Yes.**

R: At least the Christians, that you know about, so...

I: **I think they are acknowledging the gaps in our knowledge.**

R: Mm.

I: **But it's a tricky one, a tricky one to... and there's this air of mystery that there aren't books so easily on what traditional healers do -**

R: Do...Yes. Yes. It's passed down orally, to a, like a protégé or an assistant or so, yes, that's true.

I: **Yes.**

R: That's true, and actually that is also a problem for us here. Even though we know, okay, the traditional priests do stuff, we don't know what exactly they do. We've heard stories and stuff, so, yes. But then I think that if, if those people are, the people who come to you, if they say they are Christians, or they worship at some shrine or something, maybe it may be a good idea to get those people involved, um, maybe not healing, but at least for you to find out more about how they, they perceive illness, or... how you can get healing, or things like that.

I: **What about the future of psychology? Is there something that we need to be taking away from these treatment approaches?**

R: Okay, well, hm. That, that's an interesting... I think that, um, in some ways our role is defined, because psychology takes into a consideration a whole lot of things to, to bring them all together for each person. At the same time, sometimes for some of us or some of the clients that we see, they are looking for you to tell them what to do, what the problem is, what they want you to tell them, which is something psychology doesn't do, traditionally, but these priests would tell you, if you don't do ABC, XYZ will happen, you know. Sometimes it has been shown to help when they are told directly what to do, so that would be something we might consider, um, including in our practice every once in a while. But then it becomes a problem because the person could become dependent on you, if you don't tell them to do this or that or that then they don't know what to do and things like that, so we would need to work it out better anyway, but it helps when that's the situation. A lot of the time that's what happens, when they've been to their pastor or their sorcerer or their priest, they've been told they need to do this and that and that, even the medic, medical field, they've been given medication - "Take this medication on this day and that day and that day", or something, so they're used to being told, "You do this and that and that and that", and then they come to the psychologist and you're like, "Okay, what do you think needs to be done?" or, "Where do you think we can go from here?", things like that, then they know, they don't believe you as much.

I: Yes.

R: (Laughter).

I: Interesting, isn't it? Thank you very much for your time, I think that's all.

R: You're welcome.

I: Is that okay, is there anything you'd like to say at this point?

R: Mm, no. I would just really be interested in your findings.

I: Me too, yes! (Laughter).

R: Yes, yes, it's an interesting area, and I wouldn't be surprised if we could find a similar thing here.

I: Yes.

R: Ex-pats living in this country who don't quite get the help that they're used to getting from us here. There may be another, a reason that somebody— (laughter).

I: (Laughter) I'll turn the tapes off now. We have time for a chat don't we? Are we going to get some lunch?

B.16.17. Focus group- transcription

Thank you so much for agreeing to take part. So we have a room full of trainee clinical psychologists.

Short pause (00:00:12).

The first bit of the discussion I was hoping that you could explain your understanding of the different types of healers in Ghana... what do you think the different types of traditional healers are?

Medium pause (00:00:29).

Please speak loudly feel free.

Yes one of them is the fetish priest.

Okay.

Yes. Err, it is this because my part, where I come from we normally believe that when something out of the ordinary happens... then we believe something's strange is involved in causing that. So the first thing you normally do, after they have tried going to the hospital, then we consult their priest who tells them what the cause is. So we can see maybe the ghost of a father or a dead person who the person maybe mistreated or did something that could possibly be that the person stole an item and the gods were agitated and this is dangerous... So based on what the practice we see, then the same priest tells what should be done. So the person could be asked to maybe replace the items he stole or if the person has hurt someone or caused an insult he has to be brought to appease the gods so that the priest acts as a link between the patient who is suffering from this or that or what he has done, and the spirits. So the person is asked to perform certain acts. The sprits who are harming or causing the disorder, are then appeased after that, they did that the person would be well again. So that is what a traditional healer is.

Okay. That is one type of healer. Is that what everyone thinks of when I ask about healers?

Short pause (00:02:35).

There is also herbalists. They use natural herbs, tonics and some concoctions. To heal people...

Short pause (00:02:59).

There is also the Church. Well we have a strong belief in the Church so that even if the person does seek medical help we believe that the Church, we go to the Church and you pray or the pastor prays for you or you confess. Your spirit is, is absolved of that sin or whatever is causing this order and when it has taken place within the spirit then the doctors can then go on and administer their drugs and then it is will have effects in the physical... very simple but we believe we have to deal with the spiritual aspect of it, the physical aspect of it will not be entirely... we have a strong belief in the spiritual aspect of it.

Short pause (00:04:03).

Are there similarities and or differences between a psychologist and a healer?

Short pause (00:04:13).

Yes they are similar.

Yes

Yes.

Ghanaians go to our church or a fetish priest to talk to them about their problems... or something that is happening you know. And it is the same... we are also offering this service... some might go and see a psychologist, they are also solving your problem. But many people think that to help with their problems they must appease the gods... the therapies must involve spirituality... they must understand the cause... the priest will tell them who or what is causing their problems and perform something that can stop it...

The fetish priest can offer something differ... maybe consultation of the bones... they can offer an explanation of the problem.

So can traditional healers help people with mental health problems?

Yes.

Yes [multiple speakers].

Yeah it does. The answer is yes. We don't work the same way or in the same environment but it is about what happens between 2 people...

I think some do just talk...

I really think that whole concept of them being able to help mental health problems.. err, its, its, placebo... see... in that they talk to you, you believe it was for you. The same when you go to the traditional healer, rituals they perform, are all things outside the body is accept for bone setting, medicines or something to take or something... but apart from that they do it outside the body... you believe that what they are doing is real and as I said they come back changed.

So the patient has confidence in the healer, something happens and they feel better...

I think it is therapy.

It is therapy.

It is, well they have the, obviously there is the placebo aspect but it is therapy... I mean it is therapy because being able to talk to somebody who when they have the experience of something has the knowhow as psychologists do... we do it and we do observations and they do all those things as well, they do all those things as well and because, well they are more or less a part of us... the ecological validity comes in, they sort of understand us or they have been trained to understand us within an environment, within our environment so yes I think it is therapy, yes it is.

It is. [multiple speakers]

The only difference is that erm when they are seeing a psychologist you can decide to default... Psychologists they don't charge that much and you don't have to agree to go many times... but

if you go in and see a spiritualist who has started the process it has given you the thing that you have to do to come and appease the gods... to remove the punishment for the sins that you have committed and you default... that one carries a different outcome... things will get worse. So for spiritualist we cannot default, once you've started you need to go through.

[multiple speakers]

Even with that I think it has to do with a certain trained spiritualist, it is not all of them.

[multiple speakers]

I think most of them act, you know where we have the payment system where for instance after you have seen, you probably make payment before you see the therapist but in this instance sometimes treatment is initiated and then while treatment is going on they tell you, "The spirits say they want a fowl, the spirits say they want this or that, the spirits say they want a goat" because after everything their spirit is demanding that so you give a sacrifice, like after every four years. So if you default the sickness is likely to come back. So you have made a commitment. So once you go to a spiritualist for help it is like a lifetime thing, so that is one difference that we can put across between psychology and then the spiritual process. Most of them will ask for something, it is not free, you will definitely have to give them something, you don't come in and pay for instance 40 Ghana cedis you talk and then you go... you do some sacrifice and if you default the consequences are going to be probably worse than what you brought.

Just to come in... this payments are part of it. I don't think... ok so the patient will go to collect the animals or go to the shrine or wherever to make payment... I see them to be part of the process, the treatment process. Just like the therapist can give you a number of sessions to attend, you default you may not heal. So it applies to the spiritual healers too... so that you need to complete it, so if you default it will not work for you. So I see it to be a similarity.

I think there is more of afraid to default because they operate on the fear principle... they put some fear in you. So you go in there, you seek treatment but you know that you owe the person something. You, you, in a clinical setting you develop a relationship with your therapist sometimes, you don't want to let a therapist down because you developed that fear. But in this instance it is fear, you are just too scared because the whole environment... they will operate on the fear principle.

(multiple speakers 00:10:14).

That is why they are different.

I think they also perform, I mean psychological treatment you can default... you can reverse your progress but you can come back... or progress.

But then with traditional healers I think the fear of default is worse... because our system believes in their power... they are more like a god... and we believe that our communication, I mean when it comes to mental health issues it has to do with a spiritual entity. So more or less that is why most people if he is talking about default that is where most of people wouldn't like

to default when it comes to looking at fetish priests, when it comes to psychology or a psychologist it is much easier to default. Because with them they are perceived as more or less like a god. My life or my status or everything depends on this traditional healer.

And then –

And then to add on that I think it can also serve as markers. These are the things that need to be within every four years. So you know that these are the things I am doing, these are the things I am supposed to abstain from. It all sort of works together, these are my markers, I know there is four years, I am doing these things, these are the things I am abstaining from, a sort of –

Checker.

Yes as a checker and it also evolves there.

Kind of like a care plan...

Yes.

Yeah to add to what they've said... going to a shrine like this once a year to renew your contract or whatever serves as more like a booster session...

Exactly, exactly.

But the thing is in the traditional setting if you miss the 'booster session' you definitely pay for it and I can give a practical example of my uncle. His father died, but his father was part of this traditional healing, so he died and the ritual was meant to be performed yearly so his first born son died, then his brother's first born son also died and it went that way three through the family so they had to see a diviner who said he was part of this ritual you people were not performing, and they performed it and everything came out alright. So these things we say sometimes are not true but they exist and the traditional power it really works, it is not more like a placebo.

There is another thing that they give, traditional healers give advice unlike psychologist, they say do this don't do this. A psychologist doesn't do that so I think that is a difference.

I, I, somehow I don't agree with that whilst giving them advice. They might, what they are doing might not be able, you might not be able to quantify it as a psychologist but then I believe there is one thing that has been passed on from years and years of trying a system, doing away with it trying the system and then somehow one system works for us and then we stick to it. So even though you might not be able to quantify it as a psychologist I believe that within their role it is a bit more than just advice that I would give you.

Fine. In the same way like psychologists do we look out for a problem, we find different solutions to the problem, we present it to you, they decide, I think this is much better for me but the tradition is that "we don't eat this, your grandfathers auntie is causing this view stay away from her", that is strictly advice-giving, it doesn't give you an option, it is direct. Psychologists don't do that. We give you so many options, if you do this you get this, if you do this you get that but a traditional healer -

No, some theories believe in giving advice.

Yeah traditionalists [laugh].

No. I mean some psychologists can yes.

Some but not majority of them.

Yeah.

They have differences in models of therapy.

The same with traditional healers... we are talking about one line of traditional healer.

Which ones?

You are talking about the fetish priest.

But when we say traditional healers we can't -

The reason why the fear principle works here is that we believe that our spirits are not only responsible for our lives as we are living, but then they were responsible for our ancestors, and are responsible for us now and there are those which are here can do harm. So if you do anything against them right now it will carry on to your generations and those after, that is why we try not to have any problem with them... how we approach them. So we try to obey what advice the traditional healer or fetish priest or the spiritualist or whatever will give us to not disobey the spirits.

Okay. Then erm, one similarity that I have observed between the traditionalist and the psychologist in Ghana here is that normally we go the hospital with our families and then so we are able to find a solution to it then we either decide depending on our level of education into certain things we go to the traditionalist and the psychologist. I for one, personally, would go and see a psychologist but I know a lot of people that would go to a traditionalist because they might not have not have knowledge about psychological practices... and so in this way it branches... it starts at the general hospital and it branches, one goes to the traditionalist and the other goes to the psychologist and then from here the difference is that the traditionalist, we see we don't have documented research or evidence on their practices. Even though they would say they have evidence, people have heard something about what the healer did for someone they know... so you can't say this to the community... the people believe there is good evidence but it is not written, it is not documented... like we are aware that those that work as a psychologist, are well documented and you can always go and read about them and their practice.

So in other words what you are trying to say is that the last resort to most of our problems which we don't find in general information or cure about in the medical setting, we tend to see the fetish priest or psychologists.

Do you agree that people normally go to the hospital first?

Yes. [multiple speakers]

No. [multiple speakers]

[multiple speakers 00:16:24]

No some come from the traditional healers, when it is getting worse. Sometimes on the verge of dying then they send the person to the hospital. So in most case they believe in that, they have to first take the sick to the ritual healing before any physical healing.

[multiple speakers 00:16:53]

But don't forget that the majority of the masters are in the villages or far away from this place and therefore because of lack of education they still believe that even if they said "this is a mental health issue" I still have to consult the traditional healer, so that is also one...

I think that [multiple speakers 00:17:13].

Interesting!

I think you can't say it that simply, but it depends on the person's worldview. If you are very educated...

[multiple speakers 00:17:24]

...depending on their belief system, whatever it is that is worrying them, what they think the cause of that problem is. Many educated people would visit their church before going to a hospital....

I think that is [multiple speakers 00:17:38]

What they know you don't know.... so you are not able to offer treatment in that area...

Yes. [multiple speakers]

You are not saying to me this is not true...

No.

No.

Prior to the scientific age and prior to the hospital system our people had a way of connecting with God. My father for instance told me that his great grandfather had some spiritual powers that he could do very wonderful things if you just touch his knee your pain will vanish you know. So as an African you grow up with such things. I know that as an African I am unique, I am special. I have certain abilities that somebody doesn't have and I am educated but I believe in certain African things, it doesn't mean that when I get sick I am going to go and see a herbalist or anything like that but I still have certain African beliefs that are enshrined. So it doesn't matter what level of education the person has, it is the African system, it is the belief that has worked for our forefathers... you hear about great folk laws, very great things that leaders have done before even the chase system. So you hear these stories and you hear how people were helped. My father tells me that even you have a broken skin all his father has to just touch it and then it will come back together and that is a man who is very educated, and you won't see a herbalist but we believe that. The people, our African people have certain powers, God gave all of us something so they have the powers to heal even though, the people are not very qualified to do these things but because they are believers they tend to sort of deceive people, but they are very genuine people who do proper healing. But because of the changes and the supposed westernisation it is a bit funny these days.

It sounds like you are celebrating a uniqueness. As trainee psychologists is there anything to integrate or to take away from the African belief system? You made a very convincing argument but I know you are all choosing to use CBT.

[multiple voices- laughing].

It is a challenge for us now.

Yes.

We need to do a thorough assessment to see what the person believes in. We will, is that we have to, form the collaboration with this traditionalist so that we can seek their opinions or reflect or how each one of us would practice...

So you think a relationship between the two?

Yes [multiple voices].

Yes.

Does everyone agree with that?

Yes [multiple voices].

Especially in psychology where it is not a quick fix, it is not a quick fix like the doctors and the nurses and for a big chunk of the so-called educated that we have now, lots of them still combine both. Still go to the hospital and they will still go and see prayer camps or whatever. You go to the prayer camps... you go and stay there and then you come to the hospital to get your medication, we combine, a large chunk of the educated we combine.

Okay, I don't know if it is [multiple speakers] I want to ask the question.

[multiple speakers 00:21:05]

It is easier for us to walk into, I mean okay not that but... most people see traditional healers or spiritual healers in the hiding, they don't do it openly. Okay, why is it so?

Because we are moving into an era where more and more we are convinced that Western medicine is the way to go.

Not just Western medicine, we still need to have other things to battle with. So talking about psychologists forming an association with traditional healers okay, there is that Christian confidence where people will go to the bible and see that God said "I am the God who created heaven and earth, thou shall have no other images before me" okay. So even I'm a strong Christian and I believe in that... the fact that I have to liaise with a traditional healer who believes that he is a tree, that is where the spirit is, it becomes a problem for me and conflicts with my practice and at the same time with that association. Isn't it so?

But that forms part of the traditional healing.

Yes.

No, I am not talking about -

I disagree with you when you say that the Church forms part of the traditional healer.

You don't get my point! I am talking about Christianity. Okay. Now I am going to quote the **ten commandments where God says how no other divine image is anything, if it is a tree, a stone, whatever it is....**

You are bringing your personal beliefs into therapy... it is not about you.

Some people, the person that believes that madness is caused by God.

Yes.

It is not about treatment. If the person has a belief that things are caused by Onyankopong, by God. How would you work with that?

It would be the same.

You can choose. [multiple speakers]

I believe if their minds would want to go to traditional healers we do not have to stop them.

Yeah.

The only thing is that you as psychologists should investigate to know whether where he or she is going to understand if the other treatment is causing problems... what are the effects of what the healer is telling them?

No matter what you think that is the [multiple speakers 00:23:22]

Say again sorry.

No matter what you say, you can't prevent a traditionalist, the traditional healers from operating. The best way is to collaborate with them. Africa we can't do away with spiritual ideology, that ourself...

Let me ask then... how do you envisage the future? Do you think traditional healers will always have a place?

Yes. [multiple speakers]

Yeah.

Yes.

They will.

But even if they have a place it will be modified.

Yeah.

It wouldn't be as traditional as it used to be.

Right I am wondering does anyone have any examples, a patient or a friend that has told them how a traditional healer has helped them with a psychological problem? To me there seems to be an air of mystery, like you say they are not writing books, they are not writing outcome studies, I am curious.

She is not a patient. She is not my patient but she is somebody I know from Church. After she had her second child she became a bit sick, maybe psychotic, attacking everybody even when you are eating and she would tell you that what you are eating is snakes and things like that, and well her mother came in and said that when she was a little child she was dedicated to the gods, and it is about time that she went to do the job that she is supposed to do as a shrine priestess and it is because she is refusing that is why they are plaguing her with the present mental condition. So against everybody's belief the mother took her to the shrine and when she came back she appeared okay. But recently she has relapsed.

This is really very interesting.

I didn't know what I know now but I think that, it initially started as baby blues, post partum depression, that was how it started and I think it wasn't checked. I am not as knowledgeable you know at the time and she became uncontrollable, attacking everybody, her family, the husband, refusing to see the child and things like that. She was depressed and then she switched and she started doing a lot of things and they took her up the mountain and they did some stuff. She came back and she was okay I think for about two or three years managing her home, doing the parenting, recently she came to Church and there was nothing funny she started laughing. You know... she got up to go to the stage and that is how it usually starts so I think that yeah it was just something that I noticed.

Okay so as a group. If the Mental Health Bill was here as doctors would you detain her and force treatment, would you allow her to go to a traditional healer for help?

I think you have to involve the family. If the person is still competent they have to decide on their own treatment... if is the one occasion for this person then you can't decide on your own as a therapist. You certainly have to find out from the what form of treatment they would love to give to their daughter and if they are willing to meet the person at the clinic fair enough but if they want to take the person back to the traditional healer who can maybe tell them how to help her.... I don't think it is our job to judge if it is possible... maybe we should let her go but find a way of keeping her from harm. Some traditional treatments are cruel...

I think you advise the family and try to explain what is happening to the patient from our approach so they may try to breakdown the choices they have, the various people offer different things and they should have an understanding of psychological and psychiatric explanations of what is happening, I believe they should try therapy, the person can be helped to manage daily activities, and then if they still decide that they want to go to the traditional healers it is their choice. But I think people are happy when they find out that we can help them.

I wouldn't stop them from going to the traditional healer. I would rather try and – well we will try and work out the common ground, where we can combine both that aspect of the healing with whatever I can also provide because I think that because they believe it it would give them some sort of hope to sort of wait out their therapy because therapy is not a quick fix, you need a person to believe that something is working anyway so I wouldn't stop them from going to the traditional healer, I would just try and see if we can combine the therapy, the psychotherapy with the traditional therapy.

(multiple speakers 00:30:02).

Do you think the traditional healer will give you that chance to do that?

It would definitely conflict definitely because their way of doing things are different from what you the psychologist do but then one of the things to us psychologists that we also do is also we try to learn from others, not only in terms of prevention but I think with learning the healer too, as psychologists we cannot encourage people to be beaten if they are sick... working with maybe the healer for instance and also assuring that nothing harmful happens. It is much better

that just allow them to work, fine you are a psychologist but they would also love to also have a one on one talk with a healer and see how they can help this patient, if it comes to a point where his help is needed, if it comes to a point where we will have to work together.

I think increasing the clients' motivation or in this case the families' motivation will be a pressure factor in the choice of the treatment so that is why I would try to explain the condition to the family and then try to advice them to use our services more. Then still if they believe that it is spiritual there is very little we can do but then if possible they will come back to us.

Do psychologists work with spirituality?

I don't think we have the capacity for spiritual work, no.

I don't think Western psychology does... maybe we do a bit more...

Can you ever, can any of you imagine ever borrowing any interventions from a traditional healer or suggesting that a client went to a fetish priest or a prayer camp?

Yeah.

Yes I would.

Normally for instance in anxiety and some mood disorders there is a cause offered by the healer... so most of them they want to now the cause and so they go to the same places for advice... they will say, "Don't go here, don't go here on this day, don't do this on this day" and the idea into avoiding from having contacts with the cause that trigger this problem...

Okay.

So you can borrow that ideas from them.... Our patients want more direct advice than too much asking them about their ideas...

I also think for instance, we can work within the good part of the belief, focus on the good bit... prayers, prayer is something of that can help us in therapy and treatment for patients. So I think it is something that is we can use in a form of therapy. We can help them strengthen themselves with God...

What kind of therapy?

We can add to out therapy. We need to work within their belief for them to hear us... sometimes when patients go to Church that is the comfort they gain.... They talk and they pray to God. God hears them...

(multiple speakers 00:33:18).

It is not that traditional is it?

It is.

We are talking about *traditionalists*.... I would not use rituals in therapy. I am not a healer...

(multiple speakers)

No. No.

What about - you guys described this very powerful confidence that patients have in the healer.

Yes.

And that some rituals can change the way the client thinks. Would you ever use any kind of symbolism in your sessions with a client as a psychologist?

Maybe as a placebo.

As a?

Placebo.

As a placebo.

Yeah.

Or if you were Christian therapist maybe.... I think it is a problem if psychologists start doing healing. It tells them we believe... Our job. We should do our job.

(multiple speakers 00:34:10).

Yes. Let them see a healer if that is what they believe... but let me try to teach them another way.

Would you ever have any kind of ritual or symbol that isn't from your CBT model but within the patients' belief system?

Yeah.

Okay I think that when we do CBT here, it looks different to how it does in the West. We recognise that our patients are spiritual and we try to bring it in. we also understand that Africans value community and their family, maybe we do more of that kind of stuff too... you know you have to fit your work to your patient...

We have clinicians, we have psychologists, but we do not have healer-psychologists. We can't move from the fact that if the people we work with may see a healer and believe them more you know. So if the patient comes and says I believe in this and if you personally not as psychologist, you can also believe this view *personally*, it will help you teach them about psychology because you share the same idea. You will understand both and can show them what you learnt. But if they are sure they do not want to hear you, let them go. We cannot be everything and we are here to do the job of a psychologist.

If the patient comes to see me and the patient believes in tradition we can share the same idea because we are African, I can understand these ideas... Well that is what she believes or the client believes so he can do that, that is good clinical practice, they must trust us first. So I will say in Ghana, here we are using the principles of CBT but we talk about the spiritual, and so that is how we help our patients, to help the clients not to turn their backs on us... we want them to know that God can help them, and help us help them..

I think in this area you have to be very careful because as psychologists we have a clear guideline, our training tells us that we are supposed to do, what we are not supposed to do. Apart from Christianity I don't think we have some other things that we could use to interact that can harm the patient. We have to be careful not to cross the line; we must not physically harm the patient. We must also be careful not to reinforce ideas that can harm them. The spiritualist they may give specific instructions that can -

Like what?

(inaudible 00:36:38).

Yes about going to the cemetery (inaudible 00:36:42).

They may tell you why something has happened. They may blame the patient. They may blame the grandmother. These instructions can be damaging…

(multiple speakers 00:36:46).

So we have to be careful which one we use or who we refer the clients to.

And as a psychologist you know, you are not an expert in the spiritual. Right you know that that is not part of your training. I am using the positive parts of everything but I do it carefully.

The truth is that you have your, you have been trained.

Yeah.

At least the minimum number of years of training is like four years, that is the minimum so you have your own scope of training and don't forget that you are playing a unique role in the life of that person, you have your role to play, the priest has his role to play so once you start using the things that a priest would use you are attempting to do the job that the priest would do. So you don't expect that you will come to me and I will be using the cross with you. I am not supposed to play that kind of role in your life. I am supposed to be a therapist so I am going by my training. So you don't expect that I will come to the shrine or advise you to go together.

I think the question was whether we can use their, some of the symbols. So I was thinking that Christianity may offer some form of help doing whatever it is, if it is Christianity. So when you come to me and I am Christian then I believe that prayer will be a form of purification, then I would go for it. It is harder with the only traditional ideas… but most people here are Christian…

(multiple speakers 00:38:29).

Why is that, maybe the client does not have the confidence of a psychologist but you would have more confidence in a traditional healer.

The main reason, one of the things that I would say is that it fits with their belief system. The scope of our training is limited to one way, you need to also remember that these healers live in the communities they serve, they know the family histories and they see things… it is a very vital role. You are not going to tell them for their treatment they must be at one place. As a psychologist maybe you end up finding yourself in a place with a client where there is difficulties for you, they are talking about something different from your way of life, so how am I, how am I going to gain the confidence of these people? I must be honest. I am not an expert in curses… but I am a Christian and God tells me there is only one god and I worship him…. I do not know about what you are saying, but I will hear it…

You should just do your job, you shouldn't try and be the pastor or the traditional healer. Do you need a traditional healer in that situation for the patient to believe they are well?

My question so who referred the person to you, has the person came to see you, so what has happened before or what is the main motive or point of view... if they have come to see you they must understand that it is not necessary to see a healer...

Okay.

No! That is not right. Many educated people will see a healer too... for many people, they will always also treat the spiritual aspect. In Ghana, that controls more...

Okay.

Based on the information you have for the assessment and then they leave and maybe you find out more about their society, you can understand the history... they look at what people perceive to be possible in their village... If you realise that a section of the community is contrary to the cause of it then the best thing would be, the best approach to treat. Then you also have a role to play in this society like changing their minds, slowly slowly we will change it, we have to change it, not leaving them to it because there are many things we can do too, in a safe way... so we talk to them about how the healers work, and ask them to compare how we work... we educate them about different approaches...

A rather interesting comment.

Okay answer what you are saying, so you think our job is to change the minds of society and to able to educate the society to believe that is okay. Schizophrenia is biological and not spiritual. Would it, would it, would it be so wrong if the mother says that I think my daughter depressed because his sole is taint, so I have to bath her with sea water. So we are going to fetch sea water and I have to bath her with sea water in the morning. Obviously that practice and then when that is done then maybe your therapy can be more helpful. Whatever is so wrong to allow them to bath them with salt water.

If the woman believes that can cure her then she wouldn't even come to you.

(multiple speaker 00:41:52).

Some would!!

This moves us on to our next question that Western models of medicine, do they, do they cover, do they make space for the spirituality?

No they don't.

(multiple speakers 00:42:31) no.

No.

So as a psychologist do you learn African-centred theories of therapy?

Yes.

Yes.

Yes.

Yes.

Is anyone specialising, is anyone going to work in an African centre?

(laughing).

We are in specific training where you can specialise in that field, and you try to incorporate so that you integrate it. If you are aware of what transpires within our community or society. So you don't bring a particularly new thing that is no match in a way for the old way... we use African-centred ideas but mostly CBT...

I also think that with the present, what they call the Western theory also is more or less like incorporating a collective holistic spiritual into westernised form of therapy when we learn it and use it here. When you realise that what they talk about, the traditional healer they mention that they are practising traditional healing or healing patients has to be incorporated into your treatment. And we heard about angels, and curses and juju... look at the body but also incorporates the mind also. So I think this one would also help incorporate our belief into the Western form of therapy which we have already started doing.

I think that the awareness is being included in our training. We learn about traditionalism and we learn African ideas... it is taken to our training and I remember one of our lecturers said she actually has the contact details of safe religious ways where she can - she also does refer people, significant people. So I think the awareness is enough for us to be able to work holistically... to actually incorporate the spiritual, but I don't think there is any specific African ideas I would specialise in...

It is an ongoing debate!

(laughing).

It is only so far that is what I mean.

I am curious whether you think African beliefs or African values have something you should be teaching the rest of the world? Something you would like to see in mainstream psychology?

Yes.

For instance yesterday I went to my church. One of the members is ill, we are going to organise a meeting very soon, it is believed that one of the members needs help. It is believed so, it is also believed that we are able to help this woman with our prayers to God.

In the West, getting sick and the sickness doesn't have any place for spirituality. So we are believing that maybe somebody has done something in the past that is causing us to be having this abnormal life. So we want to go back and find out what is causing this so that if there is an explanation or something we can do it to stop that. So if a client believes that they have committed a crime, definitely to us we believe that when you commit a crime if you are not punished your children could be punished or your children's children could be punished, and so you cut that link between you and that crime but you must confess and pray...

I think the values that would help the rest of the world is that Africans believe in family, and we believe in respecting our elders and being a part of our community. We have a responsibility... I think connectedness is important. And honouring where we came from, our ancestors,

connections to the past help us know our place... the way we worship God too... it is our culture. These things prevent people from isolation... that is what we should teach...

Okay this is the last bit, I know you have been sat here for a long time. If you were in charge of a psychiatric hospital, would you use pastors in your hospital?

Short pause (00:47:04).

Yes I would.

Yes.

Yes.

What about traditional healers?

Yes.

Yes.

Yeah.

(multiple speakers 00:47:22).

We believe that their services are useful in a way... and if they take patient safety very importantly I think we can use them as...

Me personally, I wouldn't want them telling my clients their reasons... I think it would cause problems as our approaches are different... I would not like them to tell my patients that it is their aunt who is zapping them!

Okay. So as psychologists do you think we should have a list of accredited respected safe healers we can refer to?

Yes (majority).

But we don't right?

No we don't.

(multiple speakers 00:47:53).

Actually we do have there is a licence...

(multiple speakers 00:47:58).

(laughing).

But that doesn't mean anything!!! We do not know who is safe... we ask our patients about the places they go...

But I, I am obviously naive but my experience so far is that there is a big spectrum of types of healers....

There are some places that do fantastic work so I think we have to, there should be some kind of an oversight community that investigates or do investigation to recommend or to regulate them... brought on board so that occasionally their performance would be reviewed to make them up and doing, and to make them also accountable to their community... we need to know what is happening...

Yeah.

But for now what we have is just about the government trying to keep people safe. So we can't monitor those who are healing, but we can look for those who are harming or mishandling their clients.

With respect we have also got to be monitored. I don't know if those healers are so different, most of us want to do a good job, most of them are registered.

You are in a fortunate position that traditional healing has existed and now psychology is coming in and you are aware, you take for granted how much you understand... Is collaboration and information sharing the future? Or should we be educating people that psychologists or doctors are the right people to see?

Medium pause (00:50:55)

Yes.

I think, it's difficult to say. For instance a lawyer and his client if you don't believe in your client's story you can't put up a good defence. So if you don't understand where your client is coming from obviously the two of you will find it difficult to work. So I think showing that you understand, that okay this is a bit strange to me but you believe that it is a curse just let the person feel that - in as much as you do not believe you sort of share that sense, it is sort of possible, the person becomes a bit more relaxed around you.

I also think that erm, westernised way of life, people think it is best, so maybe African psychologists here can go there and share their stories... I think that is a fantastic idea! We can all go!

(laughing).

(laughing) True.

Because now it is only about when you learn about different beliefs that you know enough to ask... and they all are important to understanding the psychological issues because -

Yes it is more or less like he says. You understand the beliefs of the Africans, that would also help the English psychologist to also understand the patient and where he or she is coming from and also, then you could work together... you'll have to be prepared for them to ask you!

(multiple speakers 00:52:59)

I think also, we all must learn from the good healers... Yeah I think it is like what is the issue. I think from what has happened in the past, but the whole system of traditional healing has something to teach us. I think more research will take you to research into the traditionalists, you will see we are much the same. Sometimes. Treatment plans and beliefs and practices and whatever which makes the healing process successful. Maybe there is something to teach us...

In Africa most often you they don't tell you what they do, most of them they don't tell you what they do, they keep their practice secret.

And it is normally transferred to a relative or somebody who believes, an apprentice. So yes there was two very powerful medicine men died and they have been sad because he has helped a lot of people and there was not anybody who knew his ways.

Someone told me when he was a child he was hit by car, when he was in class six somebody hit his head and he developed a headache, and for about fifteen years that sickness was continued but the man he attended hospital, he had seen many doctors and they could not help him. Nothing helped his headache. He went to a herbalist and the man prepared something, some leaves, after six days everything was well, his headache had gone! His headache was gone.... The next day he was hit by a stick...

(laughing).

So when, it hit him in his –

Oh no. *(laughing)*

Yes, the thing has come back, the headache has come back!

(laughing).

So he was hit by a car and had a headache all his life, he got well and he was hit by a stick and he died of a headache... he died some days later! So it was like, I imagine there were things we can't understand... doctors did not know and the healer did not warn him...

(multiple speakers 00:55:16).

Because as he is saying all of the main approaches have strengths and weakness, that you may have all the ideas or you think you do because you have faith in your approach, so if for instance you know going maybe do African psychology, you know that well, but *together* we will know much more...

And just to add to what he said most traditionalists they know in their heads all the herbs and the ways they work and they have local names for them but to say for us of us to understand they would need to teach us, to explain.... Like my grandmother she used to treat people in our village people were buying her herbs for years, she was able to mix herbs but nobody knows the names of those herbs. My mum can identify them but she cannot put it into maybe the right mixtures of know which ones do treat things or whatever. I think we need to share our knowledge, do our own jobs but work together...

But the traditional healers I have met quite like the air of mystery... is that correct?

(multiple speakers 00:56:40).

Yes!

Yes!

They are not receiving money from any other source...

It is their business!

Yeah.

So if the patient is not getting well, they won't come back...

Yeah.

So I think that is why they keep them a secret unless they have somebody they are training...it is one of the things that makes it difficult for us to know which ones are good...

And apart from that if they are just giving us the information they have acquired over years, a lot of people won't take the time off to get to know it, to go through the process of training and they will have a lot of problems and all that.

Right I am just conscious time, we have all been sat here for a really long time. I really enjoyed listening to your debate. I think it is something has definitely been very insightful for me. Thank you very very much. Does anyone want to say anything before they go?

Yeah it is important to recognise it depends on where you go, there are some healers who cause harm, ties around your legs, beating spirits out, burning the patients and then you see him whisper but later he was interviewed by someone and that was more secret and he said the whispering really doesn't do anything, it is the herbs he has used that is actually going to do the work. But he is saying all those things, makes you feel like there is a psychic path when honestly there is nothing more than the plants but the rest makes the patient confident that something more is happening so its happens more quickly and people like that...

Patient confidence...

Yes.

Yes!

He makes a good point...

They need to find some way of making their patients' confidence and they go.

(multiple speakers 00:58:49).

They think it will work and so it does! That because we believe that the spiritual side must get healed... and why when our patient comes to us, we must make them feel confident in a different way...

No we believe that God must answer their prayers too... that it is both things that help...

Exactly.

And then the herbs will do the physical work or the medicine...

Ah ha but the healers will actually tell the patients it is the other things... they want the business!

Yes.

I think the Africans are spiritual, you know so that psychological work must include that part of them. You must hear them...

I think also they expect us to tell them what to do, like other people do.... That is not our way. Psychologists.

It's a challenge.

Yes it is a challenge for okay for me.

For all of us, you speak for all of us, it is a challenge.

What we can do is explain to them, educate them.... Help them have faith in our approach...

I think another thing that can help us is where we find ourselves in the community we can educate the villagers. And providers like the community nurses, and teachers and BasicNeeds...

So they give talks and give talks on behaviour and education, how to prevent mental illness, they talk to this class. They tell them to not smoke marijuana because it can make you mad. They tell them that mental illness is not contagious. That there should not be stigma about seeing a doctor... many people are afraid they will catch something like epilepsy so they keep away from him. The man is then miserable because he is alone and there is much stigma. They think maybe he is being punished by God and so he is to blame... they are afraid to touch him... and then something changed, the nurses visited him, a White volunteer visited, they saw her touch the man... they listened when she said "Look - it is an illness - I cannot catch it - this man needs care..." They listened...

When my mother got sick she said she dreamt that her husband wasn't successful and that the aunty was attacking him and it was all the aunty's fault and this woman believed that it was an attack from the spirits... But traditional psychology also looks at dreams. The healer asked her about her dreams to help her feel confident that the aunt could not zap her husband...

Yes. She believes because she had a dream, and once you have malaria you are likely to dream dreams.

Yeah like people have dreams, they have been knocked on the head with something, they will wake up and there is a swelling so you can't downplay that. In a northern region, they were building a road. The route, the original route was straight.... They had to move a huge boulder...

(multiple speakers 01:00:59).

Yeah because of that. The people knew it had power but the government wanted the road there... They took out the stone, by the next morning it was still there which means that the powers exist, you can't downplay them like that.

True.

But there feels like there is some conflict in the room. Some people are sure it is real...

Yeah it is real.

(multiple speakers 01:01:22).

It is real if you believe...

Of course some of us have experienced it but some of us are Christians and believe we should only worship one god...

(multiple speakers 01:01:38).

I am not sure it is *not* real... I cannot condemn it outrightly. But I am a Christian... I would not go to see a fetish priest!

Right - you must be bored of sitting but thank you so so much. You have given me a lot to think about.

Right so, as I mentioned earlier, when I listen to the tapes back I want to email you all. Not "you said this" or "you said that" but as a group, I want to see if I have understood

properly and to invite you to feedback... So that is why I have your email address is that okay?

(multiple speakers 01:02:16).

Yes...

No problem Obruni....

Yeah.

Great, thank you so much. Really. Thank you very much!

(multiple speakers 01:02:21).

You are welcome.

C. CLIENT STUDY.

CAN PSYCHOLOGICAL THERAPY BE USEFUL WHEN THE CLIENT'S HEALTH BELIEFS DIFFER STARKLY TO EUROCENTRIC THEORY?

C.1. Introduction

The client, 'John' (whose name and identifying details have been changed to protect his identity), was from Iran and aged in his mid-fifties. He had long hair and a beard, and identified himself as a Buddhist. He presented with a long list of physical health complaints. John had a history of heroin addiction and was referred to psychology as his keyworker felt he was 'depressed'. John believed he was cursed.

C.1.1. Implicit rationale for the choice of the case

Whilst, typically, trainees present clinical work that neatly fits a theoretical approach, ironically, I chose to present this client because it did not. The Eurocentric emphasis of my training, and mainstream theory, felt like an obstacle at times with John. I feel this case highlights what I felt was missing in my clinical training, and the gaps in useful literature regarding sensitively modifying interventions whose culture differs from the dominant West. The work with John demonstrates the process of negotiation I went through, recognising my own allegiance to mainstream theory, whilst trying to engage John in a way that was useful to him.

C.1.2. The context of the work, the referral and background information

John was engaged in a drug and alcohol service in which psychological therapy is available to service users via key worker referrals. Engagement in therapy is not time-limited, nor is the approach prescribed. In general terms, the psychological therapies service adopts an integrative approach and allows flexible treatment plans.

The referral information was basic. I was informed that John was regularly engaging in therapeutic activities. He had not smoked heroin for four years and had significantly reduced his methadone prescriptions whilst engaged in the service. He was initially prescribed 60mls of methadone daily, and had reduced to 15mls by the time we first met.

C.1.3. Convening the first session

I met John in the waiting room and escorted him to the therapy room. He had a soft manner and politely offered his hand as he introduced himself. We walked together and he thanked me profusely for seeing him, a sentiment he repeated several times. His first language was Farsi, and his English was proficient, but he spoke with a strong accent. He walked slowly with a noticeable limp and stiffness, using a walking stick to support himself. Upon reaching the room I gestured to a chair, and he bowed his head as he sat down. He seemed apologetic and looked nervous. He sat down and began to make a retching sound from deep in his throat; a sort of hacking sound like gagging broke up his speech. He explained that this was one of the symptoms of his curse...

I wanted to put John at ease and began to explain the way the service operated (confidentiality agreements, etc.). I took John's history and tried to get a sense of what he was hoping to get out of the sessions. The noise John made in his throat continued for most of the session. There were moments it subsided momentarily before it resumed with renewed vigour.

C.1.4. The presenting problem

John's retching was the first indicator of the repertoire of physical symptoms he was experiencing. In our first session, John reported his wife had cursed him, and the physical symptoms he was experiencing were the result of the curse. He wanted to leave his wife but felt convinced that whenever he took action towards leaving her, he was struck down by a physical ailment. He believed that his wife had put her menstrual blood in his drink on the day of their wedding, binding them together by this curse.

John reeled off a list of physical health complaints. He had been to his GP frequently and several walk-in clinics and emergency rooms over the last months. Most weeks he had sought medical advice somewhere, for something. The physical symptoms ranged from severe headaches, pain behind his eyes, joint pains, digestive complaints and poor sleep. His left knee also caused him pain. John met the diagnostic criteria for depression (low mood, diminished interest or pleasure in almost all activities, low energy, feelings of worthlessness and significant weight loss).

C.1.5. Rationale for treatment approach

The realities of many of our service users' lives were grim, with long histories of insecure relationships, trauma and abuse. Whilst the NICE guidelines recommend CBT for depressed

clients, the guidelines of the service recommended integrative psychological therapy. McLeod describes integration as differing from eclecticism in the way that a practitioner aims to create new theories or models by incorporating aspects of different approaches versus using the most appropriate intervention or theory for the patient at the time (McLeod, 1993). I hoped to unite models not only in terms of practice, but also at a theoretical and a philosophical level. The Bateman and Holmes model was the framework for the sessions, providing a guideline for integration of treatment approaches (see figure C1).

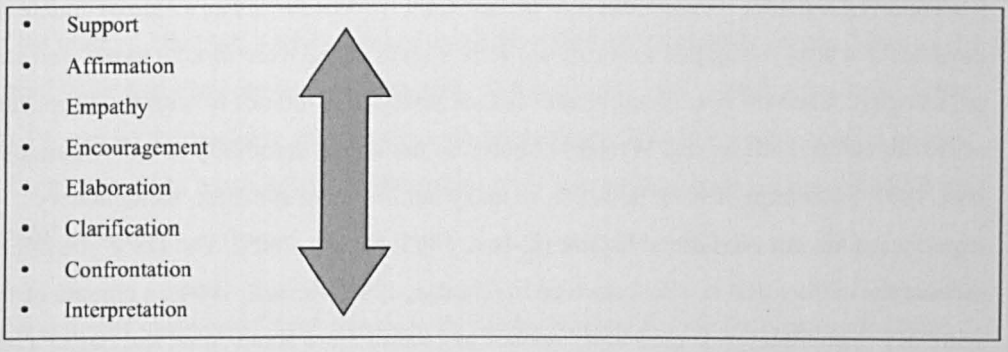


Figure C1: The Bateman and Holmes framework for integration (Bateman & Holmes, 1995)

Bateman and Holmes suggest that the therapist needs to shift up and down the scale of interventions when working with a client, and that the more damaged a client is, the more shifts will be required of the therapist. Initially, the theoretical orientation of the therapist should be positioned at the top of the scale proposed, adopting a more person-centred framework to develop a robust therapeutic relationship. Later sessions involved moving up and down the scale of interventions, to incorporate useful interventions from different approaches (cognitive, behavioural, schema and psychodynamic) that were more interpretative and confrontational. The final months of therapy were predominantly schema-focused; a position that reflected the evolving formulation of John's presentation that was achieved by frequent shifts up and down the Bateman and Holmes framework.

C.1.6. Initial hypothesis and formulation

As a large number of toxic or psychoactive substances can cause psychotic reactions, a provisional hypothesis of substance-induced mental disorders was in my mind (DSM-IV: Opioid-related disorders, 292.11, Induced psychotic disorder with delusions). Whilst John spoke

of the 'curse', his beliefs seemed fixed and were clearly negatively impacting all aspects of his life. Initial historical information did not reveal any prominent delusions prior to his drug-taking, and heroin could have been etiologically related. However, his dose of methadone was low, and there was no reason to suspect he was using drugs he was not prescribed. Similarly, a secondary hypothesis linked childhood trauma to increased risk of psychosis in adult life as John recounted his childhood (e.g. Read et al., 2008; Varese et al., 2012). However, John was not experiencing hallucinations or intrusive thoughts. He had a firm belief in something that seemed bizarre to me. He was socially isolated, anxious, apologetic, grieving, ashamed and sad.

Initial hypotheses revealed my difficulties in the first session. My clinical style is not particularly diagnosis-focused, nor was the service I worked for. I was aware of clutching at these ideas whilst I struggled to formulate John's ideas. They were foreign to me, and easy to pathologise. John was describing beliefs as fact: beliefs that did not fit with my Eurocentric, scientific cultural influences. Western cultures do not assign credibility to hallucinations, (al-Issa, 1995; Adebimpe, 1997); however, in many non-Western societies, hallucinatory experiences are not considered bizarre (al-Issa, 1995; Martin, 2009). The DSM classification reflects the culture that it was conceived in (Caplan, 1995; Russell, 1994), a climate of fact not faith. My formulation was constantly revised as I learnt more about John, and began a more culturally sensitive formulation of his presentation.

C.1.7. Negotiating a contract and therapeutic aims

John and I agreed to meet weekly. The contract between us required both of us to give as much notice as possible if we needed to cancel a session, and stipulated that we would review our progress together three months later. Clarifying the therapeutic aims was more complicated: implicit in John's explanation of his experiences was a belief that the curse could be 'undone' by the appropriate expert, a position I could not claim as my own. I did not recommend that John saw a healer because I believed this would have reaffirmed John's magical explanation of his experiences. My own allegiance to psychological theory resulted in me not believing in his. This reflects an imposition of my Eurocentric approach. However, this imposition was minimised by making space for John's beliefs, culture and spirituality. I did not want to alienate him or cause him to disengage and so the sessions represented a meeting of two worldviews.

Motivational interviewing techniques and guided discovery methods were used to explore what life would look like if the curse were lifted, enabling some common ground in terms of therapeutic aims. John wanted to feel like 'old John'. 'Old John' was someone that was more

confident, able to cope with life, gain work and engage socially. John was also adamant that he wanted to leave his wife.

C.1.8. Biographical details of the client

John had grown up in Iran, the eldest of several children. John reported that his father had been a violent and aggressive alcoholic. He described his mother as a kind, patient woman. John's father had left his family when John was 9 years old. John described his role in the family as being one of responsibility, helping his mother with his siblings and getting work as soon as he could to help his mother with financial responsibilities. John's hacking sound subsided as he spoke of his mother. His body visibly relaxed as he described how she had cherished him as the 'special son' as he had been caring and supportive of the family. John's mother had died when John was 19, and he did not have any contact with his siblings. John had been a soldier in Iran and had been exposed to much horrific violence in Iran's war against Iraq. He described himself as a peaceful man.

John had a series of unsuccessful relationships before he married for the first time in his late forties. It was shortly after getting married that he moved to the north of England. John described feeling content in England, working as a teacher and supporting his wife financially. He described his wife as a kind and gentle woman, who he had rescued from an abusive relationship in Iran. John had been raised with Islamic faith but reported that he had identified as a Buddhist when he moved to England. At this time, he attended a Buddhist centre regularly.

John's wife died in England. He did not make eye contact as he presented the next autobiographical details. He said 'things became bad' after the loss of his first wife and that he had begun to spend more and more time out of the house drinking alcohol. Whilst at the home of some friends who had become his drinking partners, he tried heroin. He had begun to smoke heroin daily as it 'stopped things'.

John lost his job and became more socially isolcated. His eyes were fixed on the floor when he stated 'things were not good after my wife'. Through his new drug-taking friends, John met an African woman. She had mental health problems and had been prostituting her body to fund her drug addiction. John described feeling compelled to help her, attributing his rescuing behaviour to the values his mother had taught him. He said it was a 'gift from God' to be able to see suffering, and he knew he was 'special' because his mother had always told him that. He said his friends had called him 'stupid' for getting involved, but he had to help her because of his gift. He stated that the woman had begged to stay in his home so she could give up drugs. He

had agreed. He said that things were good for a while whilst he helped her. John married the woman eight months after they met, and described feeling optimistic for the future at this time.

John continued to look down as he said 'but things changed the next day'. He stated that the woman had lied to him and was continuing to abuse drugs. He was required to give her money to sustain her drug addiction and the woman was verbally and physically abusive if John refused. John said the woman had tricked him and had not loved him. John reported that despite being desperate to be rid of his new wife, the curse she had placed on him meant he was physically incapable of leaving her. He presented his long list of physical ailments as proof of his hypothesis. The couple had been married for three years when we first met. They shared a home but lived separate lives. He reported that the woman was prostituting herself again, this time from her bedroom in their home. John was conflicted: stating he was desperate to leave her, but incapable of doing so.

C.1.9. Summary of theoretical orientation, the therapeutic plan and main techniques used

As per Bateman and Holmes' framework (1995) (figure C1), person-centred approaches offered the framework for our early sessions. I would follow John wherever he went, encouraging him with empathic, non-judgemental responses. I wanted to socialise him to the idea of 'talking therapies' in a way he would experience positively. From a schema therapy perspective, this could be described as needing to be identified as a 'secure base' (Young, Klosko & Weishaar, 2003). This was especially salient due to John's nervous presentation. The retching noise he made gradually subsided within sessions, which seemed to serve as a sort of barometer for his internal state. As he relaxed in my company, the noises would reduce. When discussing something difficult or upsetting, the retching sound would reappear. Linehan states integrative therapy should involve teaching coping strategies and self-soothing behaviours early on (Linehan, 1993). A task for our early sessions involved teaching John some relaxation exercises.

The limited available literature suggests the symptom profile of depressed Iranians involves somatic metaphors and complaints are usually expressed as substitutes for emotional discharge (Seifsafari, Firoozabadi, Ghanizadeh & Salehi, 2013; Lipson & Meleis, 1983; Krippner & McIntyre, 2003; Hakimshooshtary, Alagheband, Sharifi, Arabgol, Shabani & Shahrivar et al., 2007). These studies showed the importance of somatisation in a group of patients who seemed to have no word for their emotions (Seifsafari et al., 2013). In many cultures, especially in developing eastern countries, talking about emotions is distasteful and is considered a sign of

weakness (Seifsafari et al., 2013), whereas it may be viewed as culturally and socially acceptable to talk about bodily complaints (Krippner & McIntyre, 2003). John's need for pharmacological interventions, initially, was the catalyst for his engagement in the service and I doubt he would have entered psychological therapy any other way. The limited available research suggested Iranian males have less positive attitudes towards seeking professional help for personal problems than norm groups (Fischer & Turner, 1970; Rahimi, 1989; Sharifi, Daliri, Amini & Mohammadi, 2011). These ideas were very helpful in shaping the therapeutic plan. I would need to socialise John to the idea of articulating his internal world, and offer him the skills he would need to do this. To prevent disengagement, it was important for John to experience sessions positively.

C.2. The development of therapy

C.2.1. The therapeutic process, key content issues, changes in the formulation and the interventions used

Early sessions revealed John's hopes that he would meet an expert that would offer him concrete advice. Cultural expectations for the therapeutic relationship had to be carefully considered. He repeatedly thanked me and insisted the sessions were helpful, but my instincts were that John felt dissatisfied by the idea of simply talking about things. He continued to present at various medical facilities for the first months of therapy, suggesting to me he was not completely convinced that a talking therapy would be sufficient to help him. Whilst John's health beliefs related to supernatural causes, his confidence in our sessions was unlikely to be high.

John's belief in the curse seemed to fit with the literature which suggested articulating emotions and thought processes might be difficult for Iranian clients and my hypothesis was that John was somatising and was under huge amounts of stress. I suspected the belief in the curse served as a sort of defence mechanism for John, rendering him helpless whilst he believed his body was controlled by another. The curse protected him from the expression of the shame he felt.

John was more comfortable recounting details in a matter-of-fact style, and struggled to answer questions that required him to describe how he *felt* about something. John would categorise things as 'good' or 'bad' and sometimes he would say he felt 'sad'. He seemed to lack the vocabulary to articulate his internal world, and my supervisor suggested I incorporate picture cards of different emotions to equip him with the resources to explain and elaborate on the emotions he could describe. Indeed, Martin (2009) suggests that there are less descriptive words

for emotional states in Farsi than in English, which demonstrates something about the cultural acceptability of expressed emotion. The introduction of the cue cards enabled a dialogue about the different emotional states, and offered me an insight into his understanding of these feelings. They served to develop a shared language between us. John would gesture to the pictures at times, offering me the opportunity to clarify and encourage him to elaborate on what he meant. Initially, John began articulating a range of positive emotions more capably but seemed to struggle more when describing negative emotions.

During the development of therapy, it felt as though John was keen to please me. He was early for every session, desperately polite and felt incredibly willing as he learned to articulate his internal world. Transferencially, I felt aware that I represented John's mother to him at times. Mallinckrodt, Porter and Kivlighan (2005) propose that it is necessary to accommodate to and gradually modify the presenting stance of the client in relation to attachment. They suggest that successful therapy requires initial 'concordance' (Racker, 1968) on the part of the therapist. This means partial acceptance by the therapist of the role allocated by the patient's unconscious expectations and procedures; however, John seemed to categorise people: they were perfect or terrible and I needed to occupy multiple positions. The person-centred framework of our earlier sessions involved creating the core conditions for psychological change (Rogers, 2004), which John experienced positively, which led to him categorising me in the 'good' camp. Whilst it felt important that I gain his trust, I was also mindful I would need to activate unhelpful schema modes in the therapy room, which meant bypassing his defences and challenging his rules about categorising people. In sessions, John was keen to present himself as a caring, loving, gentle man, and I began to wonder about the *other* side of John. It was as if he was afraid of his darker side.

As time went on, John became increasingly comfortable describing his internal world. We continued to use the visual cues to aid this process. John began to make connections between how he *felt* and the physical symptoms he experienced. He reported that writing things down helped him in-between sessions, and he started keeping a diary, which he would bring into session some weeks.

The progress session-to-session was not always apparent. Each week, John would report any physical ailments without prompting. Some weeks I wondered if I had been wrong to dismiss the diagnostic manual, as I nervously listened to his visions and beliefs. John would describe 'seeing things', which made me fear he was experiencing visual hallucinations; however, on exploration, he was describing ideas, predictions and dreams. Some weeks John's diary was full of dreams he had had, predicting natural disasters or fatalities within his family; some weeks he would seem to have renewed his conviction in the curse.

John began to feel more comfortable exploring his darker side. Negative emotions had been punishable in his childhood: his father ridiculed tears and his mother, whose love and approval he craved, had rewarded his sweet, caring side. John described his father's failings and his weakness for alcohol, and I began to hypothesise that John's schema of defectiveness had roots in the similarities he perceived himself to share with his father. John articulated a fear that there was something 'wrong with the darkness that took over' when he got angry. John eventually described fearing that if he let his anger out, it would be uncontrollable. Some months into sessions, he began to describe the guilt and shame he felt with regard to his history of being 'helpless to drugs'. He cried as he explained he felt a failure for being 'weak' and 'wasting his life this way'. He said he was 'not special like mother, but bad like father'.

John's health beliefs began to reflect an understanding that stress and difficult emotions can create physical symptoms. At the 'encouragement' stage of the Bateman and Holmes scale, I explored the alternative hypotheses John articulated for 'the curse'. We looked at evidence for the different explanations he expressed. I tried to monitor my own investment in the theory I had an allegiance to (figure C2), but the ideas had to come from John. The work with John gradually shifted towards a position where he articulated multiple narratives of his experiences, versus the very simple hypothesis he had initially held regarding his explanatory model of his experiences. Board work helped formulate the links between thoughts, feelings and 'symptoms'.

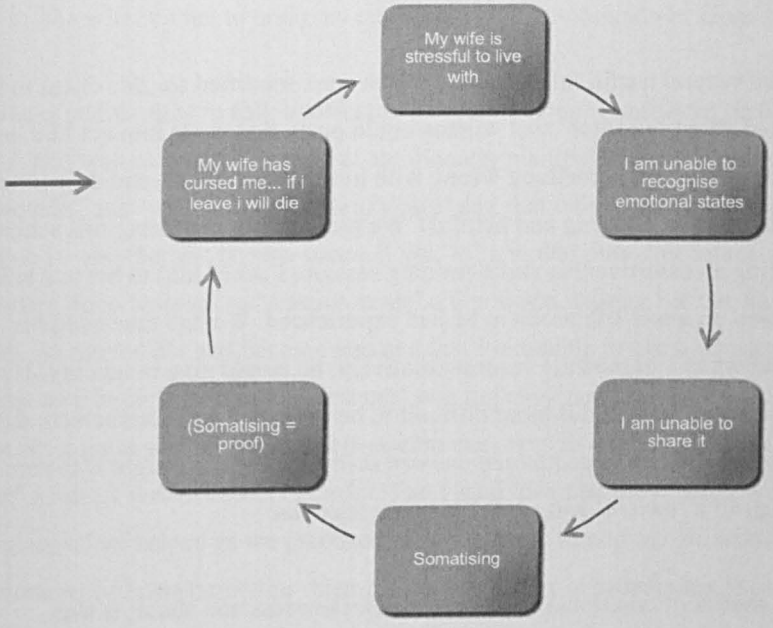


Figure C2: Picture of the psychological formulation of John's curse.

Understanding John's formative years was helpful in contextualising John's belief in the curse. The dissonance between 'special, caring John' and the failure or defectedness he felt deep down, was apparent. Young (1990) defines 'maladaptive schema modes' as the memories, emotions, bodily sensations and cognitions associated with the destructive aspects of childhood organised into patterns that repeat across life. The presentation of a caring, gentle man seemed to compensate for the version of his father he feared he was. The curse protected him from the expression of his felt 'badness' whilst he claimed he was literally powerless to behave differently. He felt a failure due to his inability to be 'strong like a man'. The idea that he was rescuing his wife because he was 'special' protected him from the reality that he was being exploited: the curse moved the locus of control to an external force.

At the 'confrontation' and 'interpretation' end of the Bateman and Holmes scale, the 'triangle of insight' involved making links between what was happening in therapy with what was happening in his daily life and his childhood experiences (Jacobs, 1989). Meaning-making is intrinsic to all therapies: I shared interpretations and formulations during moments it felt appropriate. The descriptions of John's previous relationships indicated a pattern of rescuing women he felt he needed to care for, indicating potential maladaptive schemas and coping strategies. John's relationship with his mother had impacted his relationships with women and it felt important to help John recognise the similarities between his role as the 'special child' within the family, and his need to rescue women in his adult relationships. The 'special' mode compensated for the 'defected' mode.

Schema therapy offered several useful interventions which were modified for this client to be less complex. We talked about 'a switch' that women could push, that made him act like he had learnt to as a boy (afraid there was something wrong with him like his father, and desperate to please his mother by being sweet, caring and helpful). We played with activating this schema mode in sessions. During an assertiveness skills-training session, I asked him to borrow some money, a role-play based on a real-life problem he had experienced. We had rehearsed his assertive responses, but when I framed the request emotively, he would give in quickly. He began to notice the occasions he found it more difficult to be assertive, and commented that '*you have seen my weakness, I am forced to help women distressed!*' This insight was very helpful, and the analogy of a 'switch' was useful in many sessions.

To overcome schema modes of emotional deprivation, defectiveness and abuse, it was important for John to recognise situations that might activate schema modes and feel more confident in alternative ways of coping. We rehearsed assertive skills, problem-solving, activity

scheduling and goal-setting. John completed 'challenges' every week, and flourished in the positive social feedback he received as he became more socially active and confident. He enrolled on a course at a local college, made new friends, re-engaged with old friends, became more house-proud and joined a Buddhist centre where he could meditate and discuss his spiritual self. Like British research, research in Iran suggests a negative correlation between perceived social support and mental illness (Bakhshani, Birashk, Atefvahid & Bolhari, 2003). We found ways to increase John's perceived social support and enhance John's positive coping mechanisms to help him deal with stress more positively in his future.

The sessions with John were often frustrating and slow. We would repeat conversations week by week, and there were times I wanted to rush ahead of him and impose my own views (much like he was willing me to embrace his beliefs and offer a concrete solution to remove the curse). Despite this temptation, John set the pace and his likeability and unpredictability made the repetitive moments less frustrating. John needed the time and space to make connections and play with ideas that were new to him, and to eventually challenge a defence that served a function. I reminded myself of the only helpful analogy I could muster: 'How would I feel being sent to a prayer camp to treat an illness I thought physical?'

There were magical moments in some sessions too, the 'break through' moments. John's self-awareness and ability to articulate his internal processes increased dramatically. As John gained confidence in himself, he seemed to physically grow taller and his posture looser. One week, about a year into our sessions, he announced he had told his wife that he wanted a divorce. He held his head up, holding direct eye contact with me as he said: 'I was shocked! I said it and she knew it. She will beg me to undo my decision. But I cannot undo it. Gone is the power!'

The weeks and months to follow offered John several opportunities to go back to his wife. She begged, and was extremely capable at emotionally manipulating him. She would plea she 'needed him' and 'would die if he didn't care' and that only a 'bad person would not do the right thing – she thought he was *special*', etc. John would play voicemails and show texts to his keyworker. John reverted to 'rescuer mode' a few times, bailing her out financially when she begged. He moved out and became less and less vulnerable to her strategies over time. Letting go of the comfortable position of 'rescuer' was not easy for John; he feared that by not rescuing, he was not a good person. We did self-esteem exercises to address this fear. The schema 'switch' analogy was extremely helpful. The visual idea that there was a weak spot that others could manipulate helped as we practised different ways of coping. He would ask to role-play conversations or bring particular dilemmas into sessions in preparation for the week to follow.

C.2.2. The pattern of therapy

John and I reviewed our progress every three months. Progress was slow, but on each review, John would insist it was helpful and we made a plan for where we would like to be at the next review. He was engaged with therapy for 18 months, when we decided to start to stagger our sessions to fortnightly meetings, and then monthly reviews. John and I met for 22 months in total.

C.2.3. The therapeutic alliance

Ghazi-Moghadam (2009) interviewed Farsi-speaking therapists and found that Iranian patients expect assertiveness from their clinicians and prefer authority figures that exert power in a therapeutic relationship, an idea echoed by John's expectations for an 'expert'. This was considered; however, it felt important to socialise John to a therapeutic relationship that was collaborative: a safe place to explore his darkest thoughts and to be emotional. Adopting an authorative position may have resulted in John feeling comfortable taking advice, but the power imbalance would have been an obstacle to achieving a therapeutic alliance in which John felt empowered and respected. By the end of the sessions, we had developed a third language between us: analogies we had devised together and visual prompts he could gesture to having previously established what each card meant to him. We understood each other's cultures: I had been honest with him about my interpretation of his behaviours but had also allowed space for him to explore his. I occupied multiple positions in terms of who I represented to him, and how he viewed me. I had not been trapped into the role of expert advice-giver. The tentative shifts up and down the Bateman and Holmes framework enabled a therapeutic alliance that felt secure and respectful of John's agenda and pace.

C.2.4. Difficulties in the work (critical evaluation of interventions and suggestions for improvements)

A major difficulty in the work resulted from a clash of cultures between my training and worldview, and his. John needed to feel respected, and this involved recognising that I had my own allegiance to a worldview that should not be imposed upon John. This boundary was incredibly murky; by the end of therapy, John had confidence in a psychological formulation for his experiences, which, to some extent, demonstrates that I did impose my own beliefs. However, John's culture and faith were recognised and respected, and it was his goals that were the focus of therapy. Stepping outside of my training, by recommending spiritual or magical

healing, would have been an alternative strategy with serious ethical challenges. I felt convinced that John needed the support of our service and that there was enough common ground between his goals for therapy that culturally sensitive psychological therapy was possible. However, obstacles that resulted from a clash of worldviews were apparent and required careful negotiation on my part.

My initial hypotheses, clutching at diagnostic manuals, indicate my initial misguided formulations when confronted with health beliefs that seemed so foreign to me, and the panic I felt with the bizarre ideas I struggled to make sense of. Essentially, the philosophical orientation of psychology does not leave much space for *other* worldviews and values. The work would have been improved if my prior knowledge of Iranian culture had been more proficient. However, the experience was empowering in terms of teaching me to *ask* the client about health beliefs, being honest with the client and not falling into a trap of being persuaded to work outside of my training (spiritual healer), pathologising beliefs nor alienating or rejecting a client who might be more at risk of disengaging.

C.2.5. Making use of supervision

My supervisor was extremely helpful throughout my work with John, helping me with process issues and the evolving treatment plan. Our initial focus was on formulating John's presentation, noticing my initial shift to a more medical position and encouraging me back to an integrative formulation of John's presentation. Offering John a diagnostic label felt unhelpful, especially in relation to the literature we read about the stigma surrounding mental illness in Iran. Instead of pathologising John's experiences and beliefs, we decided to take time to understand and contexualise them. Over time, we were able to assess the flexibility and function of these beliefs, and revise our treatment plan. My supervisor encouraged me to focus on John's relationships, suggesting that his historical pattern with women meant I should consider John getting back with the manipulative ex as a dangerous potential 'relapse'. This analogy was interesting in the drug and alcohol service we worked in: relapse prevention offered me a useful framework.

Making connections between John's formative years and his schema modes were the focus of several supervision sessions, and we played with creative ways of confronting John with these ideas. Motivational interview techniques were rehearsed that would enable me to encourage alternative narratives that John offered, facilitating an exploration of the flexibility of some of John's beliefs.

Supervision generated useful reading that helped normalise John's somatising and low levels of expressed emotion. Useful strategies were also suggested in response to these challenges. The sessions with John probably had more than an equal proportion of the time in supervision: I think the sessions felt experimental and exciting to my supervisor too. Most significantly, supervision was empowering. It authorised me to be creative and trust in the 'art' of therapy more than the 'science', embracing what my university supervisor would have called 'the safe uncertainty'.

C.2.6. Learning from the case about yourself as a therapist

Being confronted with the bizarre or foreign seemed to evoke in me a need to grasp hold of theory and retreat towards the 'scientist' end of the scientist-practitioner paradigm. However, paradoxically, it was the difference between John's culture and mine that required me to work more creatively, at the 'practitioner' end.

John offered me the opportunity to reflect on my own culture and the philosophical allegiance of mainstream psychology to Eurocentric values. I realised that I reverted back to diagnostic frameworks, and the inherent 'expert' status assumed by this position, in times where I lacked the framework to conceptualise what John was saying to me. Such was the clash of cultures: a sort of tug-of-war in my mind between going with the client, versus taking him back to my comfortable position.

C.3. The conclusion of therapy and the review

C.3.1. The therapeutic ending and arrangements for follow-up

I did not want John to experience the ending as me abandoning him. John had transferable skills and had made significant progress. We staggered sessions, initially to fortnightly meetings. We also arranged for John to increase sessions with his key worker initially. In our last months together, we used typed handouts that acted as prompts for the strategies we had rehearsed. I familiarised his keyworker with these strategies to reinforce messages consistently. Our last sessions occurred monthly, allowing John to review and rehearse strategies before being discharged from psychological services.

In our final meeting, John brought with him a card, with a handwritten message inside thanking me for helping him 'overcome the curse'. I knew that talking about his emotions had been a significant achievement for John, and this physical reminder of him seemed to represent a transitional object: John wanted me to remember him and offered a physical reminder of our time together.

C.3.2. Evaluation of the work

The sessions with John allowed me to observe several positive changes in John. These changes serve as markers of some successes of the sessions. However, the time I spent with John was a learning experience for me and also offered the opportunity to recognise some of the ways I could have improved the work.

Upon reflection, it is impossible not to question how the fact I was a White British woman impacted the sessions. The clash of cultures presented several challenges and I wonder if a shared culture between us would have benefited the work. However, given the stigma surrounding mental health issues in John's home country, I also wondered if it was beneficial that I was a foreigner. I wonder if John would have experienced more shame and difficulty exposing his vulnerabilities if he had viewed me as a member of his culture.

My gender also impacted the sessions: John's relationships with women, and his mother, had been a focus of our work. I suspect the course of therapy would have been different with a male therapist. John had quite fixed rules about gender-appropriate behaviour, and it felt as though talking about feelings and thoughts were not considered very 'male' in his eyes. Perhaps a male therapist would have been able to model something different in terms of challenging this idea. Alternatively, perhaps talking to a male would have been more difficult for John.

One limitation of the work related to my own ignorance of Iranian culture and history. Many therapists feel overwhelmed when confronted by the horrors survivors of war present with (Patel & Mahtani, 2007), and there were moments that I felt paralysed in terms of how to respond to the appalling details John was telling me.

C.3.3. Liaison with other professionals

John's keyworker and I would meet on a monthly/six-weekly basis to share information. John's keyworker was psychologically minded, and willing to be consistent with the messages John

was getting from me. It was useful to hear her experience of John and the changes she noticed in him.

John would occasionally request I liaise with other members of support staff, for example asking me to phone someone regarding his benefits. We would discuss such requests and find strategies to increase John's confidence that he could do these things for himself (for example, writing down bullet points of things he wanted to say, before phoning, helped him make his point more effectively).

C.3.4. What you learnt about psychological practice and theory

John is an excellent example of the complex interface between culture, faith and experience of psychological distress. The literature explaining Iranian patient profiles was helpful but could have led to an oversimplification. Background information, and specifically, lectures relating to culture and health beliefs, would have helped me in the moments I felt particularly British. However, essentially, I learnt that as long as I asked open questions and created space for his spirituality, culture and beliefs, I would create an environment of mutual learning.

John also taught me the importance of noticing non-verbal cues and asking about physical health. Whilst I felt convinced his bodily symptoms were linked to his psychological state, I had no training in the body or the spirit. Martin (2009) offers qualitative data explaining how Iranian clients felt frustrated by clinicians' focus on the 'mind' when they presented doctors with illnesses of the spirit ('ruh' in Farsi). John had sought regular medical advice for his physical conditions; therefore I felt reassured the doctors felt there was no immediate health concern. Working with John involved focusing on his posture and physical symptoms more than I would usually. The way John sat, or retched or rubbed a joint that appeared to be causing him discomfort were useful cues to the process of therapy. I would encourage him to articulate what he was thinking and feeling, but I tried to acknowledge where he was coming from by avoiding a strictly 'psychological' agenda. John had rehearsed mindfulness and meditation exercises at the Buddhist centre; these resources were useful in helping him notice the link between emotional states and physical symptoms.

The work with John offered me opportunities to learn about myself as a therapist and to contextualise my allegiance to mainstream psychological theory. These lessons had a positive impact on my clinical practice as I explored the significance of culture, a term too often applied to the foreign. John helped to recognise the cultural values underpinning mainstream psychology whist confronting me with ideas that did not easily fit the conceptual framework of my training.

C.4. References

Adebimpe, V. R. (1997). Mental illness among African Americans. In Ihsan Al-Issa & Michael Tousignant, [Eds] *Ethnicity, immigration and psychopathology* pp. 95-107. New York & London: Plenum Press..

al-Issa, I. (1995). The illusion of reality or the reality of illusion: Hallucinations and culture. *British Journal of Psychiatry, 166,* 368-373.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th edn.). Washington DC: American Psychiatric Association.

Bakhshani, N. M., Birashk, B., Atefvahid, M. K., & Bolhari, J. (2003). Correlation of social support and negative events with depression. *Iranian Journal of Psychiatry and Clinical Psychology*, 9(2), 49-33.

Bateman, A. W. & Holmes, J. (1995). *Introduction to psychoanalysis: Contemporary theory and practice.* Routledge: London.

Caplan, P. J. (1995). *They say you're crazy: How the world's most powerful psychiatrists decide who's normal.* Reading, MA: Addison-Wesley

Fischer, E. H. & Turner, J. (1970). Orientation to seeking professional psychological help: Development and research utility of an attitude scale. *Journal of Consulting and Clinical Psychology, 35,* 79-90.

Ghazi-Moghadam, S. (2009). *A qualitative study of the perceived attitudes toward counseling and effective counseling practices in working with clients of Iranian origin.* A dissertation submitted to the faculty of the graduate school of the University of Minnesota. Last accessed 12th May, 2013 http://conservancy.umn.edu/bitstream/57460/1/GhaziMoghadam_umn_0130E_10761.pdf

Hakimshooshtary, M., Alagheband, Rad J., Sharifi, V., Arabgol, F., Shabani, A., & Shahrivar, Z. et al. (2007). Profile of major depressive disorder symptoms among patients in Tehran. *Iranian Journal of Psychiatry and Clinical Psychology, 2,*35-41.

Jacobs, M. (1989). Psychodynamic counselling in action. London: Sage.

Krippner, S. & McIntyre, T. M. (2003). *The psychological impact of war trauma on civilians: An international perspective.* Greenwood Publishing Group.

Linehan, M. M. (1993). *Skills training manual for treatment of borderline personality disorder.* New York: Guilford Press.

Lipson, J. G. & Meleis, A. I. (1983). Issues in health care of middle-eastern patients. *Western Journal of Medicine, 139,* 854-861.

Mallinckrodt, B., Porter, M. J., & Kivlighan, D. M. J. (2005). Client attachment to therapist, depth of in-session exploration, and object relations in brief psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 42,* 85-100.

Martin, S. (2009). Illness of the mind or illness of the spirit? Mental health-related conceptualization and practices of older Iranian immigrants. *Health & Social Work, 34*(2), 117-126.

McLeod, J. (1993). *An introduction to counselling.* Buckingham: Open University Press.

Patel, N. & Mahtani, A. (2007). Asylum 6: The politics of working with refugee survivors of torture. *The Psychologist, 20*(3) (March 2007), 164-166.

Racker, H. (1968). *Transference and counter-transference.* London: Hogarth. (Reprinted London: Karnac, 1982).

Rahimi, A. (1989). *Attitudes of selected Iranian students toward seeking professional psychological help.* Ph.D. dissertation, University of Southern California.

Read, J., Fink, P. J., Rudegeair, T., & Whitfield, C. L. (2008). Child maltreatment and psychosis: A return to a genuinely integrated bio-psycho-social model. *Clinical Schizophrenia and Related Psychoses, 2,* 235-254.

Rogers, C. R. (2004). *On becoming a person a therapist's view of psychotherapy.* London: Constable.

Russell, D. (1994). Psychiatric diagnosis and the interests of women. In J. Z. Sadler, O. P. Wiggins, & M. A. Schwartz (Eds.), *Philosophical perspectives on psychiatric diagnostic classification* (pp. 246-258). Baltimore: Johns Hopkins University Press.

Seifsafari, S., Firoozabadi, A., Ghanizadeh, A., & Salehi, A. (2013). A symptom profile analysis of depression in a sample of Iranian patients. *Iranian Journal of Medical Sciences, 38*(1), 22-29.

Sharifi, V., Daliri, S., Amini, H., & Mohammadi, M. (2011). Psychiatric problems in general outpatient clinics: Prevalence and reasons for help seeking. *Iranian Journal of Psychiatry and Clinical Psychology, 16*(4), 484-489.

Varese, F., Smeets, F., Drukker, M., Lieverse, R., Lataster, T., Viechtbauer, W., Read, J., van Os, J., & Bentall, R. P. (2012). Childhood adversities increase the risk of psychosis: A meta-analysis of patient-control, prospective- and cross-sectional cohort studies. *Schizophrenia Bulletin, 38*, 661-71

Young, J. (1990). *Cognitive therapy for personality disorders: A schema focused approach*. Saratosa: Professional Resource Exchange.

Young, J., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy: A practitioner's guide*. New York: Guilford Press.

D. PUBLISHABLE PIECE

'THE AFRICAN ALWAYS BELIEVES THAT THERE IS ALWAYS A SPIRITUAL SIDE TO EVERYTHING.'

LESSONS FROM GHANAIAN COLLEAGUES: WORKING WITH AFRICAN CLIENTS.

D.1. Abstract

Aims: Inspired by the research efforts in the UK to improve service user engagement and outcome, the present study aimed to learn from Ghanaian colleagues working within the field of mental health. This study aimed to take a fresh perspective on the challenges facing psychology in an increasing multi-cultural Britain, by visiting a cultural centre of traditional, spiritual and religious health beliefs: Ghana. The project hoped to gain an understanding of Ghanaian mental health professionals' experiences of working in a culture where traditional or spiritual explanations for experiences that are classified as mental illness by Western psychiatric approaches are common.

Methods: Theoretical sampling was used to incorporate the expertise of mental health professionals in Ghana. Eight mental health professionals were interviewed using semi-structured interviews (four clinical psychologists, one psychiatrist, 2 psychiatric nurses and a charity worker specialising in mental illness). A focus group of twelve trainee clinical psychologists was also facilitated. The data was thematically analysed according to the procedure of Braun and Clarke (2006).

Findings: The data revealed several challenges to the delivery of psychological services in Ghana. The participants identified several strategies in response to these challenges as they described their work with Ghanaian clients.

Discussion: The findings are considered in terms of the challenges facing the UK to improve service engagement, and experience of, services for Africans living in the UK. Clinical implications are discussed.

Keywords: culture, health beliefs, Ghana, Africa

D.2. Introduction

In modern Britain, it is estimated that one in six of the population identify themselves as belonging to an ethnic group other than 'White British' and these figures are on the increase (Office of National Statistics, 2011). However, BME service users use, and experience, mainstream services less positively than the White majority (Kiev, 1965; Hemsi, 1967; Sashidharan, 2003). There is an alarmingly higher rate of compulsory admissions for Black compared with White patients (Ineichen et al., 1984; Moodley & Thornicroft, 1988; Harrison et al., 1989; Dunn & Fahy, 1990; Moodley & Perkins, 1991; Owens et al., 1991; Birchwood et al., 1992; Crowley & Simmons, 1992; Lloyd & Moodley, 1992; Perkins & Moodley, 1993;

Thomas et al., 1993; Davies et al., 1996; Koffman et al., 1997; McCreadie et al., 1997; Parkman et al., 1997; Singh et al., 1998; Takei et al., 1998; Commander et al., 1999; Bhui et al., 2003; MHAC, 2008). Black service users make less use of early treatment options (Keating et al., 2002; Rwegellera, 1980). Research suggests that in the UK, Black people are often reluctant to engage with mainstream mental health services and tend to do so in times of crisis or breakdown (Bhui, Stansfeld, Hull, Priebe, Mole & Feder 2003). Mental health services are unattractive to some ethnic groups, who complain of more coercive treatments and adverse experiences (Cochrane & Sashidharan, 1996). The impact of poor use of primary care services, and more frequent use of involuntary admissions result in the use of high-cost services (SCMH, 2006); preventative strategies in response to this problem would be money well spent.

Mental health services are now legally obliged, like many other public institutions, to address criticisms that psychiatric and psychological disciplines are imbued with racism. The Race Relations (Amendment) Act (2000) represents a shift in the law, making it illegal for direct and indirect racism to exist in all public authority services. The Department of Health launched a 'Delivering Race Equality (DRE)' programme in response to the amended act, demonstrating its intent to address ethnic inequalities (Wilson, 2009). Similarly, the 2010 NICE guidelines on schizophrenia call for psychosis services to address inequalities in service use and experience, and recommends that clients' explanatory models of illness should be better understood by service providers.

All applied psychologists need support addressing ignorance of issues of culture and faith. Our first task relates to addressing ignorance surrounding culturally influenced health beliefs and alternative help-seeking and healing approaches. Psychology regularly encounters criticism for being racist as it is underpinned by Eurocentric values, beliefs and worldviews, resulting in it lacking cross-cultural relevance (Sue, 1981; Wrenn, 1962; Naidoo, 1996; Fernando, 1995). Eurocentric values reflect principles of individualism, positivism, competitiveness, dualistic thinking, a belief in control over nature, hierarchical decision-making processes, a rigid time orientation, future orientation, property ownership and nuclear family structure (Blackmon & Vera, 2008). However, many other cultures emphasise different values.

In Ghana, mutual help, collective responsibility and honouring community obligations are seen as important (Utley, 2009) and traditional African religions and beliefs underpin much of society. In Africa, negative life events, including states of illness, especially psychiatric disorders, are often attributed to the activities of external causes such as evil spirits, enemies and the gods, etc. (Aina, 2006). Hysterical phenomena are considered to be due to possession

by some extraneous force (Parrinder, 1951). External causes are blamed for physical and mental ill health, and these 'external causes' reflect traditional African values (Aina, 2006). Breaching taboos and local customs, disturbances in social relations, hostile ancestral spirit possession, attacks from witches, demonic afflictions, sorcery and afflictions by the gods are all possible explanations for ill health (Edigbo, Oluka, Ezenwa, Obidigbo & Okwaraji, 1995; Aina, 2006). Research has demonstrated that culture influences help-seeking behaviour and expressions of distress (Bhui, Bhugra & Goldberg, 2002; Gater et al., 1991; Bhui, Stansfeld, Hull, Priebe, Mole & Feder 2003). However, few have explored the culture clash between Eurocentric ideas and alternative worldviews, attempting to offer practical solutions to the challenges facing mainstream services. This clash is arguably at the heart of the challenges we face improving the service use, and experience of services, for our BME clients. Understanding these challenges, and generating strategies to respond to these challenges, should be a primary agenda for mainstream psychology, and cease existing on the periphery. The discipline must strive to a position of universal relevance and equality. Fundamentally and philosophically, this involves a willingness to learn from others. This research aimed to shine a spotlight on the expertise of our Ghanaian colleagues.

Ghana

As one of the first countries to gain independence in 1957, Ghana was one of the pioneers of primary health care in the region (Twumasi, 1979). English is the official language, although several other local languages are still spoken widely. When compared to other African countries, Ghana is relatively well resourced for mental health care (Jacob, Sharan & Mirza et al., 2007; Ofori-Atta & Read et al., 2010). That said, as in many low-income countries, mainstream mental health services are under resourced, frequently lacking appropriate medication (Yaro et al., 2009) and mental health staff (Ofori-Atta & Read et al., 2010). There are three government psychiatric hospitals in Ghana and these facilities are clustered in the southern urban areas (Doku et al., 2008), leaving vast spaces without easy access to hospitals. In 2005, the human resources for mental health care were reported to be: 15 psychiatrists, 468 psychiatric nurses, 132 community psychiatric nurses (based in the ten regions covering 69 of the 138 districts), 7 psychologists, 10 medical assistants, 6 social workers and 1 occupational therapist (Ofori-Atta, Read & Lund, 2010). Charities, non-government organisations and private facilities add to these figures.

D.3. Methods

A qualitative methodological design was selected as quantitative methods are less conducive to conducting an in-depth exploration of an area about which relatively little is known

(Henwood & Pidgeon, 1992). The advantages of conducting qualitative research include its ability to attend to the complexity of the phenomenon being researched; its ability to facilitate the active engagement of participants; and its primary aim of advancing understanding. Methodological designs involving observing participants (e.g. ethnography) were rejected in favour of a research design that recognised that the particiapants were the experts and prioritised positive participant experience (semi-structured interviews).

Sampling/inclusion criteria

The inclusion criteria aimed to encompass professionals that worked within the provision of mental health care who could offer expertise. Theoretical sampling was used to include relevant and diverse participant perspectives. Ghanaians were eligible to participate in the study if they worked within the field of mental health, and described what they do as offering 'psychological help'. Due to differences in training, it would have been difficult to equate qualifications.

Background

The researcher, a White British female, made frequent trips to Ghana over ten years before the research was designed. Participation in Ghanaian ceremonies, celebrations and aspects of community living enabled the researcher familiarisation with some aspects of Ghanaian culture. These experiences acted as a catalyst for the design of this study, as did frustrating gaps in the literature, inadequate clinical training in this area and negative domestic media coverage of traditional African healing approaches.

Ethical considerations

City University granted ethical approval. Permission was also granted by senior clinicians in Ghana to conduct research within the psychiatric hospitals.

Interviews

One-to-one, semi-structured interviews were planned with participants. Each interview lasted up to ninety minutes, with the average interview lasting just over an hour. Interviews were recorded on an audio device and later transcribed.

Each interviewee was asked three set questions:

1. How do you define the term 'traditional healer'?
2. Have you ever worked with a client that attributed their difficulties to traditional explanations?
3. If so, how did you work with this client?

The rest of the time was free for more reactive questions necessary to clarify and expand on the information given. Dearnley (2005) asserts that the open nature of questions encourages depth and vitality in the participant's discourse and allows new concepts to emerge. The researcher's open questions 'function as triggers that encourage the participant to talk' (Willig, 2001, p. 22). At the end of each interview, participants were asked to reflect on the experience of being interviewed.

Participants

Eight mental health professionals were interviewed (4 clinical psychologists, 1 psychiatrist, 2 community psychiatric nurses and a charity worker specialising in mental illness). A focus group of twelve trainee clinical psychologists was also facilitated. The participants ranged in terms of experience, qualifications and age (ranging from twenty-five to fifty-four). All participants were Ghanaian nationals and lived and worked in Ghana. Both genders were represented, although more females took part in the study (13:6). Two participants had trained overseas (America and Britain).

D.4. Data analysis

Thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data (Braun & Clarke, 2006). One of the major advantages of employing thematic analysis (TA) for this research was that it was able to generate unanticipated insights in research areas where relatively little is known and is thus a useful tool for producing qualitative analyses suited to informing policy development (Braun & Clarke, 2006). Thematic analysis is able to incorporate key approaches from conflicting epistemological positions (Guest, MacQueen & Namey, 2012): it is described as a 'contextualist' method, sitting between the two poles of essentialism and constructionism (Braun & Clarke, 2006), and characterised by theories such as critical realism (e.g. Willig, 1999). TA enabled the project to be explicit about what the participants *actually said*, versus what the researcher *thought* about what the participants said in terms of contextualising the data and its relevance to psychology in the UK.

An absence of clear guidelines around thematic analysis means that there is an 'anything goes' critique of the approach (Antaki et al., 2002; Attride-Stirling, 2001; Boyatzis, 1998; Tuckett, 2005). There is a naive realist view of qualitative research; 'giving a voice to data' involves active selection, editing and interpretation (Fine, 2002; Ely et al., 1997; Taylor & Ussher, 2001; Braun & Clarke, 2006). Braun and Clarke's (2006) stages of thematic analysis were the framework for analysis. Transcribing involved engaging and reflecting on the data. Initial chunks were then highlighted and preliminarily coded. At this stage, codes

summarised what was happening in the 'chunk' and were varied and many. These initial codes helped identify significant themes and were revised and refined before a coding manual was created. After the initial analysis was conducted, the participants were contacted to validate the preliminary findings. Summaries of the themes identified were emailed to all participants, with prompt questions to generate discussion. Minor amendments were made at this time. The data was then coded again, with the coding manual, to establish an accessible summary of the majority of the data collected. Direct quotations were used to illustrate the themes and sub-themes, with the aim of keeping the analysis as close to the original data as possible. The discussion chapter allowed the researcher the opportunity to present an interpretation of these findings, and attempt to contextualise the findings in terms of other literature and research.

Reflectivity

It is relevant to reflect on the fact that the research was conducted by a White British woman, which may have impacted how the participants responded, how the data was interpreted and what chunks of data were attended to. The research explored how African clients experience 'white treatments' and the fact that an English woman was interviewing African colleagues is a potential limitation of the design. Perhaps participants would have answered differently if interviewed by an African researcher. However, the researcher's naivety to the subject enabled the naive questions to be asked and mirrors the situation of mainstream services in the UK. The fact that the researcher and the participants were in the same line of work enabled the researcher to shift between emic and etic positions.

Whilst no process of analysis can simply give voice to the data, the research design was transparent in its aims to learn from Ghanaian colleagues about a phenomenon that they had a lot more knowledge of than the researcher. It was necessary to clarify points and encourage participants to elaborate on their answers by disclosing how interesting their perspective was. During the interview process, it was interesting to note that the UK was considered a place lacking a strong Christian faith.

> *'We are very different from the Western world, we Africans, we Africans are very spiritual, feel, erm I believe this, if you look around you find a whole lot of church buildings around. If you go to England you can hardly find one church.' Participant 4*

Other comments helped to reveal the global Eurocentric dominance and social and financial privilege associated with White skin. One participant joked I should marry their nephew! I was aware of actively challenging assumptions I suspected the Ghanaian participants held

about me. I revealed I had visited Ghana several times over the last ten years and disclosed I stay in Chokor, one of the poorest areas in Accra. Often the participants would then exclaim, 'Well then you are Ghanaian!' My experience of Ghana has helped me learn enough of the culture to conduct the research respectfully.

D.5. Findings

The data was organised into four categories, each consisting of sub-themes (see figure D1). The first theme involved data that related to the parallel belief systems the participants described. Understanding an ability to occupy multiple positions in terms of worldviews and beliefs was fundamental to understanding the data. Parallel belief systems were described in terms of the participants' own beliefs, the healers' approach and the Ghanaian patients.

The second theme describes the relationship between disciplines and approaches, including sources of tension, areas of commonality and collaboration, and data that documents how Ghanaian mental health professionals negotiate boundaries between approaches. The third theme includes data that describes the Ghanaian patients' help-seeking behaviour, and how the psychological and psychiatric services have tried to respond to barriers in an attempt to enhance pathways to their services.

The final theme relates to the specifics of working psychologically in the Ghanaian context. This theme includes subthemes relating to client expectations, challenges associated with formulating client presentations, specialist knowledge of Ghanaian mental health professionals, incorporating spirituality and action-orientated strategies that were described to increase the effectiveness of psychological therapy.

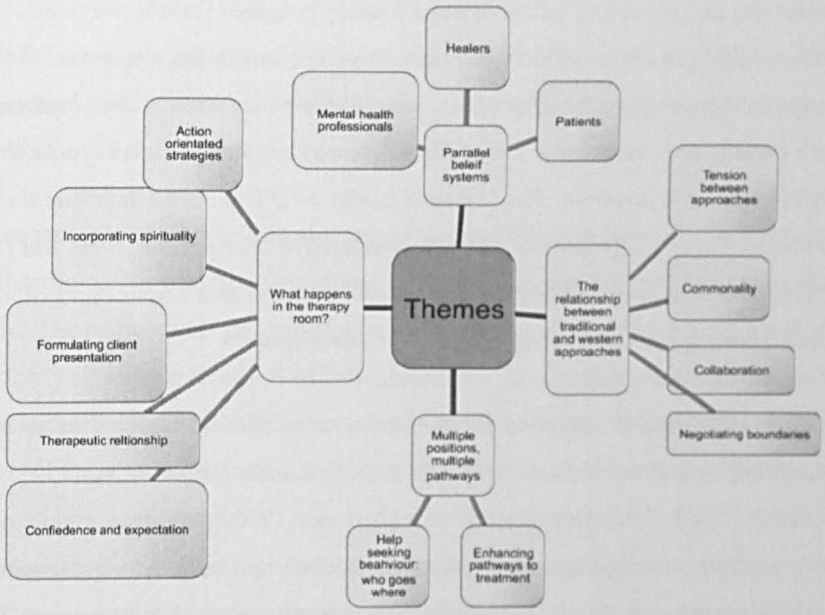


Figure D1: Map of themes and subthemes within the data

D.6. Theme one: '*I believe in tradition and I believe in medicine…*'

Parallel belief systems

Understanding that Ghanaians can congruently occupy multiple positions in terms of worldviews, and integrate and consolidate these approaches, is of fundamental importance in understanding the data. The participants introduced the idea that fact and faith can co-exist with apparent ease, a notion that represented an advantage of the Ghanaian mental health professionals and highlighted a significant component of their ability to understand their patients. Descriptions of the participants' own belief system, the alternative healer's approach, and the Ghanaian patients' explanatory models of their symptoms all included information about multiple positions in terms of worldview and belief systems.

Ghanaian mental health professionals integrated their culture and clinical training. The participants were not dismissive of, or rejecting of, the health beliefs associated with traditional African ideas, and demonstrated an understanding that there was truth in an approach that was so different to their training. Most commonly, there was a description of not *believing* in these ideas whilst recognising them as *true*.

'I know. You see, this is Africa and I don't believe in witches and I don't believe in curse. But I know it exists. There are cases where (... ...) erm it does happen, well I don't believe in it but I know - as a Christian and as, with my level of education I don't believe it is possible. But I know it exists. So if it is a true, it is true that the person has been really cursed, the rituals can solve the problem. Fine. But I wouldn't be able to erm to know when this is spiritual because I don't have that skill okay but I believe that I know that it does exist. Yes.' Participant 6

The participants represented a privileged position in terms of education and social status (factors described by the participants as being correlated with a stronger belief in modern/Western ideas). They were trained in mainstream (Western) ideas, and demonstrated an allegiance to their training, in many respects. However, it is critical to understand that these participants were also shaped by beliefs that underpin much of their culture. They seemed comfortable recognising the skills and expertise associated with healing approaches.

It was important to understand the historical context of what they were describing. In a world in which Eurocentric ideas are dominant, participants explained that many Ghanaians strive to be identified as 'enlightened', which means superficially identifying with a modern worldview. Respondents reported that whilst traditional ideas are still widespread amongst the population, people are often reluctant to identify themselves as traditional purists as a result of Christianity. It seemed traditional ideas transpose religions and science as they are firmly rooted in the culture, although traditional healing is often shrouded in secrecy:

'And don't forget that some years back, or in as a result of religion, Christianity and the rest the traditional healers have been more or less demonised. That they are evil, erm they are hidden and they have nothing good to offer. So they have either protested quietly or recoiled erm into the background.' Participant 3

By contextualising the belief systems associated with the different worldviews, it becomes easier to see how Ghanaians are able to occupy multiple positions. Descriptions of traditional and alternative healing practices revealed a similar parallel belief system to that of the mental health professionals. Some healers were described as purists to their approach, viewing Western treatments with suspicion and resentment (which is understandable in terms of their historical relationship). However, many healers were described as integrating different healing approaches. Indeed, the term 'traditionalism' was revised, as in modern Ghana; ideas from Christianity and science have transposed indigenous beliefs, in many cases. Therefore, the term 'alternative' better captures the work of healers operating outside mainstream approaches. Respondents described how traditional ideas had shaped Christianity in Ghana:

'Um, some of them may prefer the Christian belief and mind you our understanding of Christianity is quite, um, culturally influenced. Um, a lot of Africans transpose our cultural belief system into Christianity and it might be different from the way you in Britain...' Participant 2

Ghanaian patients' health beliefs also represent multiple worldviews. Throughout the data, spiritual, religious or traditional explanations for psychological suffering were described as the norm. The respondents described a small subgroup of patients that they felt would seek help at the hospital as a first port of call. However, participants were unanimous in explaining that Ghanaians represent an ability to occupy multiple positions in terms of how they interpreted experiences of mental illness, and subsequent help-seeking behaviour.

'Sometimes you find that even though the person is Christian, professing to be Christian, they have been to some of those other places...' Participant 7

The participants explained that if a patient identifies himself or herself as aligned to one particular faith or worldview, it does not always translate to a specific route to treatment. Pathways to treatment reflected a trial-and-error approach.

D.7. Theme two: *'You must work together, you cannot build walls between us.'*

The relationship between Western approaches and alternative healing approaches

All of the respondents articulated sources of tension between approaches: charlatans offering placebos, financial exploitation, sexual abuse and difficulties regulating aspects of unsafe practice were reported. Ghanaian mental health professionals expressed concern regarding several practices, including: the use of physical restraints (chains, tree trunks, etc.), the use of flogging and beating, fasting, scarification, burns, sleep deprivation, blood flow restriction, dehydration/starvation and the use of Western medication without proper training or monitoring. Restricted bathing, dirty living conditions and infections resulting from poor hygiene were also described.

'Flogging the patient. Now why are they doing that? They are doing that on the understanding that they are beating out the spirits that has invaded the body, right? The other thing is starvation, which they call, um, fasting. They basically starve the

patient. Now we try to tell them the man is ... or the woman is sick. How effectively is this person going to fast and pray when they are sick? OK?' Participant 2

The participants described risks associated with delayed presentation at medical facilities. Similarly, the participants expressed concern regarding the psychological harm associated with moral or magical explanations of mental illness. They described the stigma and poor treatment of sufferers of mental illness and explained many Ghanaians fear conditions are contagious or the result of a person's sins.

The participants seemed able to distinguish between safe and unsafe healers; they described a spectrum of different healing approaches with some areas of overlap between mainstream approaches and alternative healing. A fundamental similarity seemed to relate to the fact that they recognised that many of the healers are offering primary care. The participants articulated appreciating that many of the healers offered treatment to patients that would otherwise receive no treatment at all.

'What they do is good, because they are the first place people can go... let me put it this way - if I am sick, and you come to visit me, even if you just touch me, I feel relief because somebody cares...' Participant 5

Some participants articulated that areas of commonality related mostly to approaches the Western world would define as counselling.

'I think they employ principles of psychotherapy in a way, especially with counselling. In performing rituals and so on they actually end up should I say making the patient feel valuable - or valued and they listen to them and then they offer advice, so in mild to moderate depression, some anxiety disorders they are able to effectively treat them and that is why people still keep going there because there is something they are doing right...' Participant 2

Respondents described collaboration between medical and alternative approaches on a number of levels. A driving force in the process of collaboration was attributed to community psychiatric nurses (CPNs) and various outreach and community engagement projects. Participants also described the successes of BasicNeeds (an international organisation) that aims to identify healers and forge relationships with these healers. Participants reported strategies that alternative healers experienced positively (conferences organised to encourage information sharing, social gatherings and free resources) and stressed the importance of not judging the healers with whom they collaborated.

An interesting challenge reported by the respondents was about how to negotiate the relationship between the different disciplines. There was an expressed fear that clinicians have a way of avoiding work with a client who is treatment-resistant by attributing the illness to a spiritual cause.

> *'I think a doctor that recommends traditional treatment has forgotten his job...'*
> *Participant 2*

The ethical issues involved in negotiating how to bring spirituality into the room without stepping outside of one's own discipline was considered a challenge by many of the clinicians I interviewed.

D.8. Theme three: *'You'll be sure that the majority of the patients you'll be seeing do not choose you as a doctor as a first option.'*

Multiple positions, multiple pathways

Due to the plurality of Ghanaians' health beliefs, and as a symptom of the interface between different healing approaches, data relating to 'pathways to treatment' was a significant theme. Several challenges were identified to the delivery of mainstream psychological and psychiatric treatments.

Whilst structural barriers account for physical obstacles to treatment, attitudinal barriers were significant too. The clinicians were unanimous in reporting that attitudinal barriers (alternative health beliefs) resulted in many patients presenting at mainstream services as a last resort. Alternative health beliefs were thought to reinforce and maintain stigma surrounding mental illness, and the secrecy that shrouds alternative healing practices is appealing to those fearing the stigma associated with being a patient at the psychiatric hospital.

Many of the interviewees described difficulties engaging patients in psychological and psychiatric services due to differences in health beliefs. Most of the interviewees spoke of the importance of spirituality in Africa, which was reflected by their accounts of clients seeking help with spiritual, traditional or alternative healers as a first port of call. Addressing the spiritual side to an illness or problem was reported to be of great importance to the Ghanaian patient and alternative healing was described as common alongside, preceding or post mainstream treatment. The respondents reported that clients delayed presenting to psychological and psychiatric services because they first sought alternative healing. Respondents suggested that a patient's family or community often served to reinforce an

alternative explanation of the mental illness and thereby maintain existing help-seeking patterns.

> *'No some come from the traditional healers, when it is getting worse. Sometimes on the verge of dying then they send the person to the hospital. So in most case they believe in that, they have to first take the sick to the ritual healing before any physical healing.' Focus group*

The data suggests advice from friends and relatives has a significant impact on where an individual will seek treatment. Instead of having a firm allegiance to one approach (religious, traditional or Western), the Ghanaian patient was more likely to try what they felt could work. Many participants described seeing patients that engaged in alternative healing practices as well as psychiatric/psychological treatment; these patients often attributed positive treatment outcomes to the alternative healer or the power of God.

Other challenges associated with the interface between systems and health beliefs related to risk of disengagement, non-compliance and future help-seeking being at alternative sites of healing if a patient experiences a relapse.

The participants described strategies relating to addressing public health concerns, aimed at educating the population about Western models of psychological suffering and mental illness. These strategies include laws that aim to regulate alternative healing practices, community outreach and education programmes and a Mental Health Bill (that was passed in March, 2012). Respondents described community education programmes that were often facilitated by community nurses or organisations like BasicNeeds.

> *'Slowly slowly. We go to villages, churches, schools.... educating the young ones is good. We tell them whatever. And they see from what we do. But we cannot change their minds... not to entirely forget about traditional ideas - no!' Participant 5 (R1)*

Working in the community is vital if attitudinal barriers are to be addressed. The culture clash between Western and local indigenous worldviews can be reduced by gently exposing the population to positive experiences of psychiatric and psychological services.

D.9. Theme four: *'But I think that is what is not being addressed from the mainstream Western medical, spirituality.'*

Eurocentric interventions in the Ghanaian context – what happens in the therapy room?

The fourth theme explores the specifics of working psychologically in the Ghanaian context. The psychologists interviewed for this research described trying to modify Western techniques to suit their clients. Many favoured CBT for the time-limited nature of their therapy, but reported that they modify it to fit the cultural context. Psycho-education was a significant component of the work, encouraging the client to have more confidence in psychological therapy. Involving family members, and sometime pastors or other significant individuals, was described, as the participants recognised the significance of the major stakeholders in a person's treatment. Involving significant members of the community was used as a strategy to reinforce what the professional was saying to the patient, and to increase patient confidence in the treatment plan.

Many of the interviewees felt that their patients did not have much confidence in the treatment being offered by the hospital, as it did not fit with their beliefs regarding the cause of the illness. A client's lack of conviction in psychological and psychiatric models of treatment was a recurring theme, and was reported to be an obstacle in the delivery of mainstream treatments. Many of the participants interviewed thought that some people who could benefit from seeing a psychologist are not aware of the service they offer.

Part of the appeal of alternative healers was attributed to the concrete, directive advice they give, offering an *explanation* for a person's suffering and strategies to *remove or undo* the cause in some way. In contrast to this approach, mainstream practitioners are trained towards fostering a collaborative relationship, gently guiding patients towards self-discovery. Participants explained they thought this approach was experienced as unsatisfactory by many Ghanaian patients and resulted in low expectations for treatment. Participants explained that as many Ghanaians are not very socialised to the idea of therapy, they expect a similar relationship to the ones they have with their pastor or healer. Similarly, as psychologists are seen as members of the 'medical' camp, which is a position of high social status, expert advice is expected.

Several respondents described needing to work hard to gain the patient's trust. One respondent explained that entwined with the cultural values of connectedness was a need for some reciprocal conversation. The participants described pre-therapy with their clients. Some participants described responding to the expectations that their clients had for direct

advice, by employing testimonials of other patients with similar complaints they had treated successfully, or by being more directive in early sessions. The use of relaxation tools in the first session was also described, as a useful way of offering evidence that the approach could help.

The issue of when to disclose the therapist's own belief system was also discussed as it was thought to impact the client's expectations for therapy. The issue of how to handle direct questions about the practitioner's belief in traditional ideas was also raised. This data seemed to describe therapeutic relationships that were congruent, transparent and respectful.

> *'Now they ask me whether I believe in witchcraft. It's always a difficult point to say, "Well I don't believe in witchcraft", in which case a patient will not have trust in me or I will say, "Well I'm a Christian, the Bible talks about witchcraft, yes, but, um, they may be existent, but what I know is that whether there is witchcraft or not, people like you have presented with these symptoms to me severally and the so-called spirits have left them. They responded to my treatment."' Participant 2*

Disclosing the clinician's belief in God seemed to help bridge the gap between the different worldviews.

Another emerging theme relating to obstacles to psychological work related to the difficulties in formulating a client's presentation and/or defining what constituted mental illness. Respondents described how delusions are maintained or reinforced by the family or community, or how ideas that sound like delusions may be socially acceptable in the client's local context.

> *'You see the, the problem for me is we buy into the concept that erm if you believe somebody has hexed you then that's just a part of the culture, it's not, well a certain, at a certain point you will have to make a determination that you are paranoid, you know. And I think we, we, we take the, the perhaps a romanticism of African beliefs too far. So I, we haven't written enough about it to alert clinicians to say, "Okay when, when you see somebody that's come with this belief treat them as you would the person that is paranoid..."' Participant 1*

The participants were not unanimous in their descriptions of how they formulate clients' health beliefs. One explanation of this discrepancy in the data is that Western classifications did not always fit.

Clinicians described several therapeutic strategies for working with this client group. An understanding of traditional African healing practices and beliefs and aspects of a shared

culture seemed a major advantage to their work. The participants revealed that operating within a shared culture aided their work with clients. These included such aspects as the importance of family, community and spirituality. A shared culture between clinicians and patients enabled interventions from mainstream psychology to be sensitively modified to meet the needs of the Ghanaian population. Ghanaian psychologists also had the significant advantage of being taught about traditional healing practices as part of their clinical training. Respondents reported that they were encouraged to visit prayer camps and healing centres, and that their training involved lectures on these approaches.

> *'...But we do have a class on, a couple of classes maybe, on traditional healing and what, what they do, what you expect and someone who has been there, to present with, um things like that, how you can work within their system.' Participant 7*

Specialist training equips clinicians to conduct risk assessments, and have dialogues about health beliefs that will shape a person's experience of mental illness and their confidence and expectations for treatment. Many of the participants described trying to incorporate spirituality into their therapy. Many felt that spirituality was not properly addressed by mainstream Western psychology, and that it was difficult to work with African clients without taking a more holistic approach to treatment.

The participants described many strategies to incorporate spirituality. Using the bible or other religious texts, especially scriptures that speak of forgiveness and second chances, was reported to be used in treatment sessions by many of the respondents when clients feared their illness resulted from sins they had committed. Working within a patient's belief system was described as a balancing act between reaffirming the belief and challenging a belief in a way that would alienate the client. The participants' ability to occupy multiple positions when integrating their own faith and culture into the treatment is evident.

> *'And I try to use the bible as a Christian, because the knowledge erm faith healers, wherever they get their spirit from, their power is coming from God. And the knowledge I have as a psychologist, I believe is also coming from God. So if you believe that God, I mean give both knowledge why don't you use both? And two methods is always better than one, that is my idea.' Participant 6*

Participants described encouraging a client to develop a good relationship with God. Building a stronger spirit was thought to help those that believed someone had cursed them, without challenging or reaffirming the belief directly. Respondents described focusing on the positive aspects of the patient's belief. Engagement in a church was described as a behavioural tool that could be used to help treat mental illness. As with all cognitive behavioural therapists, the clinicians described behavioural activation assignments that reflected the resources

available to the client, and the values that impact the client's motivation to engage with homework tasks. Respondents explained that regular attendance at a church involved socialising, singing and dancing, all of which have benefits to mental health.

D.10. Discussion:

Similarities: Obstacles to treatment

This study suggests there are similarities between Ghana and the UK in terms of obstacles to the delivery of psychological services. Differences in help-seeking and client engagement have been reported in the UK (e.g. Rwegellera, 1980; Commander et al., 1999; Bhui, 2001; Keating et al., 2002; Bhui et al., 2003; Morgan et al., 2005), as have difficulties gaining client trust and encouraging clients to disclose their beliefs (e.g. Nicholls, 2002). Similarly, problems with cross-cultural diagnoses and formulating BME clients' difficulties have been described outside Ghana (e.g. Littlewood & Lipsedge, 1981; Sashidharan, 1993). Trials associated with maximising the effectiveness of therapy (e.g. Sue, Fujini, Hu, Takeuchi & Zane, 1991) and managing higher than expected disengagement/relapse rates (Bhugra, 2001) have also been documented in the UK. The fact that research demonstrates that Africans are over represented in terms of forced admission to psychiatric services supports the hypothesis that a significant and under-researched variable is that of difference in help-seeking behaviour and interpretation of symptoms. In his study in Newham, Copsey (1997) made a similar conclusion:

> *'The belief system underpinning nearly half of Newham is grounded in non-Western culture. This culture has a long history of integration between the mind, body and spirit. Spiritual values are an essential part of life.' (1997, p. 14)*

The Ghanaian data revealed that Ghanaian mental health professionals perceived reluctance in some of their clients to disclose their explanatory models of their experience. The limited English research available has alluded to the fact that in the UK, service users fear that the professionals involved in their care will not understand their beliefs:

> *'You have to be cautious about what you say because not being mainstream, a little off track, you have to be very careful you're not condemned for what you believe by the professionals.' (Nicholls, 2002, p. 2).*

A fear of disclosing health beliefs of culturally relevant ideas creates a serious obstacle to

engagement and treatment. Over thirty years ago, Katon and Kleinman (1981) stated that a clinician's first task should be to understand a patient's explanatory model of their illness. Achieving this level of cultural competency is both difficult and complex, and may oversimplify the obstacles between two starkly different worldviews that have little knowledge of each other (Koss, 1987).

Another obstacle relating to a philosophical clash of worldviews and values relates to the difficulties of accurately diagnosing BME service users that present with alternative health beliefs. The high incidence of schizophrenia amongst African and Caribbean residents in England could reflect misdiagnosis by British psychiatrists unfamiliar with foreign beliefs (Littlewood & Lipsedge, 1981; Sashidharan, 1993; Sharpley et al., 2001; Hickling et al., 1999). It is plausible, based on the current research evidence, that British psychiatry pathologises experiences that have cultural relevance and meaning to those with alternative worldviews. As recent research with voice hearers suggests, not all unusual experiences are pathological (Jackson, 2001; Jackson & Fulford, 1997; Romme & Escher, 1993; Romme, Honig, Noorthoorn & Escher, 1992).

Another challenge facing mainstream services relates to the potential risks associated with alternative healing practices. The Ghanaian mental health professionals involved in this study identified several facets of risk associated with alternative healing practices. However, there is very little research in the West regarding alternative healing practices and psychiatric disorders. In 1998, Larkin wrote about preventable child fatalities in the USA associated with faith healing, warning that even if laws were stricter, those with strong religious or spiritual convictions that refuse to access medical care for their children were unlikely to change their actions. In the UK, the media attention given to the high-profile child deaths associated with witchcraft and magical/spiritual African worldviews has sparked an interest in safeguarding issues and culture; however, clinicians trained within a Eurocentric approach learn little in terms of alternative healing approaches and are probably naive to the potential risks associated with such practices. This study suggests safeguarding initiatives should be done in collaboration with the community and alternative healers.

Lessons for the UK

Involve family members

In the UK, research suggests that relatives of Black patients often report negative experiences of mental health services (Sashidaran, 2003; Arksey et al., 2002, Department of Health, 2005;

National Association for Black Mental Health, 2002), and wish to be more involved in the treatment plan (Newbigging, 2000), although much of the research is anecdotal. Even in family therapy there seem to be cultural differences in how professionals are experienced (Warren et al., 1973). Hall and Sandberg (2012) conducted qualitative research that explored how African Americans overcame barriers to engage in family therapy. Whilst their findings highlighted structural barriers (affordability, accessibility and availability) as well as attitudinal barriers (stigma, mistrust, the desire for privacy and the resistance of a family member to engage in therapy), there were several factors that could help minimise these barriers. The importance of the impact of friends and family in shaping the decision to engage in therapy was emphasised: supportive and non-supportive messages from friends and family were identified (Hall & Sandberg, 2012). Time spent with the family, explaining treatment approaches and involving them where possible are likely to be experienced positively by African service users. Singh (1999) suggested that if a patient brings a relative or friend to counselling, the therapist should allow the patient to invite them into the room and actively involve them in the session. Singh suggests that recognising that the family are important stakeholders in the treatment, and increasing family members' understanding and confidence in the treatment approach, can result in the family members acting as 'allies' that can encourage a patient to engage in services (Singh, 1999). Bhatti and Varghese (1995) explored family therapy in India and reported that the involvement of family members reduced the duration of hospitalisation, increased the family's acceptance of the patient and enhanced family coping.

Modify interventions

This research supports others in suggesting that psychological therapy can be modified to be more culturally sensitive (Rathod, Kingdon, Phiri & Gobbi, 2010; Wilson, 2009; Rathod, Phiri, Harris, Underwood, Thagadur, Padmanabi & Kingdon, 2013; Hays, 1995; Naeem et al., 2011; Clinical Trailblazers' programme; Hampshire Partnership NHS Foundation Trust, cited in DRE review paper). To do this successfully, it is necessary to first understand sources of conflict between the cultural values of ethnic minorities and the more mainstream values often used in conventional psychotherapies (Nagayama-Hall, 2001).

Modifications could include involving family members more, more pre-engagement (Hampshire Clinical Trailblazer), educating patients and their families about our approach and encouraging them to share their explanation of their experience by creating a therapeutic relationship that is respectful, collaborative and willing to incorporate a person's spirituality (Rosmarin, Auerback, Bigda-Peyton, Björgvinsson & Levendusky, 2011). An understanding

of a client's cultural background was highlighted as an important factor (Hampshire Clinical Trailblazer). A similar study in America found CBT could be successfully modified for African-American women by adding 'culturally specific therapy modules' such as 'spirituality/ religiosity' 'family issues' and 'healthy relationships' (Kohn, Oden, Munoz, Robinson & Leavitt, 2002). Research has supported the idea that when cultural factors are recognised in therapy, African-American clients are more likely to rapport positive outcomes (e.g. Sue et al., 1991).

Family therapists have led the way in identifying that work with African Americans should employ a 'strengths perspective' instead of focusing on pathology (Bell-Tolliver, Burgess & Brock, 2009). Strengths should be the focus of therapy, and include things like recognising strong kinship bonds, strong religious orientation and adaptability of family roles. Recognising these values and beliefs can help build trust between clinician and client (Bell-Tolliver et al., 2009).

Incorporate spirituality

In the UK, research suggests that our African clients feel alienated if they feel their spirituality or religiosity is not accepted (e.g. Copesy, 1997; Nicholls, 2002). The scientist/rationalist paradigm has exerted a powerful influence on the development of healthcare practices (Capra, 1983; McSherry & Draper, 1998; Swinton, 2001), and spirituality does not easily fit in with the professional and secular image of the discipline (West, 2000). The limited available research suggests that spiritually integrated psychotherapy may be desired by, and be beneficial to, a subset of our clients (e.g. Rosmarin, Auerback, Bigda-Peyton, Björgvinsson & Levendusky, 2011), and is currently inadequately addressed by mainstream theory (MacDonald & Holland, 2003).

In contrast with the general population, only a minority of psychiatrists in Britain hold religious beliefs: 73% of psychiatrists reported no religious affiliation, as compared with 38% of their patients, and 78% attended religious services less than once a month (Neeleman & King, 1993). Research documents similar low levels of religious beliefs and affiliation amongst psychologists (Ecklund & Scheitle, 2007), suggesting we are the least religious of all scientists (Gross & Simmons, 2009). These statistics suggest it is because religion does not feature within mental health professionals' own values, it is neglected. However, Gubi (2008) proposed that 'practitioner vulnerability' might account for some of the reluctance for spirituality not being better encompassed by psychology.

Research suggests that many clinicians report waiting for a client to raise spiritual issues (Crossley & Salter, 2005). This study joins others in suggesting that a culturally competent clinician should ask about spirituality during the assessment (Pargament, 2007; Cornah, 2006; Swinton, 2001), and that there should be space for it within sessions (Crossley & Salter, 2005; Clarkson, 2002; King-Spooner, 2001; Purton, 1998; West, 2000). Clinicians should feel comfortable encouraging the client to engage with religious/spiritual figures and that the clinician should have enough knowledge of a person's worldview to not pathologise, dismiss or ignore a person's spirituality. This is not yet a component of standard practice (King- Spooner, 2001; Coyle & Lochner, 2011; Crossley & Salter; 2005). A failure to incorporate spirituality and religiosity can mean clients with strong religious beliefs may be wary of seeking therapy in non-religious settings (Mbiti, 1990; Mayers et al., 2007; Coyle & Lochner, 2011), and if they do engage, they may be unwilling to disclose potentially intimate material during assessment, especially if they fear that this might be evaluated negatively (Coyle & Lochner, 2011).

Increase client confidence

Many modified interventions for clients of African descent suggest that developing trust (Willis, 1988) and increasing client confidence (Hines & Boyd-Franklin, 1982) are important components. Some studies suggest that factors like discrimination and racism result in Black service users placing their trust within their kinship and church, rather than external professionals (McAdoo, 1977). Acknowledging that Black service users may hold low expectations for therapy, or may be less socialised to the idea of therapy than their White counterparts, should result in the clinician taking time to explain their approach and what they are trying to achieve (Grevious, 1985) so that they increase their understanding that there is something to be gained by not disengaging (Willis, 1988). There is a need to address stigma and lack of awareness about mainstream approaches within some communities (e.g. Jassi, 2008).

Work in the community

The Ghanaian mental health professionals described the importance of working in the community and forging effective links with religious and spiritual groups in the local community, a sentiment echoed by some British research (Copsey, 1997; Cornah, 2006; Jassi, 2008). In the UK, the introduction of Community Development Workers (CDWs) demonstrates an attempt to engage the community and address attitudinal barriers to engagement in mainstream health services. Community involvement is a key component in addressing inequalities in service use and service experience; mainstream services must learn from the community they serve.

Clinical training

As in Ghana, training and education of the workforce is one important way of addressing inequality within the health service (Sashidharan, 2003; Jassi, 2008; DoH, 2005). In the UK, training on issues relating to culturally competent practice is inadequate and specific training on models of treatment operating outside mainstream ideas is not common (Singh, 1999). There is an absence of research that qualitatively or quantitatively explores psychologists' understanding of alternative health beliefs and alternative healing practices.

Professional training is, at present, devoid of a cultural component and calls for undergraduate training leading to professional qualification to include cultural competency components as a minimum requirement (Sashidharan, 2003). Experts in the health field suggest that there is a link between both cultural competence and cultural sensitivity and the elimination of racial and ethnic health disparities, as increased cultural competence and sensitivity on the part of the provider often results in positive health outcomes for the patient (Betancourt, Green, Carrillo & Park, 2005).

The law

Internationally, the World Health Organisation (2002) report on traditional medicine calls for policymakers to develop national policies on traditional medicine with specific regulatory capacity. In the UK, laws like those outlined in the Health and Safety Act, Environmental Health and the Consumer Protection Division may serve to regulate healers to some extent as they apply to anyone offering a service for money. However, currently, it is unclear if alternative healers without formal qualifications are registered with or regulated by any governing body. Research is necessary to explore who is offering treatment for those with mental health problems in specific contexts, and what such interventions involve.

Collaboration

Whilst some literature highlights the need to collaborate with African churches, due to the importance of these churches to the community (McRae, Thompson & Cooper, 1999; Sanford, 2010), there is very little available research to gauge the willingness of alternative healers and religious/spiritual leaders to work with community psychologists. Vassol (2005) reported that African-American pastors were willing to work with mental health professionals. In the UK, Dr Nigel Copsey describes his work as 'co-ordinator for spiritual, religious and cultural care in the mental health services of East London' and highlights that within his trust, the multi-disciplinary team are working to forge links with the community (Copsey, 2002). Copsey depicts a philosophy of collaboration and attempts to develop partnerships with community groups, including faith groups and spiritual resources, relevant

to mental health care. Others have led the way in generating ideas for integration between traditional healing and psycholotherapy (e.g: Sima, 2005; Anderson, 2005; Sollod, 2005; Moodley & West, 2005). In their book '*Integrating Traditional Healing Practices into Counseling and Psychotherapy*' Moodley and West explore various healing approaches and highlight potential links between traditional healing and psychotherapy (Moodley & West, 2005). In Paris, Nathan has developed an effective service for immigrant clients by integrating traditional and modern methodologies, adopting some of the techniques used by traditional healers (Nathan, 1993, 1994). Such schemes offer valuable experience regarding the complexities and challenges of marrying different approaches and could be used to inform similar projects. Multicultural Britain, for example, the ethnically diverse East London described by Copsey, faces the complexity involved in service provision for many diverse groups. Collaboration with churches, healers and the community can encourage earlier engagement in mainstream services, aid mutual learning and help inform culturally sensitive service development.

D.11. Conclusion

In the UK, mainstream psychology has not adequately explored the health beliefs that shape many of our population's experience of mental illness. We do not know who is offering religious, spiritual, traditional and/or alternative healing. No attempts have been made to quantify the prevalence of such healers, nor explore specific practices offered by such healers. There has not been research to indicate the popularity of such healers, although the very limited qualitative data does suggest healers are used by some of BME individuals experiencing mental illness. Similarly, research is needed to explore mental health professionals' understanding of alternative explanations of symptoms, and alternative healing approaches, to aid the development of training.

This research supports others in calling for research to continue to address BME inequalities in terms of the use of, and experience/outcome of, mainstream mental health services, and proposes that understanding culturally specific health beliefs and help-seeking behaviour could be fundamental in this process. Whilst direct suggestions for policy and practice should be considered tentatively and whilst acknowledging the need for research in the UK to add to the work of this research project, the data suggests that several implications should be considered to attempt to address inequalities in service use and experience of mainstream psychological services by BME communities. Furthermore, this study suggests further research should attempt to learn from other international contexts and cultures that have a different emphasis to the values intrinsic to modern, western life.

Acknowledgements:

I would like to acknowledge and thank those that helped facilitate this project: the Ghanaian mental health professionals who were generous with their time and expertise. The supervision of Dr. Courtney Raspin is also gratefully acknowledged.

D.12. References:

Aina, O. F. (2006). Psychotherapy by environmental manipulation and the observed symbolic rites on prayer mountains in Nigeria. *Mental Health, Religion & Culture, 9*(1), 1-13

Anderson, M. (2005). *Psychotherapy as ritual: connecting the concrete with the symbolic* In R. Moodley, & W. West (2005). *Integrating traditional healing practices into counseling and psychotherapy*. Thousand Oaks, Calif.: Sage Publications

Antaki, C., Billig, M., Edwards, D., & Potter, J. (2002). Discourse analysis means doing analysis: A critique of six analytical shortcomings. DAOL. *Discourse Analysis Online [electronic version], 1*(1).

Arksey, H., O'Malley, L., Baldwin, S., Harris, J., Mason, A., & Golder, S. (2002) Literature review report: Services to support carers of people with mental health problems. *National Co-ordinating Centre for NHS Service Delivery and Organisation, London*

Attride-Stirling, J. (2001). Thematic networks: An analytic tool for qualitative research *Qualitative Research, 1*, 385-405.

Bell-Tolliver, L, Burgess, R & Brock, L. (2009). African American therapists working with African American families: An exploration of the strengths perspective in treatment *Journal Of Marital & Family Therapy, 35*(3) 293-307.

Betancourt, J. R., Green, A. R., Carillo, J. E., & Park, E. R. (2005). Cultural competence and health care disparities: Key perspectives and trends. *Health Affairs, 24*, 499-505

Bhatti, R.S. & Varghese, M. (1995). Family therapy in India. *Indian Journal of Social Psychiatry, 11*(1), 30-34.

Bhugra, D. (2001). Services for ethnic minorities: Conceptual issues. In D. Bhugra & R Cochrane (Eds.) *Psychiatry in multicultural Britain*. p330-349. London: The Royal College of Psychiatrists: Gaskell publishing.

Bhui, K. (2001). Over-representation of Black people in secure psychiatric facilities. *British Journal of Psychiatry, 178* (6), 575.

Bhui, K., Bhugra, D., & Goldberg, D. (2002). Causal explanations of distress and general practitioners' assessments of common mental disorder among Punjabi and English attendees. *Social Psychiatry and Psychiatric Epidemiology, 37,* 38-45.

Bhui, K., Stansfeld, S., Hull, S., Priebe, S., Mole, F., & Feder, G. (2003). Ethnic variations in pathways to and use of specialist mental health services in the UK: Systematic review. *The British Journal of Psychiatry 182,* 105-116.

Birchwood, M., Cochrane, R., Macmillan, F. et al. (1992). The influence of ethnicity and family structure on relapse in first-episode schizophrenia: A comparison of Asian, Afro-Caribbean, and White patients. *The British Journal of Psychiatry, 161,* 783-790.

Blackmon, S. & Vera, E. (2008). *Eurocentrism.* In F. Leong (Ed.), *Encyclopedia of counselling,* 3, 1148-1149. Thousand Oaks, CA: SAGE Publications, Inc.

Boyatzis, R.E. (1998). *Transforming qualitative information: Thematic analysis and code development.* London: Sage.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3,* 77-101.

Capra, F. (1983). *The turning point: Science, society and rising culture.* London: HarperCollins.

Clarkson, P. (2002). *The transpersonal relationship in psychotherapy.* London: Whurr.

Cochrane, R. & Sashidharan, S. P. (1996). Mental health and ethnic minorities: A review of the literature and implications for services. In *Ethnicity and health.* CRD Report 5. York: NHS Centre for Reviews and Dissemination, Social Policy Research Unit, University of York.

Commander, M. J., Cochrane, R., Sashidharan, S. P., Akilu F., & Wildsmith E. (1999). Mental health care for Asian, Black and White patients with non-affective psychoses: Pathways to the psychiatric hospital, in-patient and after-care. *Social Psychiatry and Psychiatric Epidemiology, 34,* 484 -491.

Copsey, N. (1997). *Keeping faith: The provision of community mental health services within a multi-faith context.* The Sainsbury's Centre for Mental Health. Available:

http: www.centreformentalhealth.org.uk/pdfs/keeping_faith.pdf. Last accessed 29th October 2012.

Cornah, D. (2006). *The impact of spirituality on mental health.* Mental Health Foundation. Last accessed March, 2013 at: http: www.mentalhealth.org.uk/content/assets/PDF/publications/impact-spirituality.pdf?view=Standard

Coyle, A. & Lochner, J. (2011). Religion, spirituality and therapeutic practice. *The Psychologist, 24*(4), 264-266.

Crossley, J. P. & Salter, D. P. (2005). A question of finding harmony: A grounded theory study of clinical psychologists' experience of addressing spiritual beliefs in therapy. *Psychology and Psychotherapy: Theory, Research and Practice, 78*, 295-313.

Crowley, J. J. & Simmons, S. (1992). Mental health, race and ethnicity: A retrospective study of the care of ethnic minorities and Whites in a psychiatric unit. *Journal of Advanced Nursing, 17*, 1078 -1087.

Davies, S., Thornicroft, G., Leese, M., Higgingbotham, A., & Phelan, M. (1996). Ethnic differences in risk of compulsory psychiatric admission among representative cases of psychosis in London. *British Medical Journal, 312*, 533-537.

Dearnley, C. (2005). A reflection on the use of semi-structured interviews. *Nurse Researcher, 13*, 19-28.

Department of Health. (2005). Delivering race equality in mental health care: An action plan for reform inside and outside services and the Government's response to the Independent inquiry into the death of David Bennett. London: DoH.

Doku, V., Ofori-Atta, A., Akpalu, B., Read, U., Osei, A., Ae-Ngebise, K., Awenva, D., Lund, C., Flisher, A.J., Petersen, I., Bhana, A., Bird, P., Drew, N., Faydi, E., Funk, M., Green, A., & Omar, M. (2008). A situation analysis of mental health policy development and implementation in Ghana. Accra: Mental Health and Poverty Project. *Inhouse publication: MHaPP.*

Dunn, J. & Fahy, T. A. (1990). Police admissions to a psychiatric hospital: Demographic and clinical differences between ethnic groups. *British Journal of Psychiatry, 156*, 373-378.

Ebigbo, P. O., Oluka, J. I., Ezenwa, M., Obidigbo, G., & Okwaraji, F. (1995). Harmony

restoration therapy: An African contribution to psychotherapy. In *The practice of psychotherapy in Africa.* Paper presented at Proceedings of the First National Conference on Psychotherapy organised by the International Federation for Psychotherapy, Lagos, Nigeria, November, 1995 (pp. 10-32).

Ecklund, E. & Scheitle, C. (2007). Religion among academic scientists. *Social Problems, 54,* 289-307.

Ely, M., Vinz, R., Downing, M., & Anzul, M. (1997). *On writing qualitative research: Living by words.* Routledge/Falmer.

Fernando, S. (1995). Study did not deal with "category fallacy". *British Medical Journal, 310,* 331-332.

Fine, M. (2002). *Disruptive voices: The possibilities for feminist research.* University of Michigan Press.

Gater, R., de Almeida e Sousa, Barrientos, G., Caraveo, J., Chandrashekar, C. R., Dhadphale, M., Goldberg, D., Al Kathiri, A. H., Mubbashar, M., Silhan, K., Thong, D., Torres-Gonzales, F., & Sartorius, N. (1991). The pathways to psychiatric care: A cross-cultural study. *Psychological Medicine 21,* 761-774.

Grevious, C. (1985). The role of the family therapist with low-income black families. *Family therapy, 12*(2) 115-122.

Gross, N. & Simmons, S. (2009). The religiousity of American college and university professors. *Sociology of Religion, 70,* 101-129.

Gubi, P. M. (2007). *Prayer in counselling and psychotherapy: Exploring a hidden meaningful dimension.* Jessica Kingsley Publishers.

Guest, G., MacQueen, K.M., & Namey, E. E. (2012). *Applied thematic analysis.* Los Angeles: Sage Publications.

Hall, C. & Sandberg, J. (2012). "'We shall overcome": A qualitative exploratory study of the experiences of African Americans who overcame barriers to engage in family therapy. *American Journal Of Family Therapy, 40*(5), 445-458.

Harrison, G., Holton, A., Neilson, D., Owens, D., Boot, D., & Cooper, J. (1989). Severe mental disorder in Afro-Caribbean patients: Some social, demographic and service factors. *Psychological Medicine, 19,* 683 -696.

Hays, P. (1995). Multicultural applications of cognitive-behavioural therapy. *Professional Psychology: Research and Practice, 26*, 309-315.

Hemsi, L. K. (1967) Psychotic morbidity of West Indian immigrants. *Social Psychiatry, 2,* 95-100.

Henwood, K. L. & Pidgeon. N. F. (1992) Qualitative research and psychological theorising. *British Journal of Psychology, 83,* 97-111.

Hickling, F. W., McKenzie, K., Mullen, R., & Muray, R. (1999). A Jamaican psychiatrist evaluates diagnosis at a London psychiatric hospital. *British Journal of Psychiatry, 175,* 283-285.

Hines, P., & Boyd-Franklin, N. (1982). Black families. In M. McGoldrick, M. J. Pearce,& J. Giordano (Eds), *Ethnicity and family therapy.* New York: Guildford Press.

Ineichen, B., Harrison G., & Morgan, H. G. (1984). Psychiatric hospital admissions in Bristol. I: Geographical and ethnic factors. *British Journal of Psychiatry, 145,* 600-604.

Jackson, M. (2001) Psychotic and spiritual experience: A case study comparison. In I. Clarke (Ed.) *Psychosis and spirituality: Exploring the new frontier.* Ch 10 pp. 165-190. London and Philadelphia: Whurr Publishers.

Jackson, M. & Fulford, K. W. M. (1997). Spiritual experience and psychopathology. *Philosophy, Psychiatry and Psychology, 4,* 41-65.

Jacob, K. S., Sharan, P., Mirza, I., Garrido-Cumbrera, M., Seedat, S., Mari, J. J., Sreenivas, V., & Saxena S. (2007). Mental health systems in countries: Where are we now? *The Lancet, 370,* 1061-1077.

Jassi, C. (2008). Improving access to psychological therapies for Black minority ethnic communities: A short review and guide for implementation. *Advancing Practice in Bedfordshire, 5*(3). Last accessed on January 8th 2013 http://www.advancingpractice.co.uk/5(3)%20access%20to%20psychol%20therapies%20for%20bme.pdf

Katon, W. & Kleinman, A. (1981). Doctor-patient negotiation and other social strategies in patient care. In L. Eisenberg & A. Kleinman (Eds.), *Relevance of social science for Medicine.* Dordrecht: D. Reidel.

Keating, F., Robertson, D., McCulloch, A., & Francis, E. (SCMH) (2002). Breaking the circles of fear: A review of the relationship between mental health services and the African and Caribbean communities. *London: The Sainsbury Centre for Mental Health.*

Kiev, A. (1965). Psychiatric morbidity of West Indian immigrants in an urban group practice. *British Journal of Psychiatry, 111*, 51-56.

King-Spooner, S. (2001). *The place of spirituality in psychotherapy.* In S. King-Spooner & C. Newnes (Eds.) *Spirituality and psychotherapy.* Ross- on-Wye: PCCS Books.

Koffman, J., Fulop, N. J., Pashley, D., & Coleman, K. (1997) Ethnicity and use of acute psychiatric beds: One-day survey in North and South Thames regions. *British Journal of Psychiatry, 171*, 238-241.

Kohn, L. P., Oden, T., Munoz, R. F., Robinson, A., & Leavitt, D. (2002). Brief report: Adapted cognitive behavioural group therapy for depressed low-income African American women. *Community Mental Health Journal, 38*(6), 497-504.

Koss, J. (1987). *Ethnomedical categories in the diagnosis and treatment of Hispanic patients: A review of the studies and implications for research.* Simon Bolivar Research Monograph, Chicago, IL: University of Illinois Press. pp. 187-206.

Littlewood, R. & Lipsedge, M. (1981). Some social and phenomenological characteristics of psychotic immigrants. *Psychological Medicine, 11*, 289-302.

Lloyd, K. & Moodley, P. (1992). Psychotropic medication and ethnicity: An inpatient survey. *Social Psychiatry and Psychiatric Epidemiology, 27*, 95-101.

MacDonald, D. A. & Holland, D. (2003). Spirituality and the MMPI-2. *Journal of Clinical Psychology, 59*, 399-410 .

Mayers, C., Leavey, G., Vallianatou, C., & Barker, C. (2007). How clients with religious or spiritual beliefs experience psychological help- seeking and therapy: A qualitative study. *Clinical Psychology and Psychotherapy, 14,* 317-27.

Mbiti, J. S. (1990). *African religions and philosophy* (2nd edn.). Oxford: Heinemann Educational Publishers.

McAdoo, H. (1977). Family therapy in the black community. *American Journal of Orthopsychiatry, 47*(1), 75-79.

McCreadie, R. G., Leese, M., Tilak-Singh, D., Loftus, L., MacEwan, T., & Thornicroft, G. (1997). Nithsdale, Nunhead, and Norwood: Similarities and differences in prevalence of schizophrenia and utilisation of services in rural and urban areas. *British Journal of Psychiatry, 170*, 31-36.

McRae, M.B ., Thompson, D. A., & Cooper, S. (1999). Black churches as therapeutic groups. *Journal of Multicultural Counseling and Development, 27*(4), 207-221.

McSherry, W. & Draper, P. (1998). The debates emerging from the literature surrounding the concept of spirituality as applied to nursing. *Journal of Advanced Nursing, 27*, 683-691.

MHAC (2008). *Risk, rights, recovery: The Mental Health Act Commission twelfth biennial report* 2005-2007.

Moodley, P. & Perkins, R. E. (1991) Routes to psychiatric inpatient care in an inner London borough. *Social Psychiatry and Psychiatric Epidemiology, 26*, 47-51.

Moodley, P. & Thornicroft, G. (1988). Ethnic group and compulsory detention. *Medicine Science and Law, 28*, 324-328.

Morgan, C., Mallet, R., Hutchinson, G., Bagalkote, H., Morgan, K., Fearon, P., Dazzan, P., Boydell, J., McKenzie, K., Harrison, G., Murray, R., Jones, P., Craig, T., Leff, J., & AESOP Study Group. (2005). Pathways to care and ethnicity: 2. Source of referral and help seeking. *British Journal of Psychiatry, 186*, 290-296.

Naeem, F., Waheed, W., Gobbi, M., Ayub, M., & Kingdon, D. (2011). Preliminary evaluation of culturally sensitive CBT for depression in Pakistan: Findings from developing culturally-sensitive CBT Project (DCCP). *Behavioural and Cognitive Psychotherapy, 39*, 165-173.

Nagayama Hall, G. C. (2001). Psychotherapy research with ethnic minorities: Empirical, ethical and conceptual issues. *Journal of Consulting and Clinical Psychology, 69*, 502-510.

Naidoo, A.V. (1996). Challenging the hegemony of Eurocentric psychology. *Journal of Community and Health Sciences, 2*(2), 9-16.

National Association for Black for Black Mental Health. (2002). *Tell it as it is.* London, NABMH.

National Collaborating Centre for Mental Health (Great Britain). (2010). *Schizophrenia: The NICE guideline on core interventions in the treatment and management of schizophrenia in adults in primary and secondary care*. London: Royal College of Psychiatrists.

Nathan, T. (1994). *L'influence qui guérit [Healing influence]*. Paris: Editions Odile Jacob.

Nathan, T. (1993). Ethnopsy 93 [Ethnopsychiatry 93]. *Nouvelle Revue d'Ethnopsychiatrie, 20*, 7- 14.

Neeleman, J. & King, M. B. (1993). Psychiatrists' religious attitudes in relation to their clinical practice: A survey of 231 psychiatrists. *Acta Psychiatrica Scandinavica, 88*, 420-424.

Newbigging, K. (2000). *Report from the carers' event: Making space*. Manchester, North West Mental Health Development Centre.

Nicholls, M. (2002). Strategies for living: spirituality and mental health. *The Mental Health Foundation, Updates*, 4(6).

Office of National Statistics. (2011). *Statistical bulletin: Population estimates by ethnic group 2002-2009*. Available: http://www.ons.gov.uk/ons/publications/index.html?pageSize=50&sortBy=none&sortDirection=none&newquery=ethnic&content-type=publicationContentTypes. Last accessed 29th October 2012.

Ofori-Atta, A., Read, U. M., Lund, C., & MHaPP Research Programme Consortium. (2010). A situational analysis of mental health services and legislation in Ghana: Challenges for transformation. *African Journal of Psychiatry*. http://www.dfid.gov.uk/r4d/PDF/Outputs/MentalHealth_RPC/A_situation_analysis_of_mental_health_Ghana.pdf

Owens, D., Harrison, G., & Boot, D. (1991). Ethnic factors in voluntary and compulsory admissions. *Psychological Medicine, 21*, 185 -196.

Pargament, K. I. (2007). *Spiritually integrated psychotherapy: Understanding and addressing the sacred*. New York: Guilford Press.

Parkman, S., Davies, S., Leese, M., Phelan, M., & Thornicroft, G. (1997). Ethnic differences in satisfaction with mental health services among representative people with

psychosis in south London: PRiSM study 4. *British Journal of Psychiatry, 171,* 260 - 264.

Parrinder, G. (1951). *West African psychology: A comparative study of psychological and religious thought.* Cambridge: Lutterworth Press. Reprinted in 2002.

Perkins, R. E. & Moodley, P. (1993). Perception of problems in psychiatric inpatients: Denial, race and service usage. *Social Psychiatry and Psychiatric Epidemiology, 28,* 189-193.

Purton, C. (1998). Unconditional positive regard and its spiritual implications. In B. Thorne & E. Lambers (Eds.) *Person-centred therapy: A European perspective.* London: Sage Publications.

Race Relations (Amendment) Act. *Government legislation.* (2000). Chapter 34. Further extension of 1976 Act to police and other public authorities. Available: http://www.legislation.gov.uk/ukpga/2000/34/introduction. Last accessed 12th October 2012.

Rathod, S., Kingdon, D., Phiri, P., & Gobbi, M. (2010). Developing culturally sensitive cognitive behaviour therapy for psychosis for ethnic minority patients by exploration and incorporation of service users' and health professionals' views and opinions. *Behavioural and Cognitive Psychotherapy, 38*(5), 511-533.

Rathod, S., Phiri, P., Harris, S., Underwood, C., Thagadur, M., Padmanabi, U., & Kingdon, D. (2013). Cognitive behaviour therapy for psychosis can be adapted for minority ethnic groups: A randomised controlled trial. *Schizophrenia Research, 143*(2-3), 319-326.

Romme, M. A. & Escher, S. (1993). *The new approach: A Dutch experiment.* In M.A. Romme & S. Escher (Eds.) *Accepting voices.* pp.11-27. London: Mind Publications.

Romme, M. A., Honig, A., Noorthoorn, E. O. ,& Escher, S. (1992). Coping with hearing voices: An emancipatory approach. *British Journal of Psychiatry, 161,* 99-103.

Rosmarin, D. H., Auerbach, R. P., Bigda-Peyton, J. S., Björgvinsson, T., & Levendusky, P. G. (2011). Integrating spirituality into cognitive behavioural therapy in an acute psychiatric setting: A pilot study. *Journal of Cognitive Psychotherapy, 25*(4), 287-303.

Rwegellera, G. G. (1980). Differential use of psychiatric services by West Indians, West Africans and English in London. *British Journal of Psychiatry, 137,* 428-432.

Sainsbury Centre for Mental Health (2006). *Policy Paper 6: The costs of race inequality.* London: SCMH.

Sanford, G. J. (2010). *Increasing mental health awareness and utilization of services among African Americans: A church-based program.* Spalding University.

Sashidharan, S. P. (1993). Afro-Caribbeans and schizophrenia: The ethnic vulnerability hypothesis re- examined. *International Review of Psychiatry, 5,* 129-144.

Sashidharan, S. P. (2003). North Birmingham Mental Health Trust (for the National Institute of Mental Health and the Department of Health). *Inside/outside: Improving mental health services for Black and minority ethnic communities in England.* London: Department of Health, NIMHE. Last accessed January 2nd, 2013. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4019452.pdf

Sharpley, M., Hutchinson, G., McKenzie, K., & Murray, R. (2001). Understanding the excess of psychosis among the African Caribbean population in England: Review of current hypotheses. *British Journal of Psychiatry, 178,* 60-68.

Sima, R.G. (2005). Sharing healing secrets. In R. Moodley, & W. West (2005). *Integrating traditional healing practices into counseling and psychotherapy.* Thousand Oaks, Calif.: Sage Publications.

Singh, A. N. (1999). Shamans, Healing, and Mental Health. *Journal of Child & Family Studies, 8*(2), 131-134.

Singh, S. P., Croudace, T., & Beck, A. et al. (1998). Perceived ethnicity and the risk of compulsory admission. *Social Psychiatry and Psychiatric Epidemiology, 33,* 39-44.

Sollod, R.N. (2005). *Spiritual and healing approaches in psychotherapeutic practice.* In R. Moodley, & W. West (2005). *Integrating traditional healing practices into counseling and psychotherapy.* Thousand Oaks, Calif.: Sage Publications.

Sue, D. W. (1981). *Counselling the culturally different.* New York: John Wiley & Sons.

Sue, S., Fujino, D. C., Hu, L., Takeuchi, D. T., & Zane, N. W. S. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consulting and Clinical Psychology, 59*, 533-540.

Swinton, J. (2001). *Spirituality and mental health care: Rediscovering a 'forgotten' dimension.* London: Jessica Kingsley Publishers.

Takei, N., Persaud, R., Woodruff, P., Brockington, I., & Murray, R. M. (1998) First episodes of psychosis in Afro-Caribbean and White people: An 18-year follow-up population-based study. *British Journal of Psychiatry, 172*, 147-153.

Taylor, G. W. & Ussher, J. M. (2001). Making sense of S&M: A discourse analytic account. *Sexualities, 4*, 293-314.

Thomas, C. S., Stone, K., Osborn, M., Thomas, P. F., & Fisher, M. (1993). Psychiatric morbidity and compulsory admission among UK-born Europeans, Afro-Caribbeans and Asians in central Manchester. *British Journal of Psychiatry, 163*, 91-99.

Tuckett, A. G. (2005). Applying thematic analysis theory to practice: a researcher's experience. *Contemporary Nurse, 19*, 75-87.

Twumasi, P. A. (1979). Community involvement in health care: The Kintampo experience in Ghana: A study in the changing health model. *Ghana Medical Journal,* 80-84.

Utley, I. (2009). *Ghana: The essential guide to customs and culture.* London: Kuperard.

Vassol, E. L. (2005). *African American pastors' perceptions of their congregants' mental health needs.* Kansas State University. Dissertation. Last accessed July, 2013 at: http: krex.k-state.edu dspace/handle/2097/114

Warren, R., Jackson, A., & Nugaris, J. et al. (1973). Differential attitudes of Black and White patients towards treatment in a child guidance clinic. *American Journal of Orthopsychiatry, 43*, 384-395.

West, W. (2000). *Psychotherapy & spirituality: Crossing the line between therapy and religion.* London: Sage Publications.

WHO (2002) World Health Organisation - Policy perspectives on traditional medicine. *Traditional medicine: Growing needs and potential.* Available: http: whqlibdoc.who.int hq 2002/WHO EDM 2002.4.pdf. Last accessed 20th August, 2012.

Willig, C. (1999). Beyond appearances: A critical realist approach to social constructionism. In D. J. Nightingale & J. Cromby (Eds.), *Social constructionist psychology: A critical analysis of theory and practice*. pp. 37-51. Buckingham, UK: Open University Press.

Willig, C. (2001). *Introducing qualitative research in psychology*. Berkshire, UK: Open University Press.

Willis, J. (1988). An effective counseling model for treating the black family: Family therapy. *The Journal of the California Graduate School of Family Psychology, 15*(2), 185-194.

Wilson, M. (2009). Department of Health, National Programme Lead. *Delivering race equality in mental health care: A review*. Available: http://www.nmhdu.org.uk/silo/files/delivering-race-equality-in-mental-health-care-a-review.pdf. Last accessed 17th November, 2012.

Wrenn, C. G. (1962). The culturally encapsulated counselor. *Harvard Educational Review, 32*, 444-449.

Yaro, P., Deme-Der, D. N. W., Antwi-Bekoe, T., & Donnir,G. M. (2009). Psychotropic medicine shortages in Ghana: A situational analysis. *The Ghana International Journal of Mental Health, 1*(1), 157-170.