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Message from the Patron

The first issue of the South American Journal of Public Health (SAJoPH) from Texila American University (TAU) is published today, the 19th August, 2013. TAU is located in Guyana, South America which offers Health Science programs with a high level of professionalism. It also offers Online programs in which the students are spread over the world from 34 countries. It is a great success in every respect. Not only is the quality of the scientific articles high, so is the enthusiasm and willingness with which our students submitted their contributions. The editorial quality and the design of our own scientific journal are also in line with what may be expected of a scientific journal.

This first issue of the SAJoPH is the result of the dedicated contributions of many persons. I thank our reviewers for making themselves available. But most of all I would like to thank all authors who submitted a paper to the journal. I hope you enjoyed the experience of getting a paper criticized and often improved by the reviewers' and editors' comments. Most of you will now see it published, at last as an e-publication.

The Editorial Board aims to provide an opportunity for students to learn how to make the transition between assignment-writing and producing publishable academic work. This provides the students with a great learning experience. A learning experience that not only helps the students to get their work published in SAJoPH, but one that also helps the students to publish their work in international journals in the future. This learning experience consists of several steps that are quite similar to the submission process of international journals. By submitting their article to SAJoPH the students can get acquainted with the submission of articles on a professional level.

The objective of SAJoPH is, not only to publish papers written by students but also to provide the students with the necessary knowledge and experience that they will need during their entire scientific career. Furthermore, receiving extensive feedback on all the different aspects of the article, gives the students a chance to improve their skills in academic writing. We encourage all students to use this great opportunity and to submit their work to SAJoPH.

SAJoPH is consistent with this view on public health education. It offers a complete platform for the first steps in a scientific career. Therefore, I sincerely encourage students to publish their research in the columns of this magnificent journal. Naturally, I would also like to take this opportunity to wish all readers, both inside and outside Texila American University, happy reading and I hope you enjoy this first issue.

S.P.Saju Bhaskar

(Chief Executive Officer)

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GLOBAL HEALTH AND HEALTH PROGRAMS, IMPLICATION IN PRACTICE - A REVIEW

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ABSTRACT

Health is gaining greater attention on the global scenario. There has been an overall change that has seen a shift from global nation-based health-policy-making structures towards more diversity and greater emphasis on private sector actors. The not for profit civil society and non-governmental organization are now seen as a vital heath partner especially for health campaigns.
Funding for global health is also changing as pressure mounts against vertical disease focused funding in favor of horizontal funding aimed at strengthening health systems. Players in the global health scene are also changing to include public private partnerships as well as a greater appreciation and inclusion of civil society.
For global health to be effective worldwide and especially in Africa, the focus must be towards a broader system of funding that is not disease specific but also has an emphasis on strengthening the health system. Building and maintaining capacity for healthcare provision is also critical for effective action against health threats. Focus must also be on enabling partnerships while taking care that the broader public sector agenda is not overridden by vested interests especially in public- private partnerships
Global health must also widen its focus from communicable disease to address threats posed by widespread increase in risk factors for non- communicable disease and broader social and economic factors that impact health in this era of rapid globalization. The trend must be towards using an evidence base to employ strategies that will in the long run provide cost effective interventions while ensuring appropriate and sustainable technologies are utilized to address health concerns.

INTRODUCTION

The world is becoming increasingly interconnected and globalization now impacts virtually all aspects of every person's life. Increases in the flow of people, products, services, and information between and among countries and continents are having a dramatic influence on the world's health and how health care is delivered (Lee, 2004).
This review focuses on the changing face of health care delivery in an era of rapid change and interaction among the various regions of the world as the forces of globalization grow stronger. Global health is gaining more attention in the Political and economic arena as the world comes to terms with realization the health threats in one region can adversely impact the whole globe within a short time span. It is thus becoming more apparent that concerted change must be orchestrated to ensure that such threats of increase in communicable diseases worldwide and well as risks for non-communicable diseases (Olilla, 2005). She argues that players in the global health are changing as the transition from international health to global health change. Even so,initiatives to tackle the health problems are increasingly being influenced by trade and industrial interests with the emphasis on technological solutions.

New players in global policy

Global health policy has become increasingly fragmented and verticalized. Infectious diseases have gained ground as global health priorities, while non- communicable diseases and the broader issues of health systems development have been neglected (Buse, 2002). Approaches to tackling the health problems are increasingly influenced by trade and industrial interests with the emphasis on technological solutions,such as those encouraging essential drugs, breast milk substitutes, and weaning foods in the last four decades. In recent times, the public health NGOs have been important, for example, in shaping pharmaceutical related policies and advocating for the needs and rights of HIV-infected people.

Global health priorities

Global health are derived from mortality and burden-of-disease calculations, they are related to the causes of the majority of deaths and ill-health in sub-Saharan Africa (Global Fund, 2007) but do not represent the majority of ill-health in any other region. They cover less than a third of the global illhealth (Godal, 2007). In the world today, non-communicable diseases are a cause of the majority of ill-health in developing countries, and their importance is increasing rapidly. They affect all socioeconomic groups and in many cases the risks are a big burdenin the poorest sections of the populations (Global Fund, 2007).Global health priorities are now being defined through several processes and by several actors and at various forums. In 2000 and 2001, HIV/AIDS, tuberculosis and malaria came to be discussed in a variety of forums at the UN as well as outside the UN, and commitments toaddress the three diseases were made, for example, by theG8, the World Bank, the World Economic Forum and the European Commission (UNAIDS, 2007, England, 2007).

Millennium Development Goals (MDGs) according to Bosman (2000) are a product of consultations between international agencies, but were eventually adopted by the United Nations (UN) General Assembly in September 2001 as part of the road map for implementing the substantially broader Millennium Declaration, which it had adopted in September 2000 (IMF, 2007).Out of the 8 goals for the MDGs , three of are health focused, namely those on child mortality, maternal health, and HIV/AIDS, malaria and other diseases.The UN-led Millennium Project has the objective of ensuring that all developing countries meet the MDGs. The whole UN system is charged with ensuring that the MDGs are addressed, and secondly report to the Secretary General on theirachievements in that direction. In terms of health policies, this has meant, for example, pressures from some of the member states, such as the UK, has made the WHO to refocus its work on the MDGs, most notably to the goal concerning HIV/ AIDS, malaria and tuberculosis, while giving less attention its wider mandate as the normative health organization that sets norms and standards and promotes the building up a wider health systems (de Renzio, 2007). It is rather critical that the MDGshave become an important tool to steer both the UN system towards a narrower agenda with more emphasis on selected interventions and country presences, however more recently increased attention has been placed on the need for addressing development , specifically health policy issues and systems more comprehensively (European commission, 2007; IMF, 2007; Rivers, 2003) In the same light, development aid for health is also largely steered towards tackling communicable infectious (Global fund, 2007). This evidently must change to address broader global health issues and to eradicate health inequities.

Funding Transition for Global health

Funding for global health needs reorientation to address broader issues in health other than the fixation on HIV, Tuberculosis and Malaria especially by the Global fund and President's Emergency Plan For AIDS Relief -PEPFAR (Ooms et al, 2008). Even these funding systems are increasingly focusing on expandinghuman resources and improving procurement and supply chains, patient information, and laboratory systems (Moore et al, 2007). Moore et al further argue

that pressure is on for a more broad approach to global health issues and especially a focus on strengthening health systems. Ooms et al (2008) further state that there is a need to move away from the vertical approach (disease specific) that results in fragile, isolated islands of sufficiency and eventually generalized insufficiency: the move should be towards the diagonal approach that aims to build islands with a broad and solid base, and to gradually connect those islands. Buse and Waxman (2001) warned that the vertical approach adopted by Public-Private Partnerships might create "islands of excellence in seas of under provision."

Buse et al 2001 also note that AIDS treatment services in low-income countriesdo not deserve the label 'excellence', as they oftenserve less than a third of the people needing treatment;they are merely islands of sufficiency. Furthermore, 'seas of under provision' sound like depths that will never be filled, while in fact it would take relatively modest resources (on a global scale) to fill them; 'swamps' might be a more appropriate image.

It is becoming increasingly evident that AIDS treatment cannot be provided in isolation from health systems. A vertical approach works for a while, and then it hits the ceiling of insufficient health workers and dysfunctional health systems, particularly in countries with high HIV prevalence (Medecins sans Frontieres, 2007) . AIDS treatment alone, will require expanded health education systems, in-service training systems, human resource management, skills and task shifting, and improved supervision and referral systems. Wages and working conditions must therefore be improved across the board to retain health workers and to stop external and internal brain drains (Ooms et al, 2008).

Research approaches for global health

Craig et al (2010 assert that Research plays a critical role in health and especially in directing health action and priorities. They further argue that developing acceptable and meaningful ways to evaluate the short-term contributions for global health research (GHR) and forecast its long-term impacts is a strategic priority needed to defend decisions being made in GHR development. Planning and investing to support the underlying GHR elements and competencies that allow for adaptive, innovative, and supportive research partnerships to achieve ‘health for all’ are more likely to have long-term impacts than building research strategies around specific diseases of interest(Lee, 1999). Tijssen (2003) implies that it is therefore important that donors support programs that allow adaptation and flexibility for ongoing learning while working in ‘messy’ socio-ecological systems. Researchersand their partners need to have the latitude to be dynamic, innovative, and opportunistic to identify and target underpinnings of health that can be manipulated to achieve wider prevention of undesired health outcomes and create resilience and health equity. Most donorstend to require a more narrow focus for their investments. GHR priorities are usually selected based on burden of disease measurements superimposed on resource limitations affecting the coping capacity of a nation (Ollila, 2005). This trend needs to change if we are aiming to have broad and long term changes that impact Global health. GHR should also be encouraged not only in health practice but also in training programs where funding can be solicited for interested students, as an incentive to enhance the profile of GHR.

Remedial approaches for Global health

It has been noted that approaches for improved global health policy-making has become increasingly fragmentedand verticalized, with the increasing emphases on selected interventions, the increasing number of partnerships and especially because of the founding of new entities for various health issues. This has to change to ensure a focus on strengthening health systems to achieve global goals e.g. MDGs. Greater emphasis needs to be put on comprehensive infrastructure building. The current trends are in contrast to the stated aims of integrating health policy making with the broader development agenda or with comprehensive health sector planning.

There is a general emphasis on innovations and innovative approaches which encourages the use of new technologies and the building of new structures (Olilla, 2004). However problems of unsustainability and inequity have arisen with the high levels of funding required, an emphasis on fast results, and the construction of new structures both at global and national levels (Hardon, 2000).Such approaches need to be carefully thought and carefully implemented in resource limited settings of developing nations to ensure sustainability (Poore, 2004).

In many instances national priorities often differ from the global priorities, and the thinking around global public goods recognizes this as a starting point. Yamey (2002), has argued that the increased emphasis on global programmes and global priority setting is problematic from the point of view of undermining national sovereignty and empowerment. He furthermore states that partnership activities are often not in sync with emerging processes within countries aimed at developing their national health systems. (Starling et al, 2002). Partnership must therefore be carefully forged and executed to ensure effective global health action at a global as well as local level.

Partnerships are an important approach to achieving global health. Partnerships can be referred to as voluntary and collaborative relationships between state and non-state participants who are I agreement to work together to achieve a common purpose, undertake a specific task, and to share risks, responsibilities, resources, competencies and benefits (UN, 2003). Richter (2004) however argues that one of the most substantive losses resulting from the shift towards the partnership paradigm is the loss of distinction between different actors in the global health arena. UN agencies, governments, transnational corporations, their business associations and public interest NGOs are all called 'partner'. The realization that these actors have different and possibly conflicting mandates, goals and roles have been lost.

The inclusion of business as an integral part of public policy is often seems to weaken the vital role of the public sector especially in norm- and standard setting and monitoring, as the implement market-building activities, often as a result of vested interests. It would be vital that the governments and the donors could improve the policy environment for private sector investment and security, and in essence facilitate the building of an extensive distribution system so as to reduce the costs for the private sector (IMF, 2004)

CONCLUSION

"Global health is a discipline of practice, research and education focused on health. It is concerned with the social, economic, political and cultural forces that shape it across the world. This discipline has been historically associated with the distinct needs of developing countries but lately is also concerned with health-related issues that go beyond national boundaries and the differentialimpacts of globalization (Rowson et al, 2012). Global health is a cross-disciplinary field, blending perspectives from the natural and socialsciences to understand the social relationships, biological processes and technologies that contribute to the improvement of health worldwide." To adequately address contemporary health threats, partnerships in health programs can be useful. However they must be carefully executed to be effective and also not undermine the public sector. Effort must also be directed to strengthening health systems and education of health care professionals. Technology can be embraced selectively and in context where they are sustainable. Efforts in collaborative research must also be encouraged to generate an evidence for global health practice. No one approach can exclusively address global health; it is an inter-play of interventions coupled with the inclusion of a broad range of partners locally and internationally.

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ARTICLE REVIEW ON "RATIONAL EMOTIVE BEHAVIOR THERAPY AND NARRATIVE THERAPY"

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INTRODUCTION

The study and application of Rational Emotive Behavior Therapy (REBT) and Narrative Therapy (NT) are essential and employed in enhancing one's self-esteem and reducing the depression and other problems, which are fundamental aspects in Guidance and Counseling. Hence an Article Review has been done on "Rational Emotive Behavior Therapy and Narrative Therapy" on the thesis submitted to Osmania University for the degree of Doctor of Philosophy in "Psychology" in March 2009.

The Article begins with one's significant period of adolescence in one's life time and the teenage problems in the recent years. This has caused the necessity of the present day adolescents coming for counseling for depression, sexual problems, drug and alcohol, the problems that were not heard of a few decades ago. The present day nuclear families increased independence, and exploration of their limits. According to Owen (1995) most of the adolescents begin to feel that they know themselves better than others, often creating conflicts with parents and peer expectations. Many adolescents have low self-esteem, the main reasons being drugs, alcohol, multiple relationships, anxiety, suicidal ideation, and underperformance.

Self-esteem refers to an individual's sense of his or her value or worth, or the extent to which a person values, approves of, appreciates or like him or herself. Self-esteem is considered the valuation component of the self concept. It encompasses an individual's beliefs, behaviors and emotions. Self-esteem plays a crucial role in the development of personality of college students.

The author talks about two Intervention Techniques to enhance self-esteem, one based on Narrative Therapy or the re-authorizing of the clients' stories, so as to change the perception the client holds. And on Rational Emotive Behavior Therapy (REBT) to bring about a constructive change in the thinking patterns of the clients.

REBT is a brief direct solution oriented therapy that focuses on resolving specific problems facing a troubled individual. This is a form of Cognitive Behavior Therapy set forth by Ellis in 1953, The concept of REBT is that the emotion suffering results primarily from our beliefs and met by the events occurring in our lives. Hence it is important should be healthy and rational since their consequences are emotional growth and happiness. The irrational beliefs shall be identified, disputed and replaced with rationals. Once the client is equipped with healthy beliefs, emotional difficulties and problematic behavior are abated. – W. Dryden (1985).

Alfred Adler has said that we are not influenced by "facts", but are by the interpretation of the facts. Albert Ellis stated that emotions, thoughts and behavior are interrelated and all three interact continuously and affect one another. REBT identifies client's basic philosophies of life, see exactly how self defeating their beliefs are and to persuade them to work cognitively, emotionally and behaviorally to change these patterns.

Many literatures have been reviewed and detailed by the author in three sections of research on Self-esteem first on Adolescence and self-esteem, second on low self-esteem and the third on intervention techniques used (Rational Emotive Behavior Therapy and Narrative Therapy).
Self-esteem is the experience of being competent to cope with basic challenges of live and of being worthy of happiness. It is positive or negative orientation towards oneself, an overall evaluation of one's worth. The benefits of high self esteem enhanced initiative and pleasant feelings. Positive self-esteem enhances one's ability to cope effectively with stress because individuals with poor coping mechanisms are more vulnerable to environmental stresses. Heyman, Dweek & Cain (1992).

Adolescent self-esteem was more a function of the reflected appraisal of the parents and female adolescents were more likely to be influenced by their parents, than were male adolescents. Openshaw, D.K; Thomas, D>L & Rollins, B.C (1984)
The global self esteem of adolescents was examined in relation to two aspects of their daily lives: a) the perceived quality of their relationships with parents and peers and b) their self evaluation in the areas of school, popularity and athletics. The quality of relationships with parents made significant contributions in self esteem of both boys and girls. The quality of peer relationships made a significant additional contribution for girls but not boys. Walker., L & Greene, J (1986).
Father's education has a small positive relationship with adolescent's self esteem and nontraditional measures had moderate to strong associations with self esteem. Wiltfang, G.L & Scarbuz, M (1990)
Subjects with high self-esteem increased task liking, after positive feedback, where as those with low self-esteem decreased task liking. – Tang, T.L & Starsfield- Baldwin L (1991)
The author has noted that there is a significant relationship among self-esteem, health values and health behavior for both younger and older adolescents and self esteem improves the mental health behavior, social and health behavior. - Rivas Torres, RM & Fernandez P (1995)
The effects of parent and peer attachment on self image in adolescence are positively related. The relationship of parent attachment to self image is stronger than peer attachment. Females show stronger self image across areas of attachment. – O' Koon, J (1997)
In another study of adolescence coping strategies and self esteem, analysis revealed that adolescents with lower self esteem utilized more avoidance coping strategies than adolescents with higher self esteem. In addition males reported utilizing avoidance coping strategies more frequently than females. – Chapman, P.L.; Mullis R.L. (1999)

The benefits of high self esteem are one enhanced initiative and pleasant feelings and two, a reduction in chances of bulimia in females in the presence of high self-esteem. - Baumeister, R.F, Campbell, J.D, Kreuger, J.I & vohd, K.D (2003)
An investigative study indicated that as self-esteem increased, stress increased, suicidal thoughts increased. Willburn, V.R. & Smith, D.E (2005).
These results revealed that adolescents scoring in the top thirds of self esteem at the age of 12 and 18 show significantly lower levels of pessimism than those whose self esteem had changed or stayed low during adolescent years.

EFFECTS OF LOW SELF ESTEEM

The impacts of low self esteem on students describe personality & vulnerability to suicide, eating disorder and negative thinking. Thus it becomes imperative to find strategies to enhance self esteem.
In the investigation of the relationship between jealousy and low self esteem for boys and girls, analysis indicated a reverse relationship for girls. Lower the self esteem, higher the jealousy. It is significantly and negatively related to self esteem.- Stewart, R.A & Beathy, M.J (1985)

Depression was significantly related to suicidal behavior. Damon (1991) found for most children low self esteem only translate in to temporary emotional discomfort, but for others low self esteem can result in depression, suicide tendency, eating disorders and delinquency. Low self-esteem people rated their general intelligence and competencies more negatively after failure than after success.

High self esteem subjects on other hand rated their intelligence a bit more positively after failure than after success. – Brown (1990)

People with lower esteem may be less likely to accept positive feedback from themselves than from an external source but likely to accept negative feedback from the self and outsider. In contrast when the positive feedback comes from a knowledgeable source both high and low self esteem people accept it. When self generated feedback was negative, participants low in self esteem accepted it. – Joseph, R.A, Bosson, J.K & Jacobs. C.G (2003)

Jealousy is significantly and negatively related to self esteem. Non users of alcohol had perceived less peer support than all users but had higher self concepts than heavy users. Subjects with low self esteem were more likely to consume alcohol to gain some degree of peer acceptance and support. Parish, J.G. & Parish T.S. (1991)

Girls with low self esteem at 11-12 years old are at significantly greater risk of developing the more severe signs of eating disorders and other psychological problems by the age of 15-16. – Button, E.J.; Sonuga Barke, E.J.S.; Davies,J, Thompson, M.(1996)

Parents with high self esteem value and encourage competitiveness and superior achievement and instill the same in the children. Children with higher self esteem have closer relationship with their parents than children with low self esteem. - Coopersmith, 1967; Gecas,V & Schwalbe, M.L 1986 and Kernis, M.H.2000

Many people with low self esteem believe sadness is part of life and that you shouldn't try to get rid of it while people with high self esteem believe in doing something to feel better if they have a negative experience or get in a bad mood. – Brown, J (2006)

People with low self esteem can use their Para-social relationship like favorite celebrities to feel closer to the ideals they hold for themselves. This can have benefit for people with low self esteem than that real relationship. – Derick J.L; Gabrriel, L.S; Tippin, B (2008)

Many among children of age group 8-9 years, self esteem increases up to the early adolescence 12-13 years, but then declines during the adolescence until the end of high school 16-18 years. This mirrors patterns in materialism, which increased in early adolescence but decreases in late adolescence during transition into younger adulthood. – Nguyen, C.L & Roedder, J.D (2007)

Symptoms of low self esteem and its impact on relationship are: 1) Not spending much time in the present moment thus affecting present relationship 2) Individuals with low self esteem often want something they can't have or is out of reach for them 3) Doing things that undermine success or constantly pulling oneself down. 4) Job-hopping and having and having intimacy issues with partners 5) they keep busy so that they don't have to deal with feelings that they keep hidden 6) and proneness to addictions.

INTERVENTION TECHNIQUES AND LOW SELF ESTEEM

Narrative Therapy and Rational Emotive Behavior Therapy focus their effectiveness on self esteem and self acceptance. The studies in REBT reflect relationship between irrational beliefs and low self esteem and they enhance self acceptance. Ellis, A (1995) states that irrational beliefs significantly contributed and caused emotional and behavioral disturbances.

A significant negative correlation was found between self esteem and irrational beliefs. Four specific beliefs were used as predictors of low self esteem; demand for approval, high self expectation, anxious over concerns and problem avoidance. It was found that subjects high in these four areas were found to have low self esteem. – Daly, M.J & Burton, R.L (1983)

REBT has helped effectively deal with self esteem, depression, social anxiety in adult volunteers. People cope with inferiority by striving for compensatory superiority through mastery, competence and perfection. Elliott, J.E (1992)
Yong R (1992) administered rational –group theory to a group of university students suffering a sense of inferiority because of their examination failures. Significant improvement was observed based on their scores on the Sixteenth Personality Factor Questionnaire (16PF), their self scoring and their academic achievement.
Sapp, M (1996) describes how REBT and the cognitive behaviour therapies were used to improve achievement based on studies with students of the middle school level. REBT postulates that self defeating behaviors stem from irrational beliefs contributing to low self esteem, academic self-concept and academic failure. Results found that the intervention improved academic achievement, academic self concept and self esteem.

A self-paced interactive multimedia computer intervention designed to teach rational thinking focused on changing a mid array of irrational beliefs across four categories of self esteem; Peer relations, Academic ability, Role in family and Body image. Students from computer intervention group significantly improved on self esteem. – Kornfield, S (1996)
Negative thoughts of undergraduates low in self esteem, wer restructured into more adaptive self statements and endorsed positive thoughts were modified in to self statements that accentuated the positive aspect of thought. This procedure increased scores o self esteem and decreased depression scores.-Philpot,D,; Bonburg, W (1996)
REBT was very effective in the treatment of adult victims of childhood sexual abuse. Results indicated significant reduction in depression, state anxiety, state anger, state guilt and low self esteem. – Rieckert J; Moller A.T. (2000)
Rational Emotive Counseling program reduces the tension and improves logical thinking among students. – Dawood N & Dirasat S (2001)
REBT is very effective on students' achieving motivation. Hence REBT shall be included in the curriculum of training counselors and secondary schools for effective use of the techniques in helping students. REBT is used as form of Intervention on children and adolescents to enhance self esteem. Vernon, A; Yankura, J; Dryden, W (1997).

NARRATION THERAPY AND SELF ESTEEM

"Narration Therapy" is an approach in counseling and community work and is sometimes known as "re-authorising" or "re-storying" conversations. It centers people as experts in their own lives and views problems as separate from people. Narrative Theory assumes that people have many skills, competencies, beliefs, commitments and abilities that assist them to reduce the influence of problems in their lives. Narrative therapy is the exploration of the alternative knowledge and skills present in the individual.

Adolescent self esteem is localized in relationships with peers and is based on different rational schemes for females than for males.
For females memories about wanting to help female friends were associated with high levels of self esteem. For males memories about successfully assisting oneself with male friends were associated with high levels of self esteem. – Thorne, A; Michaelien, Q (1996)
High self esteemed subjects more frequently justified their behavior in the negative episode, and focused on their own achievements and outcomes in the positive episode. Low self esteem subjects admitted some wrong doings, tried to excuse it in the negative episode, and described themselves as social minded and altruistic in the positive episode. High self esteem subjects aim at being admired for their abilities and low self esteem subjects aim at being for being nice. – Schuetz, A (1998)

Female consistently recalled more child hood memories than males did and were generally faster in accessing the memories, especially memories of events associated with emotion. – Davis, P.J (1996)
In another research experiment, music was used to induce a negative mood in a group of subjects and it was found that high self esteem subjects recalled more positive memories than did low self esteem subjects. Consequently the high self esteem subjects experienced a greater elevation in mood. – Setlliff, A.E; Marmurek . H.C (2002)
Findings of another research experiment strengthen the view that self esteem is a rich a source of knowledge about the self that can influence memory for some kind of autobiographical experience. – Christensen, T.C.; Wood, J.V.; Feldman, B.L. (2003)
Further it was revealed that analyzing life's narratives is critical in understanding how youths perceive themselves and social environment. – Thomas, D.M (2004)

When people evaluate the self through the lens of autobiographical memory, interpersonal distress is portrayed as specially damaging and achievement success is portrayed as especially enhancing. - Pillemer, D.B,; Ivcevic, Z & goose, A (2007)

These studies reflect the effectiveness of Narrative Therapy as an approach to enhance self esteem in students. The use of Narration Therapy in schools helps provide different and multiple alternatives to the problems. Women recall more memories from childhood and most of the memories revolve around the need to help and being in peer relationship. Themes of mastery, achievement were common in the case of memories related to positive self regard and in cases of negative memories, the themes revolved around disappointment, depression and disillusionment. The two interventions REBT and Narration Therapy increase the self-esteem in adolescents.
The author had summarized the article and the findings of the study which has important implications & suggestions for future research in the areas of self esteem and finding alternative methods to enhance self esteem in college students.

They are summarized as follows:
1. Periodic assessment of factors leading to low self-esteem can help in effectively working in enhancing self-esteem.
2. Adolescent behavior and factors contributing to self-esteem can be studied in detail to counteract the effects of low self-esteem.
3. Intervention technique could be introduced to subjects to help them effectively deal with low self esteem
4. Life skills program could be designed using concepts of Rational Emotive Behavior Therapy and Narrative Therapy.
5. Counseling in colleges could be made mandatory to work with adolescent problems.
6. Classroom activities could be designed for students to identify low self-esteem and strategies introduce to work on oneself.
7. Orientation Programs for staff, management and parents could be introduced to help them understand adolescent behavior and in instilling positive self-regard in their wards.
8. Encouraging overall development of the individual.
9. Encourage and assist in developing positive self esteem in students.
10. Encourage interaction between students and teachers and at home between children and parents.

In my opinion also the research and the article said above has highlighted well the basic concepts of Adolescents Self-esteem and the two important Intervention Techniques, namely the Rational Emotive Behavior Therapy and the Narrative Therapy. The emphasis has been on the understanding each of these concepts and seeing if a relationship between them could exist.

Adolescence is period of storm and stress and it is a period where the individual tries to define oneself and understand its role in society. Hence these studies are on Adolescent behavior, self esteem, and Narrative & Rational Emotive Behavior Therapy as techniques to enhance Self-esteem of students.

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UNDERSTANDING GLOBAL HEALTH, AND HOW IT IS RESHAPING HEALTH TRAINING - A REVIEW

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ABSTRACT:

Global health though seen by a few authors as a bid by the WHO to reposition itself and survive changing times, is now being grasped as critical to addressing existing and emerging global health threats as a result of globalization. The world is increasingly "shrinking" as migration and trade patterns take a dimension that makes the world seem like a global village. While this has it economic benefits it is creating new threats as communicable infections are transmitted from region to region sometimes in a matter of a day. Health threats in a region can be a global concern at any given time; it is therefore necessary that health personnel are effectively equipped to handle such scenario as and when they occur. It is important that training programs are responsive to the changing health challenges and position themselves to offer health training programs that ensurehealth professionals are adequately prepared to address contemporary health threats.
In a "shrinking world" health threats can end up being major catastrophe without timely intervention. This review delves into the need to ensure that health care professionals are equipped to effectively handle conditions that previously were not akin to their country. Training of health care workers must therefore be responsive to changing global trends with the realization that even in the developed nations, health promotion will only be successful if the health threats and shared risks from less developed nations are adequately addressed. Furthermore health action must be executed with an understanding of intricate cultural practice and other psychosocial economic factors that impact health. In essence it is not so much what Global health is defined as that matters but the realization that globalization is a powerful force that is impacting the health scenario and we must ensure health programs equip health workers by changes that address curricula, exposure to international training, collaborations, funding and relevant programs. These will not only provoke interest in global heath practice but ensure that we are adequately prepared to face the contemporary global health challenges.

INTRODUCTION:

Global health is a discipline that entails the study of the practice of improving health and health equity for all people worldwide through international and interdisciplinary collaboration. It is arguably an evolution from public or international health (Koplan et al, 2009).The public health scenario worldwide has undergone a lot of transition in the past three decades. Much of this attributed the worldwide increase in trade and migration that has resulted in communicable crossing boundaries in many countries. This has prompted attentions towards the connections between health and medicine across continents(PK Drain et al, 2007).

Health care workers especially in developed nations now have to contend with tropical diseases and newly emerging infections as a result of increased international travel. It is therefore necessary that the health workers are prepared adequately to face the challenges of contemporary healthcare practice (WHO, 2003).

Recent events have shown that the emergence of a health threat in one part of the world can very easily become a global threat; this has been the case with the SARs epidemic, HIV/AIDS and multidrug drug resistant TB (Institute of Medicine, 2003). The United Nations (2005) and Mathers et al, (2004) therefore deduce that increases in the capacity and exchange of health services and information can be used to better address global health threats and influence research priorities. Exposing medical students to these global health issues in their healthcare training programs is one critical way of ensuring they have the competencies to address such threats as they will be more likely to recognize and manage such threats with less reliance on expensive tests and with greater cultural sensitivity. It is therefore not strange that more western medical students have to complete an international clinical rotation in a developing nation (Drain et al,2007).

Addressing the most pressing global health problems and closing the global health gap (including health disparities in minorities and the marginalized) will require massive political and financial commitment the extensive technical solutions already available in both developed and developing countries. It also demands a reorientation in policy and strategy. It is clear that even though solutions exist, they are not accessible to the poorest and hence one of the key driving forces of the global health agenda. Thisentails resolving the participatory gap in setting global health priorities, the operational gap in building efficient and sustainable public health responses and the accountability gap in addressing the health needs of the poorest at the local and the global level (Kickbusch, 2000).This is with the greater realization that health promotion in the west is increasingly dependent on addressing threats arising from developing nations on the one hand; while on the other the appreciation that the addressing of global health needs, especially among poorer countries, will not only help promote economic development but may also reduce health inequalities and foster political stability and security This review thus focusses on an exploration of the concept of global health, the challenges it poses and the changes in training to ensure health personnel are adequately prepared to address emerging global health threats.

Global health- what is it

Global health according to Kickbusch,2000 stands for a new context, awareness and strategic approach in matters of international health. She further reiterates that its focus is the impact of global interdependence on the determinants of health, the transfer of health risks and the policy response of countries as well as international organizations and the many other actors in the global health arena. Its end, she, just like Koplan (2009), asserts is the equitable access to health in all regions of the globe.

Broadly “Global health,” is said to imply the consideration of the health needs of the people of the whole planet above the concerns of particular nations (Brown et al, 2006). It has its roots in the late 19th century, in the largely colonial, biomedical pursuit of ‘international health’. In the twentieth century a change in theemphasis of the field changed to a much broader conceptualization of global health, encompassing broader social determinants of health and essentially a global focus. The disciplinary focus has widened tremendously to encompass economics, anthropology and political science, etc. (Beagolehole et al, 2010).

In defining global health it is essential to note that it is concerned with health differences as well as commonalities in different parts of the world, and largely depend to some extent on the position of the definer or his viewpoint. Secondly, global health’s core strength lies is in its interdisciplinary character, especially the incorporation of approaches from outside biomedicine. Global health recognizes determinants such political, social and economic factors as being central causes of ill health. And last we argue the definition should be devoid of values.

However Rowson et al, 2012 in particular argue that equity which is a key element of many definitions of global health, is a value-laden concept and carries with it significant ideological baggage. Therefore its widespread inclusion in the definitions of global health is inappropriate as it portrays that only people sharing these values may be the ones seen as 'doing' global health. Nevertheless, they still agree that the discussion of values should be a key part of global health education.. Mackintosh (2001),in her work on social settlements argues that health systems across the worldend up embodying levels of inequality that the society perceives to be justifiable (equitqble).Often some level of inequality is viewed in many societies as justifiable, and the factors that influence this view vary markedly from society to society: 'The patterns of inequality in any society are framed by strong legitimizing conventions of thought: from caste-based social distinctions carrying religious significance, via deeply embedded assumptions of gender inequality, to shared expectations that the more educated should receive higher incomes' (Mackintosh 2001 p. 182).

Rowson 2012, emphasizes that it may not be controversial to suggest, therefore, that equity (fairness) has different meanings in different contexts. In a sense these writers suggest that in order for equity to be included in any definition of global health, it should be defined by those using it. However fairness means different things to different people, and to different societies, so this essence is a tall task and deemed impossible. This is great bias they when those who define equity in global health are a narrow group, namely the academics who work in global health. It is particularly problematic to argue that equity should be part of any definition of global health when the people making the definitions form such a narrow group: academics working in global health. Other than that many of those engaged in teaching, researchand practice of global health across the world are committed to global health equity and reduction of global health disparities, do not necessarily share these values of those who do not teach or practice global health: to suggest so would be absurd (Rowson et al, 2010). A commitment to equity (whatever that may mean) is not a prerequisite for involvement in the field, nor should it be.

As Bozorgmehr (2010, p. 14) states that definitions should abstain from attaching normative objectives a priori and factually describe what the field is, not what it ideally should be'. Hence in essence theconcepts and goals such as equity should be recognized as a key focus of debate within the field, not a central part of the definition, and that any 'intervention' or 'solution' to a problem always generates complex trade-offs for society (Rowson et al, 2012).

Rowson et al (2012), conclude that definitions should remain agnostic on values, yet still making it a key principle that space should be made to debate values, goals, concepts and choices in educational (and all other) global health contexts. Even So, Fried et al (2010) reiterates the close relationship between 'global health and public health; they all represent a single field with a long tradition of bringing scientifically validated approaches, technologies, and systems to bear on the world's most pressing health needs.' That is paramount to the practice of Global health and to some extent overrides the academic debates.

Demand for new approach to training

Globalization has created open access to distant regions of the world and enhancing the awareness of global health disparities (Smith,2001; Labonte, 2007). Not only does Globalization have major impact in flow of goods, people and information, it has also enhanced transfer of microbes (Bateman et al, 2001). Health professionals are now faced with numerous challenges in a bid to recognize imported diseases in immigrants and travelers. It is therefore crucial that their training prepares them for the intricacies of handling tropical and emerging diseases as well as to ensure they have capacity to understand various alternative and culturally determined medical practices (Zuckerman, 2002; Bacaner et al, 2004).More medical students and residents are themselves calling for international training/ exposure to global health, and those exposed to these report that this has enriched their clinical experiences (Gupta et al, 1999; Yudkin et al, 2003). Physicians and other health practitioners must also learn about the determinants of health and disease, including

socioeconomic, environmental, and political factors. There are becoming more globally interconnected (Bateman et al, 2001). New physicians will also be facing more cross-cultural interactions and must be comfortable with understanding cultural beliefs and novel social practices that impact health, as well as the complex interplay between culture and notions of healing. Some of literature reviewed highlights the trend that Medical students and residents with international clinical experience are more likely to opt for general primary care medicine (Murray, 2005; Gupta, 1999). They are also more likely to pursue public health qualification and venture into community health work;similarly, they tend embrace attitudes and desires to practice medicine among underserved and multicultural populations (as well as underserved and ethnic minorities) and hence more likely to be directly involved in addressing health disparities (Ramsey 2004, Miller 1999). Hence it is becoming evident that exposing students to international health can have significant impact in addressing global health issues.

New approaches to health/ medical training

In a bid to ensure programmatic changes in global health training, a number of approaches have been made especially in USA and in European medical schools (Kerry et al, 2011. These have been done and continue to be explored in various learning institutions. Integrating global health topics into core medical curricula is one such approach to expose students to global health. More institutions are now offering courses on global public health and tropical medicine in response to the global needs, there is still room for more institutions to consider offering this course. Various elective courses, for instance, medical anthropology, international development and health, or health and human rights can be offered as part of main curriculum or parallel courses. Establishing a global health pathway or track to recognize international experiences and training may also entice more students to study global health (Drain et al, 2007).

Another approach is to offer combined degree programs (e.g., MD/PhD, MD/MPH) in global health as incentive to enhance uptake of global health studies. Students intending to pursue global health can also be recipients of academic, logistic, and financial support for international rotations. More scholarships can be created to meet this need (American medical students Association, 2006).

Medical schools can also establish a global health administrator or office within the medical school to address concerns of interested and even doubtful students, they are also charge with arranging international placement and assisting with logistics Enabling international partnerships/ collaboration with developing-country institutions are also critical to ensure sustainable exchange programs for students.It may in the long run be necessary to make an international clinical rotation a routine part of medical education to enhance the number of students exposed to international health (Romanucci-Ross et al, 2004).Training programs should also be evaluated in terms of the quality of the experience for trainees from all settings and also by the incremental improvement in in-country care, infrastructure, and/or research (Kerry et al, 2011)

CONCLUSION

Globalization has brought with it many boons to the world and its people; however it has its downside of enhancing regional microbe transfer and even health risks worldwide.To adequately succeed in reducing the global burden of disease will depend on how training Programs manage the enthusiasm of trainees globally. Experimentation is also vital to explore new options and make choices of best possible interventions. Such programs must also createnew incentives and training opportunities for health leadership especially in developing countries settings. Investments in scientific innovation, and research to prevent and cure global diseases should match those in the human resources required to discover and deliver innovations in prevention and treatment. This may require time, enhancing leadership and well as political and financial commitment globally.

Enabling partnership is key, but even more important is the need for good direction, foresight, and seizing opportunities as they arise.

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MODIFYING HEALTH BEHAVIOR IN A LEGAL ENVIRONMENT

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ABSTRACT

Though legislation is a quick and easy method of preventing behavioral lifestyle that is injurious to health, many failures may occur in a legal environment, which promotes fundamental human right. Besides, the coercive approach involved in this regulatory approach to health behavioral modification is against the ethics of health education. Health education is practiced in a legal environment of human rights and freedom of choice between health promoting and health disruptive life styles. It is therefore important to device ethically permissible strategies for modifying health behavior in order to achieve success in an environment of counteracting legal considerations and compelling need for healthy lifestyle in the community

KEY WORDS: Behavioral, Modification, Legal, Environment

INTRODUCTION

Governments of all nations have an obligation to ensure enjoyment of the highest attainable standards of health as one of the fundamental rights of every human being without distinction of race, religion, political lineage, economic or social distinction.(European Parliament Report, 2007) It is therefore the duty of all governments to put in place facilities that will promote health of its citizens so that they can live an economically productive life in a conducive socio-political environment.

However, the individuals in families and communities have a fundamental human right, which allows freedom of choice in all aspects of living including behavioral life style, some of which may not be conducive to health. The 1993 Vienna World Conference on Human Rights, for example, noted that it is the duty of States to promote and protect all human rights and fundamental freedoms, regardless of their political, economic and cultural system.(Vienna Declaration, 1993) Some of these behavioral life styles include alcohol and substance abuse, dietary taboos, over-nutrition, sedentary lifestyle, premarital and extramarital sex, promiscuity, female genital mutilation/female circumcision, tattoos, ear and nose piercing, .

Governments may attempt to regulate these behavioral life styles through legislation. (Park, 2007) The regulatory approach involves governmental intervention designed to alter human behavior through regulations ranging from prohibition to imprisonment. This approach seeks change in health behavior and improvement in health through a variety of external controls or legislations. In many cases, the intended behavioral modification may not necessarily be effected as many as such practices are ‘driven underground’ These practices cannot change until individuals, families and communities begin to value health as an asset, and have adequate knowledge to evaluate their health situation in relation to the injurious behavior, overcome their socio-cultural and psychological barriers, and internalize and adopt new behaviors leading to health. It is against this background that the regulation of specific practices and attitudes affecting health promotion in a legal environment are discussed below.

Alcohol and Substance Abuse (Prueth, 2004)
Alcohol and substance abuse are often grouped together as they have common intoxicating function and addictive effects.
Alcohol is usually ingested in form of spirits, wines and beers with the aim of elevating mood in social cycles in order to improve congeniality. However, when taken in large quantities or above the level of tolerance of the particular individual, amiability degenerates to nastiness and the affected person is motivated to engage in socially disgusting or violent behavior and accidents such as rape, physical assault and road traffic accidents. Chronic complications from alcohol abuse include liver cirrhosis, Wernicke's encephalopathy.
Government may regulate use of alcohol by licensing bars restaurants and hotels and restricting the sale of alcohol to certain periods of the day. Government cannot ban the sale of alcohol because it often contributes to the per capita income of the country and provides occupation and economic gain to individuals and families. In some Islamic states, alcohol is prohibited. However, alcohol may be secretly sold into flasks and kettles for abuse in the privacy of the home. Government agencies may legislate on diving while drunk but cannot stop any vehicle to determine the blood level of alcohol except the driver is involved in traffic offences. At best, government legislation is reactive in that it only punishes offenders who have already abused alcohol. Health education offered repeatedly by skilful and charismatic health educators is proactive in that it prevents alcohol abuse by persons who are internally and externally motivated .Substance abuse involves the use of chemical substances for mood elevation. Notable among these substances are cocaine, morphine, heroine, pethidine, marijuana (cannabis sativa) glue ,opium and tobacco. Some of these are ordinarily pain killers, which have sedative and euphoric properties. They have more addictive properties than alcohol and hence are dangerous to health as well as income depleting. Addicted persons may be involved in armed robbery just to get enough money to buy these substances. All forms of crime may be committed under the spell of these substances. In addition, the intravenous administration of some of them by shared syringes and needles exposes them to blood borne diseases such as Human immunodeficiency virus, hepatitis B and other viral infections. Most Governments legislate against substance abuse but some corrupt persons, who became he heads of government through the use of money acquired from drug trafficking, often aid and abet this illicit trade. Just like alcohol legislation has not reduced substance abuse. Only health education and social environmental intervention can.

Dietary taboos
Dietary taboos are food items that certain cultures are prohibited from eating because of superstitious beliefs. Dietary taboos are common in many parts of the world. In Nigeria, certain communities do not eat giant rats, grass cutters, bush fowl, even though neighbors who are less than one kilometer away eat the meat from these animals as a delicacy. In Singapore, the Hindus do not eat beef; Malays (Muslims) do not eat pork. Yet the Chinese eat both pork and beef. All three groups live in the same environment. Though use of protein is necessary for the body growth and repair and lack of adequate protein may result in kwashiorkor (protein malnutrition) in children, government cannot force anyone to eat what the person does not want to eat because it does not want to encroach on the person's fundamental human right. Legislative regulation is therefore not effective in modifying ethno-religious behavior. Only health education and social intervention can.

Over-nutrition and Sedentary lifestyle (Hoffman, 2001)
Over-nutrition and sedentary lifestyle are known to predispose to obesity. Obesity leads to hyperlipidemia, which predisposes to atherosclerosis. Atherosclerosis leads to vascular occlusion due to thrombo-embolism. Thrombo-embolism may cause cardiovascular accident in form of myocardial infarction (Park, 2007) and cerebro-vascular accident in form of stroke. All these are accelerated by smoking and stress. It is in government's interest to protect its citizens from

myocardial infarction and stroke. However, no one can be forced by a legislation to eat less food or do more exercise. However government can use social intervention model of health education to cause behavioral changes leading to less feeding and more exercise. In Singapore, food is sold in eateries with premeasured plates so that it is difficult to overfeed. (Personal Observation, 1990) However, no one will stop a person from going to three or more eateries to take lunch. Houses are also arranged in such a way that one has to trek for about five minutes to take a bus. The bills from car parks prevent car owners from using their cars all the time for it is much cheaper to take bus than to pay bills at car parks. These costs are in addition to fueling the car. The combined effect of the predetermined food measures and movement to bus stops make most people slim in Singapore. This practice would definitely not work in Nigeria where most food sellers are more interested in economic gains irrespective of the harm done in the process. Besides, most Nigerians eat at home. Many of the available foods are rice and tubers which have a have a high glycemic index. (Ihediohanma, 2011)

Premarital and Extramarital sex, promiscuity

All these occur in various socio-cultural settings. Premarital sex is associated with the phenomenon of teenage and unintended pregnancies, abortion, the spread of STIs and HIV.(Alo and Akinde, 2010) Extramarital sex and promiscuity are also known to be predisposing factors to sexually transmitted diseases including HIV/AIDS, Legislation against these practices is ineffective because humans have a right and freedom to associate with each other. What happens in privacy of the bedroom is not the concern of the government. Government may legislate against transmission of infection from a known carrier of sexually transmitted disease to uninfected person. No matter the amount of sanctions imposed, regulation will only be reactive in that a person would already have come to harm before the sanction is imposed on the offender. Therefore legislation is not an effective method of modifying behavioral life style.

Female genital mutilation/female circumcision (Nour, 2008)

More than 130 million women worldwide have undergone female genital cutting (FGC). FGC occurs in parts of Africa and Asia, in societies with various cultures and religions. Reasons for the continuing practice of FGC include rite of passage, preserving chastity, ensuring marriageability, religion, hygiene, improving fertility, and enhancing sexual pleasure for men. (Nour, 2008) Female circumcision has been called female genital mutilation because female circumcision is believed to serve no purpose unlike male circumcision which was believed to protect Jewish women from cancer of the cervix (Zoosmann-Diskin, 1989) and also protective in the transmission of human immunodeficiency virus. (WHO) Female genital mutilation exposes female to unusual vulvo-vaginal tears during childbirth and does not reduce sexual promiscuity in affected females. There is Legislation in force in many of the southern states of Nigeria. Legislation has only served to remove the practice from government owned hospitals. Many midwives still practice it privately for financial gains

Ear and Nose piercing, Tattoos and Scarification marks

Ear and nose piercing is common in many parts of the world. It is used by women to enhance beauty. It is usually done early in life. While tattoos were done in Nigeria for enhancing beauty, scarification marks are done a form of treatment for swellings and pains as blood letting from these sites are believed to be curative. Splenomegaly, a common reaction to malaria in endemic areas is still being treated by scarification in many Nigerian cultures. However, there is new fad which drives boxers, film stars to design their bodies with tattoos. The only danger is the use of shared needles for these processes, which may predispose to blood borne infections including HIV/AIDS. Legislation cannot stop these practices which are well enshrined in many cultures.

CONCLUSION

While motivation and social intervention models of health education are ethically acceptable methods of health behavioral modification, regulatory approach to behavioral modification in form of sanction enforced legislation is against the basic philosophy and ethics of health education. However legislation may be used in emergencies to reduce the number of victims before health education becomes generally available

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CONCEPTUALIZING AND IMPLEMENTING THE FIFTH MILLENNIUM DEVELOPMENT GOAL THROUGH THE NIGERIAN MIDWIVES SERVICE SCHEME

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ABSTRACT

The objective of the fifth Millennium Development Goal is to reduce maternal mortality by three quarters by the year 2015. All 189 member countries of the United Nations were expected to develop their own strategy for implementing this objective. The Federal Ministry of Health in Nigeria developed the Midwives Service Scheme in 2009, which mirrored a model earlier conceptualized and published in Tropical Doctor 2007. Since the outset of the Midwives Service Scheme, several economic and health benefits have been realized. These include gainful employment for all newly qualified, unemployed and retired midwives, improvement in the health care delivery to erstwhile medically underserved areas, a yet to be estimated reduction in maternal mortality ratio and a better utilization of the facilities in the primary health care centers.

KEY WORDS: Conceptualizing, Implementing, Nigerian, Midwives, Service, Scheme

INTRODUCTION

The Millennium Development Goals adopted by the United Nations in the year 2000 provides an opportunity for an intensive action to improve global health. (Park, 2007)The Millennium Development Goals placed health at the heart of the development and represent commitment by governments throughout the world to do more to reduce poverty, gender inequality, lack of education, access to clean water, and environmental degradation. Three of the eight goals, eight of the eighteen targets and eighteen of the forty eight indicators are health related. Governments have set a date of 2015 by which they will meet the millennium development goals, which include the following:

- To eradicate extreme poverty and hunger Goal I
- Achieve universal primary education Goal II
- Promote gender equality Goal III
- Reduce child mortality Goal IV
- Improve maternal health Goal V
- Combat HIV/AIDS, malaria and other communicable diseases Goal VI
- Ensure environmental sustainability and Goal VII
- Develop a global partnership for development Goal VIII

Generally, there are 8 goals, 18 targets and 48 indicators. Three of the eight goals, eight of the 18 targets and 18 0f the 48 indicators are health related. The 6th target, which is to reduce by three quarters, between 1990 and 2015, the maternal mortality ratio, is the target for the Fifth Millennium Development Goal. The 16th and 17th indicators are maternal mortality ratio and proportion of births attended by skilled health personnel respectively. (Park, 2007)

Problem Identification

A major problem of maternal health in Nigeria has been high maternal mortality ratio of between 500 and 1500 per 100,000 live births in various areas of Nigeria. This maternal mortality ratio is a clear departure from the ratio in industrialized countries. It was realized that there is at least a primary health center in each of the 10 to 12 wards that formed each of the 774 local government areas of Nigeria. These primary health centers are expected to be the first contact between pregnant women and modern health care. Elements of primary health care include education concerning prevention of health problems and methods of preventing and controlling them, promotion of food supply and proper nutrition, adequate supply of safe water and basic sanitation, maternal and child health including family planning, immunization against major infectious diseases, prevention and control of locally endemic diseases, appropriate treatment of common diseases and injuries, provision of essential drugs, promotion of mental health and dental health. (Lucas, 2000) These primary health centers are distributed in such a way that they are present in all parts of Nigeria. Each ward has at least one maternity or primary health
center where clean and safe delivery is possible depending on the availability of staff. These primary health centers are easily affordable and accessible to rural dwellers, who form more than 70% of the Nigerian population. It was therefore incredible that Nigeria should have such a high maternal mortality ratio if these facilities were actually utilized.

Data Collection and Situation Analysis

In 2007, a study was designed to find out if the number and variety of workers in the primary health centers, as they were then constituted, were adequate to meet the maternity needs of communities. (Inegbenebor, 2007) It was also designed to explore the problems encountered by midwives and other workers in their bid to refer emergency cases to district and tertiary hospitals with the aim of developing a model for maternal mortality reduction, using available resources, in Nigeria.

Questionnaires were administered to 30 primary health centers in all five local government areas of Edo central senatorial district of Nigeria. The members of staff were asked to indicate the category and number of staff working in the health centers, the distribution of staff on a 24 hour shift duty and the residence of members of staff. They were also asked to state if they had ever seen causes of maternal mortality such as obstetric hemorrhage, complications of hypertension in pregnancy including eclampsia, puerperal sepsis, complications of abortion and prolonged obstructed labor. Finally, the staff wives were asked to state whether they had encountered any difficulties in treatment.

It was found that all the 30 primary health centers surveyed had at least one midwife: 20 had two midwives, five had one midwife and five others had three midwives. All had at least two traditional birth attendants who were resident in the community served by the primary health centre. Only 10 had a community health extension worker. There were no resident doctors in any of the primary health centers: doctors visited occasionally, about once in 2 weeks and when they came to investigate a maternal death due to alleged negligence. The percentage of primary health centers which had seen cases below, which needed emergency obstetric care in the past year were as follows

- Postpartum hemorrhage (100%),
- Puerperal sepsis (90%),
- prolonged obstructed labor (50%),
- severe pre-eclampsia/eclampsia (33%) and
- complications of abortion (100%).

In many cases, patients presented at night when there was no transport, no money and no midwife or doctor available in the clinic. In most of the primary health centers, midwives lived in urban areas and did mainly morning and afternoon shifts, leaving the night shifts for the traditional birth attendants, and occasionally the community health extension workers where available.

Conceptualizing a Model for preventing Maternal Mortality in Nigeria

It was noted that traditional birth attendants could not provide the early diagnosis and treatment needed for the prevention of maternal mortality in Nigeria. The need for skilled health attendant at each child birth was established. A conceptual model of one resident doctor per center, with a 24 hour coverage by midwives and a central ambulance centre for each local government area, was proposed for the reduction of maternal mortality, using the available resources in Nigeria.(Inegbenebor, 2007)

Emergence of the Midwives Service Scheme

In December, 2009, the Midwives Service Scheme was launched based on the rationale that maternal, newborn, and child health indices in Nigeria vary widely across geopolitical zones and between urban and rural areas, mostly due to variations in the availability of skilled attendance at birth. (Harrisson, 1997) The slow rate of progress in Nigeria made the Millennium Development Goal targets unachievable using current strategies alone. The maternal mortality ratio varied as follows:

- Northeast zone: 1,549/100,000 live births
- South West Zone: 165/100,000 live births.
- Urban areas 351/100,000 live births
- Rural areas: 828/100,000
- The under-5 mortality rate: 171/1,000 live births (Range 219-871/1000 live births

Though these indices were lower in south west and east they fell below global development targets. (Abimbola et al., 2012)

Staff Recruitment for the Midwives Service Scheme

Midwives were recruited as follows in the proportions indicated below:
Pre-registration midwifery graduates from midwifery schools (Intern midwives): 44%
Unemployed midwives: 45%
Retired midwives: 11%
These midwives were distributed to parts of Nigeria that had the greatest need of skilled birth attendants in such way that the primary health centers had al least 4 midwives for the 24 hour shift duty. This was to ensure that all births in designated zones were attended by a skilled birth attendant at all times of the day and night.

Referral Units

Selected general hospitals located in various zones were equipped with emergency obstetric kits and human health resources and made to serve as referral centers for emergency obstetric care. These hospitals were also equipped with ambulance services to facilitate transfers.

Funding for the Midwives Service Scheme

So far funding for the facilities has been from the Federal Government of Nigeria while salaries for the employees has been shared between the three tiers of government as follows:

Federal Government: 50%
State Government: 33%
Local Government: 17%

Is the Midwives Service Scheme meeting the set objectives?
Though there are improvements in maternal mortality ratio in the facilities under the midwives service scheme, the maternal mortality ratios in zones covered by the midwives service scheme are still worse than national average. This may be due to cultural reasons especially in the North East and North West Zones where first born babies are expected to be delivered at home. Besides, the scheme has attracted high risk deliveries to these facilities, which are staffed by interns with little or no experience. However the midwives service scheme can be improved by introducing unemployed post National Youth Service doctors and other willing doctors to the scheme. This will improve results from these primary health centers. Ambulance services should preferably be attached to groups of primary health centers located in a local government as emergencies are usually transferred to general hospitals and not the other way round.

Challenges facing the Midwives Service Scheme
In some of the zones particularly North East Zone, activities of Terrorists popularly known as 'Boko Haram' is discouraging midwives from serving in facilities located therein. This, added to religious and cultural problems, is making the zone to be left behind in the target of maternal mortality reduction. Besides, most of the participant are single young adults who are very mobile.
The federal government grant for the Midwives Service Scheme is from the debt relief granted to the Nigerian government by the Paris Club. The greatest threat to the scheme is the uncertainty about continued funding beyond the 3-year commitment from the grant. However, the National Health Bill passed in 2011 promises to further provide secure funds for the administration of PHC in Nigeria (FGN, 2011) the state governments are encouraged to be fully involved in the scheme, as the plan is for them to gradually take over the scheme in their respective states.

Benefits
The midwives service scheme has improved on the employment of midwives, who before now, moved from one private clinic to the other in search of better pay as they were grossly underpaid by private medical practices. Today their salaries have improved remarkably. Many of the primary health care facilities in the zones under the midwives service scheme are now better utilized in all elements of primary health care.

CONCLUSION

The midwives service scheme, which is closely related to the model described by Inegbenebor, in 2007, is very promising. When applied to all parts of Nigeria, it is capable of reducing maternal mortality ratio and other health indices to acceptable levels. The year 2015 is so close that the goal set by United Nations for 2015 appear to be unachievable. This however should not discourage the midwives Service Scheme, if there is a political will by all tiers of government in Nigeria.

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DOES HEROIN USE DISORDER INTERVENTION 'WORK'? A CRITICAL REVIEW

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ABSTRACT

Abstract Of all the vice problems confronting South Africa and many other countries, the heroin dependence syndrome and its consequences pose some of the most serious challenges. While the treatment and management of heroin use disorders continues to be characterized by new developments, altering perspectives, and by controversies of one kind or another, the literature findings suggest that different treatment settings may be appropriate for different heroin users. People who are treated for heroin use disorders achieve a continuum of outcomes with respect to their heroin-taking behaviour and their heroin-related problems. Treatment response is thus not a simple matter of success or failure. As with many treatments, the assessment of outcome involves degrees of improvement, and these may have different meanings for different individual cases. Although there is a general acceptance of such goals as improved health, or reduction or elimination of heroin consumption, it is also necessary to be aware of the need for flexible goals that can be adapted to individual circumstances.

INTRODUCTION

For many years, the traditional view of heroin dependence was extremely pessimistic about outcome. The received wisdom suggested that people who become dependent upon heroin seldom gave up, and that treatment had little effect. An editorial in the first edition of the International Journal of the Addictions stated that there is no relationship between treatment and the outcome and that, regardless of the treatment provided, 'the great majority of addicts simply resume drug use' (Einstein, 1966). Similarly, an early review of treatment evaluation studies noted that 'the treatment of heroin addiction has been singularly unsuccessful'. This traditional view tended to perceive heroin dependence in terms of an inevitable and progressive deterioration, and some natural history formulations have been more concerned to account for the deterioration of the addict than to allow for the possibilities of recovery (Callahan, 1980).

The history of heroin use disorder intervention has often been characterised by fads and fashions. Some of the treatments that have been used have been, at best, ineffective and, at worst, harmful and occasionally even dangerous. It is a sad reflection upon the field that practices and procedures for the treatment of heroin dependence can so easily be introduced and applied without (or even contrary to) evidence. This is illustrated by the extraordinary range of interventions that have been used to detoxify heroin dependents. Several of these treatments have been more dangerous than the untreated withdrawal syndrome (Kleber, 1981). Interventions have included the administration of hyoscine, strychnine, and nitroglycerine, as well as belladonna treatments involving the administration of scopolamine (causing hallucinations and agitation, requiring physical restraint by 'a strong nurse'). Other extreme forms of treatment have included electroconvulsive therapy, and insulin-induced hypoglycaemia (Gossop, 2003).

The risks of such treatments are indicated by reports that, in a hospital where 130 patients were given the hyoscine treatment, there were six deaths in a year. This should be judged in the context that, although the heroin withdrawal syndrome causes considerable discomfort, it is of relatively short duration and is not medically serious, much less life-threatening. The use of sodium

thiocyanate was found to lead to delirium and psychosis, often lasting as long as two months. Some of the treatments may appear reassuringly old-fashioned and little more than historical curiosities. Other treatments from the past have more modern counterparts. Bromide sleep treatment was used in the early decades of the 20 century, as was 'artificial hibernation' with up to 72 hours of sodium pentothal-induced narcosis. This also led to deaths. Kleber (1981) refers to the deaths of 2 out of 10 patients treated in this way. In recent years there has been some enthusiasm for accelerated heroin detoxification under anesthesia. Such treatments tend most often to have been provided by privately owned operated (for profit) organisations.

The notion that heroin dependence involves a progressive and irreversible deterioration is a view that has considerable resonance with popular conceptions of substance dependence. In its thc rudest form it can be found in the 'dope fiend' myth of inevitable social, moral, and physical decline. This view has been popular since at least the end of the 19 century, and it is a testimony to its staying power that a variation of this theme surfaced in the UK government anti heroin campaign, which under the slogan 'heroin screws you up' depicted rapid decline in health and loss of control over intake. A market research evaluation of the campaign showed that this led to an increased belief among young people that death was an inevitable consequence of heroin use (Gossop, 2003).

Prior to the 1970s, there was virtually no formal understanding of the addictions, and little was known about how heroin use disorders could be effectively managed or treated. During the late 1960s or early 1970s, many countries established systems of substance dependence intervention services. Prior to this, intervention was provided by very small numbers of 'specialist' doctors, or in other types of services (mental hospitals, prisons). Differences in the governing ideas behind British and American substance dependence policies were articulated in the 1916 Harrison Act in the United States and the 1926 Rolleston Report in the United Kingdom. The United States tended to pursue a policy that was reliant solely on control measures. The United Kingdom took a more medicalised view of the disorder and its management. These differences are still reflected in the contrast between the British acceptance of harm-reduction measures that can be utilised to limit the damage to the continuing heroin misuser, and the American goals of 'zero tolerance', 'users accountability', and a 'drug-free America' (Kleber, 1981).

When the UK drug clinics were first established (after 1968), they were almost all run by psychiatrists. Diagnoses were assigned to heroin dependent patients on an ad hoc basis after an informal clinical interview. The diagnoses were often unreliable and provided almost no useful information about aetiology, course, or treatment needs. The consequences of this were less damaging than they might have been since the intervention options available at that time were so limited. Out-patient intervention involved unsystematic forms of prescribing (it would be misleading to describe this as representing any planned or systematic programme of maintenance). In-patient treatment intervention usually took the form of loosely organised therapeutic communities with various 'eclectic' interventions applied, according to the clinical preferences of the staff. Behaviour therapy and biological psychiatry were still developing disciplines. Social and cognitive learning theories had yet to make an impact upon the field. The history of medicine suggests that the origins of treatment for any problem tend to follow the identification of severe cases and that, during its early stages of development, treatment consists of applying whatever remedies are available when the problem is first recognised (Gossop, 2003). Heroin use disorder myths

The users' exaggerated fear of withdrawal fulfils a similar role, offering a powerful justification for not coming off heroin. The idea that heroin withdrawal involves unbearable pain has proved to be the most convenient fiction for the media. It provides exactly the right sort of voyeuristic titillation for which the general public has shown itself to be so eager. Basketball Diaries and Trainspotting linger over the agony of heroin withdrawal. The hyperbole of these accounts bears little resemblance to what might more realistically be compared to a dose of flu: certainly heroin

withdrawal can be unpleasant and distressing, but it fails by some considerable distance to match up to the myth (Leggett, 2001; Gossop, 2000; Kenny, 1999; Pearson, 1987; Kohn, 1987; Kaplan, 1983).

Although the opiate withdrawal syndrome is one of the accepted criteria of physical dependence, it contains a very large psychological component (American Psychiatric Association, 2000; Kaplan, 1983). For most heroin users, withdrawal and craving are inextricably linked: each one produces the other. According to the principles of Pavlovian conditioning, if a user regularly associates a particular place or event with their injection of heroin, that place or event will acquire some of the rewarding properties of the drug itself. As a result, things that are of no special significance to other people can provoke a powerful need for heroin in the user. Craving and conditioned withdrawal symptoms can be triggered off by the sight of a regular scoring place, or by music that evokes strong heroin-related memories for the user (Marlatt & Gordon, 1985). Conditioning processes can also have the opposite effect. When a user is badly in need of a fix but possesses no heroin, they can obtain some relief from their craving by injecting water, or even by just pushing their needle into a vein. This event has come to provide a small part of the drug experience with which it has been so often associated (Gossop, 2000; Finnegan, 1995; Kaplan, 1983; Strang, Griffiths, Powis, Abbey & Gossop, 1992).

The actual process of withdrawing from heroin presents few medical problems and can be managed easily and with the minimum discomfort for the dependent. The time taken to complete withdrawal will vary according to the preferences of the doctor and the user, but for heroin it can be completed in anything from a couple of days to two or three weeks (Gossop, 2000). In contrast, withdrawal from alcohol and benzodiazepines, for example, carries some of the more serious medical risks, and can be one of the most distressing withdrawal periods for the individual (Gossop, 2000; Kohn, 1997; Freedman, 1992). In comparison, the opiate withdrawal syndrome can be reduced to minimal proportions by a carefully regulated withdrawal regime, yet almost all heroin dependents are terrified of withdrawal. This exaggerated fear makes more sense if it is reinterpreted as a fear of living without drugs. What terrifies the user are not the symptoms of withdrawal, distressing though these may be, but the dawning emptiness beyond, the prospect of learning to live without a chemical crutch (Gossop, 2000; Friedman, 1992).

In this context, it is futile to look for the objective causes of heroin dependence, or to talk of whether or not the heroin dependent can really give up heroin. The attitudes, beliefs and expectations of such a person are of paramount importance. If heroin dependents believe that they are completely helpless before the power of heroin, then they are indeed helpless. But the origins of the helplessness lie in the psychology of the dependent and not in some chemical property of the drug (Dos Santos & Van Staden, 2008; McIntosh & McKeganey, 2002; Gossop, 2000).

The clearest and most convincing evidence against the heroin user's need to remain dependent is that large numbers of people abandon their dependencies through their own efforts. In her studies of American servicemen, Lee Robins (1993) found that, although the use of drugs was rife in Vietnam, the numbers who became re-dependent on drugs on their return to America were extremely low (the social significance of this study is discussed later). Even among those who had been dependent on opiates (mainly heroin) in Vietnam, only 7% became re-dependent on opiates after going home, and less than 1% felt that they had been dependent on substances since their return. More than nine out of every ten addicts were able to give up. Admittedly, the circumstances in which these studies took place are very unusual, but even among the ordinary street heroin dependents it is not generally known that many successfully give up heroin (Terry, 2003; Gossop, 2000). Compared with the usual civilian statistics regarding opiate dependence, these figures are remarkably low: one might have predicted that many more of the men would have experienced serious problems relating to the use of opiates. The low re-dependence figures are also surprising in view of the psychological readjustment problems experienced by many of the returning soldiers. Post-traumatic stress syndrome was increasingly recognised among these

individuals (Terry, 2003; Gossop, 2000; Kenny, 1999). However, studies have shown that heroin dependence is far from being the irreversible condition that it has sometimes been assumed to constitute (Dos Santos & Van Staden, 2008; McIntosh & McKeganey, 2002; Winnick, 1962).

There are a number of separate influences at work here, each of which affects the likelihood of heroin ingestion. During the Vietnam War, these combined to provide the conditions in which this activity was most likely to occur. Psychologically, the experience of suddenly being removed from a safe, familiar environment to a strange, foreign and extremely threatening one increases the pressure upon the individual to take drugs. Drugs are a useful means of coping with the mixture of fear, physical tiredness and boredom that is such a familiar feature of military life during a war. Socially, the tour of duty in Vietnam was characterised by a removal of many of the usual social and moral restraints that reduce the likelihood of heroin taking. The soldiers themselves were inclined to regard their tour of duty as something separated from 'real life' and there were various social pressures to take drugs simply because so many others were using them. Last but not least, there was the physical availability of heroin and other drugs. It is difficult to imagine conditions more likely to promote their widespread use (Terry, 2003; Gossop, 2000; Kenny, 1999; Vietnam & America: A documented history, 1995).

What happened in Vietnam and afterwards conflicts with several popular beliefs about heroin dependence. It is usually assumed that heroin dependence is an inevitable consequence of using the drug, and that, once it has taken hold, it is virtually impossible for the user to rid him or herself of the habit. The Vietnam experience shows that neither of these beliefs is true. Even of those who were dependent in Vietnam, the vast majority were able to cast off their use when they returned to America (Gossop, 2000; Kenny, 1999).

This curious episode in the history of heroin taking is a good example of the ways in which changes in social circumstances can powerfully affect the ways people use heroin. The young men who served in Vietnam were removed from their normal social environment and from many of its usual social and moral restraints. For many of them it was a confusing, chaotic and often extremely frightening experience, and the chances of physical escape were remote except through the hazardous possibilities of self-inflicted injury. As a form of inward desertion, heroin represented a way of altering the nature of subjective reality itself. The Vietnam War veterans' experience contradicts the notion that heroin dependence is related to individual psychopathology or criminality: the way in which the public sees the dependent depends on who he or she is. In other words, how these heroin dependents were treated and, in turn, how they saw themselves, has more to do with social context that it necessarily does with individual deficiencies (Terry, 2003; Gossop, 2000; Kenny, 1999).

Primary heroin use disorder therapeutic modalities

There has been a significantly increased emphasis on matching clients to intervention. For many heroin dependents and especially those with long and complex histories, the assessment procedure itself may be a therapeutic process. The telling of the 'life story' — some of it spontaneously, some in answer to direct questions — helps the individual, perhaps for the first time, to see their drug taking in some sort of perspective. The account of the present social circumstances clearly identifies current problems and needs. This clarification to an outsider is, or can be, a clarification to the heroin abuser too so that what needs to be done, the way forward, becomes apparent to both (Ghodse, 1989). However, assessment is not an end to itself. The aim of assessment is to offer the individual an appropriate intervention programme. The skill of the helping professional lies in the accurate assessment of the problem and the accurate matching of heroin depend to treatment option (although heroin dependent and professional may not always agree).

Six major non-pharmacological approaches to psychosocial intervention have been identified: (i) 12-step, (ii) psychodynamic, (iii) marital/family, (iv) cognitive-behavioural, (v) contingency management and (vi) motivational approaches. Approaches based on the Alcoholics Anonymous 12-step model are still clearly dominant in the field of substance dependence intervention, and have continued to dominate despite significant inroads from both motivational and cognitive-

behavioural approaches (Rotgers, Morgenstern & Walters, 2003; Alcoholics Anonymous, 2001).
Although psychodynamic theory traditionally has not addressed itself to substance dependence, a number of innovative approaches based in psychodynamic thinking have been developed more recently. These newer approaches are particularly attractive because of their potential to enhance the implementation and efficacy of other treatment approaches. In both research and clinical settings, an increased emphasis is being placed on working with clients who have co-occurring psychiatric and substance use disorders. Because of this, psychodynamic approaches, though they were not originally developed to treat substance use disorder psychopathology, can provide useful ways of conceptualising and working with substance users (Aziz, 1990).
Marital and family approaches to substance use disorder intervention have a long and diverse history, and have garnered some of the strongest research evidence for their efficacy. In addition to strong research support, these approaches provide a means of integrating apparently disparate aspects of a client's life into a more coherent treatment and support network that can help produce and maintain changes in substance use (Rotgers, Morgenstern & Walters, 2003; Corsini & Wedding, 1995).
Cognitive-behavioural approaches, while not widely used clinically, have become more apparent in clinical programmes, at least in name. These approaches have amassed the strongest research support for the efficacy of any approaches presented in this article. Cognitivebehavioural approaches are ideally suited to client-treatment matching because they are inherently orientated to the individual, with each client's treatment being potentially different in scope and process, depending on the results of thorough pre-treatment and ongoing assessments (Hayes, Barlow & Nelson-Grey, 1999).
Contingency management approaches are behavioural therapies that increasingly have been found to be efficacious. Originating in the theoretical ideas of B.F. Skinner, contingency management approaches share the advantage with marital and family approaches that the client's environment is mobilized in the service of behaviour change and maintenance. Strongly supported by research evidence, contingency management treatments can be particularly effective in combination with cognitive-behavioural and 12-step components in a broad-based treatment 'package' (Rotgers, et al., 2003).
Motivational enhancement approaches have continued to attract both research support and clinical popularity. Perhaps the most influential development in the late 20 century substance dependence treatment intervention field, motivational enhancement approaches are now established in the mainstream of substance dependence treatments. Based on research into social psychology and behaviour change theories, motivational enhancement approaches attempt to mobilize clients to change maladaptive behaviour to more healthful patterns (Marlatt & Gordon, 1985). To some extent these approaches have gained popularity as a reaction against traditional confrontational approaches that focus on aggressively breaking through clients' 'denial'. Instead of aggressive confrontation, these motivational approaches take advantage of client ambivalence about the pros and cons of substance use to help produce movement toward change. Heroin use disorder intervention
The therapeutic landscape of substance use disorder treatment has changed dramatically since the 1960s, and especially during the past two decades. Many promising interventions and procedures and therapeutic agents have been developed. There is a range of pharmacological options, where once there were very few. There is increasing evidence about the effectiveness of many of these intervention options. There is also an understanding of the importance of the social environment, educational development, behavioural functioning, cognitive processes, and the use of active coping strategies during recovery to improve longer-term outcomes. Nonetheless, the treatment and management of heroin dependence continues to be characterised by new developments, changing perspective, and by controversies of one kind or another.
Heroin dependence interventions should be appropriately responsive to the needs of individual heroin dependent. The need for responsiveness to individual differences requires attention to

specifics. These include issues such as whether the substance is taken orally, by smoking, or intravenously, whether discontinuation will lead to clinical withdrawal syndrome requiring medical treatment in its own right, and whether the dependence is integrated within the user's personality and social lifestyle or is regarded as an isolated item of problem behaviour. The problems associated with heroin dependence generally extend beyond the dependence syndrome, and include other behaviours and disorders. Also, each heroin user may experience different problems, which may range from the acute to the chronic, and from the mild to the extremely severe. Heroin dependence problems are diverse and are manifested by people with different backgrounds and characteristics. There are also many different types of treatment approaches and interventions (Gossop, 2003).

Many heroin dependents have social and/or psychological problems that precede their dependence (Rodrigues-Llera, Domingo-Salvany, Brugal, Silva, Sanchez-Niubo & Torrens, 2006; Vasile, Gheorghe, Civrea & Paraschiv, 2002; Karam, Yabroudi & Melhem, 2002; American Psychiatric Association, 2000; Leshner, 1999). These may include social behavioural problems from an early age, educational failure, literacy problems, family disintegration, lack of legitimate job skills, or psychiatric disorders. Such problems tend not to resolve themselves simply because the individual gives up heroin and, unless specific services are made available to deal with them, their problems may continue to cause difficulties for the individual and for their chances of recovery. For many heroin dependents, recovery is not only a matter of giving up heroin-seeking behaviour but also involves tackling the social and behavioural problems that may have preceded the addiction and that have often been worsened by it (Dos Santos & Van Staden, 2008). The treatment of heroin dependence problems, therefore, may include interventions that extend beyond the focal point of heroin consumption, and that tackle the personal/psychological and social impairments that may affect those who enter treatment.

Intervention efficacy

The assessment of intervention need has been defined in terms of the ability to benefit from health care (Stevens & Raftery, 1994). The need for intervention has a neutral or pragmatic meaning and possesses specific relevance to the provision of health care which, in this context, should be interpreted with regard to the potential of specific types of interventions to remedy heroin-related problems. In the evaluation of the effectiveness of treatment interventions for heroin dependence problems, the elimination or reduction of heroin/drug use usually serves as a primary outcome measure. A more comprehensive assessment of the impact of treatment may also use secondary outcome measures to measure changes in health and social functioning (Gossop, 2003).

An important conclusion to be reached from the study by Dos Santos, Rataemane, Trathen, and Fourie (2010) and the 2008 study by Dos Santos and Van Staden, as well as from treatment intervention research reviews, is that no single type of treatment intervention can be expected to be effective for everyone who experiences a heroin dependence problem. Heroin users are a diverse and heterogeneous group, and these individual differences may be relevant to the selection of appropriate, holistic and effective treatment interventions. Different individuals prefer and may benefit from the different kinds of interventions. A range of promising alternative therapies are also available, each of which may be optimal for different types of individuals, which may be beneficial in increasing self-awareness and preventing therapeutic overload.

A total of 615 heroin users enrolled in the Australian Treatment Outcome Study (ATOS); 94.5% of the sample completed at least one follow-up interview over a 36-month follow-up. The proportion who reported using heroin in the preceding month continued to decrease significantly from the baseline to the 24-month follow-up (99% versus 35%), with this rate remaining stable to the 36-month follow-up. The reduction in heroin use was accompanied by reductions in use of other drugs. There were also substantial reductions in risk-taking, crime, injection-related health problems and improvements in general physical and mental health. Positive outcomes were associated with more time in maintenance therapies and residential rehabilitation and fewer

treatment episodes. Time spent in detoxification was not associated with positive outcomes; major depression was also associated consistently with poorer outcome. At three years, there were impressive reductions in drug use, criminality, psychopathology and injection-related health problems following treatment exposure (Teeson, Mills, Ross, Darke, Williamson & Harvard, 2008). Findings of the study by Dos Santos et al. (2010) and of Dos Santos and Van Staden (2008) suggest that the pathways to recovery tend to be complicated, and the variety of possible outcomes is extremely great. People who are treated for heroin dependence problems achieve a continuum of outcomes with respect to their heroin-taking behaviour and their heroin related problems. After treatment, some people may show initial improvement, with subsequent deterioration. Others may initially show little change but then gradually achieve a range of possibly substantial improvements. Others may oscillate between outcomes, with periods of abstinence alternating with periods of heroin/drug use. There is also no single, universally applicable measure for the assessment of outcome. Treatment response is not a simple matter of success or failure. As with many of such treatments, the assessment of outcome involves degrees of improvement, and these may convey different meanings for different individual cases (Gossop, 2003).

It is not uncommon for some heroin dependent individuals to lack the basic social behavioural skills and supports that they need to complete, and sometimes even to start, the recovery process. After many years, or even decades, of living a life that has been built upon getting high, buying, selling, talking, and thinking heroin, it is not surprising that giving up and staying off heroin should prove to be an extremely difficult task. Such individuals often require intensive and prolonged help to cope with the psychological, social, economic, and practical challenges of recovery (Dos Santos & Van Staden, 2008; Gossop, 2003).

Heroin use outcomes after intervention may include: abstinence from all forms of substance use maintained for a lifetime; abstinence followed by temporary lapse, followed by abstinence regained; reductions in (but not abstinence from) heroin use; reductions in heroin use but continued or increased use of other psychoactive substances; substitution of heavy drinking for heroin taking; no change in heroin use behaviours but reductions in heroin-related problems; and deterioration in heroin use and in heroin-related problems (Gossop, 2003).

The question ‘does heroin use disorder intervention work?’ also places too much weight on treatment intervention. It does not put the processes of treatment intervention into an appropriate perspective. Many factors contribute to outcome, and treatment intervention is only one of these. Outcome is also influenced (often powerfully) by the psychological, social, and other characteristics of the individual, the nature and severity of the problem itself, and by a wide variety of post-treatment experiences and events. It is influenced by complex interactions between all these factors (Dos Santos & Van Staden, 2008; Gossop, 2003). The probability of a positive outcome for a homeless heroin injector, for example, with a severe mental illness and HIV/AIDS is likely to be lower than that for a socially stable person with a dependence on a prescribed psychoactive substance taken orally. The probable differences in outcomes would remain even if each of these individuals received an individually tailored treatment intervention (Gossop, 2003).

CONCLUSION

From the literature review it may be concluded that the effectiveness of treatment is a complicated matter to understand and assess. The question ‘does heroin use disorder intervention work?’ is far too simple. Treatment intervention involves a variety of different practices and procedures that are used with different populations and that are designed to achieve different goals. At the simplest level, treatment intervention is required to tackle both the initiation of change and the maintenance of change. It is one thing to give up heroin. It is another to stay off it. Heroin dependence treatments include a broad range of interventions that vary in content, duration, intensity, goal, setting, provider, and target population. Research data are increasingly becoming available on the

effectiveness of the broad spectrum of treatments (Gossop, 2003; Myers & Parry, 2002).
st century, scientific information is now It is easy to forget that the treatment of individuals with substance use disorders has only been rendered in an organised service delivery system for less than 50 years. The systematic application of science to the study of substance use disorders on a large scale has only occurred for just over 25 years. Outpatient treatment has only offered an organised form of care for just over a decade. As progression is made in the 21 beginning to be used to guide the evolution and delivery of substance dependence care. Much of what is currently delivered as treatment intervention is based upon current best guesses of how to combine some science-based (e.g., cognitive-behavioural therapy and pharmacotherapies) and some self-help (12-step programmes) approaches into optimal treatment protocols. We are at the beginning stages of determining how this should best be done to produce optimal patient outcomes with an effective outlay of health care monies.

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A MEANINGFUL PSYCHOMETRIC TEST OR A DECEPTIVE OUIJA BOARD? A CRITICAL ANALYTICAL REVIEW OF THE RORSCHACH INKBLOT TEST

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ABSTRACT

Controversy has surrounded the Rorschach throughout most of its history, not because it is worthless, but because it has so often been used for the wrong purposes. Psychlit, PEP, PubMed, Google scholar, CAB Abstracts and article references were searched to identify critical commentaries and published globally in English between 1921and 2012. Findings of the review suggest that the virtues of the Rorschach are modest but genuine.

INTRODUCTION

Remarkable qualities have been ascribed to the Rorschach inkblot test ever since the 1940s, when devotees were fond of comparing its supposed penetrating powers to those of an X-ray (Klopfer, 1940). The test is still held forth as a broad-spectrum measure for a multitude of personality traits and psychological ills, including sense of self-worth, depression, inadequate coping, problem solving deficits, and psychopathy (Exner, 2003; Gacono & Meloy, 1994). Prominent Rorschach advocates have also asserted that it can provide helpful information for identifying individuals who have been abused, forecasting criminal recidivism, and predicting the onset of cancer (Meyer, Finn, Eyde, Kay, Kubiszyn, Moreland, Eisman & Dies, 1998; Viglione, 1999; Kubiszyn, Meyer, Finn & Eyde, 2000).

Such claims, which far outstrip the scientific evidence, have tended to discredit the Rorschach in the eyes of many research-oriented psychologists. As a consequence, some sectors of psychology regard the test as an unfortunate vestige from the discipline's past, only one step removed from tea leaves and crystal balls. But although such dismissals are understandable, they may be too harsh. More than 50 years of research may have confirmed woefully short of the claims made by proponents, nevertheless possess 'validity greater than chance'.

Although the book What's Wrong With the Rorschach? identifies the Rorschach's numerous shortcomings, articles such as that by Wood, Nezworski and Garb (2003) (What's Right with the Rorschach? The Scientific Review of Mental Health Practice) focus on those aspects of the test with genuine merit and suggest ways in which the Rorschach can fruitfully be used in clinical assessment, research, and therapy (Wood, Nezworski, Lilienfeld & Garb, 2003a). Controversy may have surrounded the Rorschach throughout most of its history not because it is worthless, but because it has so often been used for the wrong purposes.

The following five aspects of the Rorschach assessment, each of which has received considerable attention in the literature, define the basic nature of the instrument: Rorschach assessment is both an objective and a subjective procedure; the Rorschach measures both perceptual and associational processes, the Rorschach assesses both structural and dynamic aspects of personality functioning, Rorschach testing constitutes multifaceted method of data collection, and the Rorschach assessment rests on a sound psychometric foundation (Weiner, 2003).

Using interpretation of 'ambiguous designs' to assess an individual's personality is an idea that goes back to artists such as Leonardo da Vinci and Botticelli. Interpretation of inkblots was central to a game from the late 19th century. Rorschach's, however, was the first systematic approach of this kind (Groth-Marnat 2003).

It has been suggested that Rorschach's use of inkblots may have been inspired by German doctor Justinus Kerner who, in 1857, had published a popular book of poems, each of which was inspired by an accidental inkblot (Pichot, 1984). French psychologist Alfred Binet had also experimented with inkblots as a creativity test, and, after the turn of the century, psychological experiments where inkblots were utilized multiplied, with aims such as studying imagination and consciousness (Goldstein & Hersen, 2000). book Psychodiagnostik, which was to form the basis of the inkblot test (after experimenting with several hundred inkblots, he selected a set of ten for their diagnostic value), but he died the following year (Romesh, 2003). Although he had served as Vice President of the Swiss Psychoanalytic Society, Rorschach had difficulty in publishing the book and it attracted little attention when it first appeared (Alfred, 2009).

In 1927, the newly-founded Hans Huber publishing house purchased Rorschach's book Psychodiagnostik from the inventory of Ernst Bircher. Huber has remained the publisher of the test and related book, with Rorschach a registered trademark of Swiss publisher Verlag Hans Huber, Hogrefe AG (Psychodiagnostics: A Diagnostic Test Based on Perception, 1998). The work has been described as a densely written piece embedded in dry, scientific terminology (Acklin & Oliveira-Berry, 1996).

After Rorschach's death, the original test scoring system was improved by Samuel Beck, Bruno Klopfer and others. John E. Exner summarized some of these later developments in the comprehensive system, at the same time trying to make the scoring more statistically rigorous. Some systems are based on the psychoanalytic concept of object relations. The Exner system remains very popular in the United States, while in Europe other methods sometimes dominate, such as that described in the textbook by Evald Bohm, which is closer to the original Rorschach system and rooted more deeply in the original psychoanalysis principles (Lang, 1989; Dana, 2000).

Rorschach History

In the 1960s, the Rorschach was the most widely used projective test (Chapman & Chapman, 1982). In a national survey in the United States, the Rorschach was ranked eighth among psychological tests used in outpatient mental health facilities (Gacano & Meloy, 1994). It is the second most widely used test by members of the Society for Personality Assessment, and it is requested by psychiatrists in 25% of forensic assessment cases, usually in a battery of tests that often include the MMPI-2 and the MCMI-III (Gacano & Meloy, 1994; Gacono & Evans, 2007). In surveys, the use of Rorschach ranges from a low of 20% by correctional psychologists to a high of 80% by clinical psychologists engaged in assessment services, and McIvor, 2008; Weiner & Greene 2007).

Although the Exner Scoring System (developed since the 1960s) claims to have addressed and often refuted many criticisms of the original testing system with an extensive body of research some researchers continue to raise questions (Exner, 2002). The areas of dispute include the objectivity of testers, inter-rater reliability, the verifiability and general validity of the test, bias of the test's pathology scales towards greater numbers of responses, the limited number of psychological conditions which it accurately diagnoses, the inability to replicate the test's norms, its use in court-ordered evaluations, and the proliferation of the ten inkblot images, potentially invalidating the test for those who have been exposed to them (Lilienfeld, Wood & Garb, 2001).

Exner (1993) contends that the Rorschach makes well-validated contributions in the domain of identification of particular treatment goals, recognising possible obstacles to progress in psychotherapy, selecting appropriate treatment modalities, and monitoring change and progress over time. Therefore, data that are obtained, coded, and presented according to Exner's

Comprehensive System produce a reliable set of scores that have empirically significant and meaningful correlated in dynamics of personality functioning (Weiner, 1998). Many theorists believe that emphasis on individualisation in treatment is accomplished through making appropriate judgements about Rorschach results which yield important information regarding an individual's psychological experiences and functioning (Butcher, 1997).

Controversy

Some skeptics consider the Rorschach inkblot test pseudoscience, as several studies suggested that conclusions reached by test administrators since the 1950s were akin to cold reading (Lilienfeld, et al., 2001; Drenth, 2003; Wood, Nezworski, Lilienfeld & Howard, 2003a). In the 1959 edition of Mental Measurement Yearbook, Lee Cronbach (former President of the Psychometric Society and American Psychological Association) stated that the test has repeatedly failed as a prediction of practical criteria and that there is nothing in the literature to encourage reliance on Rorschach interpretations (Alexander, 2001). In tests have been administered by hundreds of trained professionals since that time (of a previous review), and while many relationships to personality dynamics and behavior have been hypothesized, the vast majority of these relationships have never been validated empirically, despite the appearance of more than 2,000 publications about the test' (Dawes, 1991:154). A moratorium on its use was called for in 1999 (Garb, 1999). A 2003 report by Wood and colleagues had more mixed views: 'More than 50 years of research have confirmed Lee J. Cronbach's (1970) final verdict: that some Rorschach scores, though falling woefully short of the claims made by proponents, nevertheless possess "validity greater than chance". [...] "Its value as a measure of thought disorder in schizophrenia research is well accepted. It is also used regularly in research on dependency, and, less often, in studies on hostility and anxiety. Furthermore, substantial evidence justifies the use of the Rorschach as a clinical measure of intelligence and thought disorder' (Wood, Nezworski & Garb, 2003: 636).

Illusory and invisible correlations

In the 1960s, research by psychologists Loren and Jean Chapman showed that at least some of the apparent validity of the Rorschach was due to an illusion. At that time, the five signs most often interpreted as diagnostic of homosexuality were 1) buttocks and anuses; 2) feminine clothing; 3) male or female sex organs; 4) human figures without male or female features; and 5) human figures with both male and female features. The Chapmans surveyed 32 experienced testers about their use of the Rorschach to diagnose homosexuality. At this time homosexuality was regarded as a psychopathology, and the Rorschach was the most popular projective test utilized (Chapman & Chapman, 1982; Sutherland, 2007). The testers reported that homosexual men had shown the five signs more frequently than heterosexuals. Despite these beliefs, analysis of the results showed that heterosexual men are just as likely to report these signs, so they are totally ineffective for identifying homosexuals. The five signs did, however, match the guesses students made about which imagery would be associated with homosexuality. Students read through a stack of cards, each with a Rorschach blot, a sign and a pair of 'conditions' (which might include homosexuality). The information on the cards was fictional, although subjects were told it came from case studies of real patients. The students reported that the five invalid signs were associated with homosexuality, even though the cards had been constructed so there was no association at all. The Chapmans repeated this experiment with another set of cards, in which the association was negative; the five signs were never reported by homosexuals. The students still reported seeing a strong positive correlation (Chapman & Chapman, 1982). These experiments showed that the testers' prejudices could result in them 'seeing' non-existent relationships in the data. The Chapmans called this phenomenon 'illusory correlation' and it has since been demonstrated in many other contexts (Hardman, 2009).

A related phenomenon called 'invisible correlation' applies when people fail to see a strong association between two events because it does not match their expectations. This was also found in clinicians' interpretations of the Rorschach. Homosexual men are more likely to see a monster on Card IV or a part-animal, part-human figure in Card V. Almost all of the experienced clinicians

in the Chapmans' survey missed these valid signs (Chapman & Chapman, 1982). The Chapmans ran an experiment with fake Rorschach responses in which these valid signs were always associated with homosexuality. The subjects missed these perfect associations and instead reported that invalid signs, such as buttocks or feminine clothing, were better indicators (Hardman , 2009).
In 1992, the psychologist Stuart Sutherland argued that these artificial experiments are easier than the real-world use of the Rorschach, and hence they probably underestimated the errors that testers were susceptible to. He described the continuing popularity of the Rorschach after the Chapmans' research as a 'glaring example of irrationality among psychologists' (Sutherland, 2007).

Tester Projection

Some critics argue that the testing psychologist must also project onto the patterns. A possible example sometimes attributed to the psychologist's subjective judgement is that subject's response fits with how the blot actually looks. Superficially this might be considered a subjective judgment, depending on how the examiner has internalised the categories involved. But with the Exner system of scoring, much of the subjectivity is eliminated or reduced by use of frequency tables that indicate how often a particular response is given by the population in general (Exner, 2002). Another example is that the response 'bra' was considered a 'sex' response by male psychologists, but a 'clothing' response by female (Wood, Nezworski & Garb, 2003). In Exner's system, however, such a response is always coded as 'clothing' unless there is a clear sexual reference in the response (Exner, 2002).
Third parties could be used to avoid this problem, but the Rorschach's inter-rater reliability has been questioned. That is, in some studies the scores obtained by two independent scorers do not match with great consistence (Wood, Nezworski & Garb, 2003). This conclusion was challenged in studies using large samples reported in 2002 (Meyer, Hilsenroth, Baxter, Exner, Fowler, Piers & Resnick, 2002).

Cultural differences

Comparing North American Exner normative data with data from European and South American subjects showed marked differences in some features, some of which impact important variables, while others (such as the average number of responses) coincide (Dana, 1999). For instance, texture response is typically zero in European subjects (if interpreted as a need for closeness, in accordance with the system, a European would seem to express it only when it reaches the level of a craving for closeness), and there are fewer 'good form' responses, to the point where schizophrenia may be suspected if data were correlated to the North American norms (Dana, 1999). Form is also often the only determinant expressed by European subject; while colour is less frequent than in American subjects, colour-form responses are comparatively frequent in opposition to form-colour responses; since the latter tend to be interpreted as indicators of a defensive attitude in processing affect, this difference could stem from a higher value attributed to spontaneous expression of emotions (Dana, 1999). Cultures will exhibit different 'common' objects (French subjects often identify a chameleon in card VIII, which is normally classed as an 'unusual' response, as opposed to other animals like cats and dogs; in Scandinavia, 'Christmas elves' (nisser) is a popular response for card II, and 'musical instrument' on card VI is popular for Japanese people), and different languages will exhibit semantic differences in naming the same object (the figure of card IV is often called a troll by Scandinavians and an ogre by French people) (Weiner, 2003; Dana, 1999). Many of Exner's 'popular' responses (those given by at least one third of the North American sample used) seem to be universally popular, as shown by samples in Europe, Japan and South America, while specifically card IX's 'human' response, the crab or spider in card X and one of either the butterfly or the bat in card I appear to be characteristic of North America (Dana, 1999; Weiner, 2003).
Form quality, popular content responses and locations are the only coded variables in the Exner systems that are based on frequency of occurrence, and thus immediately subject to cultural

influences; therefore, cultural-dependent interpretation of test data may not necessarily need to extend beyond these components (Weiner, 2003).
The cited language differences mean that it's imperative for the test to be administered in the subject's native language or a very well mastered second language, and, conversely, the examiner should master the language used in the test. Test responses should also not be translated into another language prior to analysis except possibly by a clinician mastering both languages, for example, a bow tie is a frequent response for the center detail of card III, but since the equivalent term in French translates to 'butterfly tie', an examiner not appreciating this language nuance may code the response differently from what is expected (Weiner, 2003).

Validity
When interpreted as a projective test, results are poorly verifiable. The Exner system of scoring (the 'Comprehensive System') is meant to address this, and has all but displaced many earlier (and less consistent) scoring systems. It makes heavy use of what factor (shading, color, outline, etc.) of the inkblot leads to each of the tested person's comments. system, latitude remained in the actual interpretation, and the clinician's write-up of the test record is still partly subjective (Goldman, 2000). Reber (1985:652) comments '.. there is essentially no evidence whatsoever that the test has even a shred of validity.'

Nevertheless, there is substantial research indicating the utility of the measure for a few scores. Several scores correlate well with general intelligence. Interestingly, one such scale is R, the total number of responses; this reveals the questionable side-effect that more intelligent people tend to be elevated on many pathology scales, since many scales do not correct for high R: if a subject gives twice as many responses overall, it is more likely that some of these will seem 'pathological'. Also correlated with intelligence are the scales for Organisational Activity, Complexity, Form Quality, and Human Figure response (Wood, Nezworski & Garb, 2003). The same source reports that validity has also been shown for detecting such conditions as schizophrenia and other psychotic disorders; thought disorders; and personality disorders (including borderline personality disorder). There is some evidence that the Deviant Verbalisations scale relates to bipolar disorder (Khadivi, Wetzler & Wilson,1997). Wood et al.(2003) conclude that 'otherwise, the Comprehensive System doesn't appear to bear a consistent relationship to psychological disorders or symptoms, personality characteristics, potential for violence, or such health problems as cancer (cancer is mentioned because a small minority of Rorschach enthusiasts have claimed the test can predict cancer) (Wood, Nezworski & Garb, 2003; Graves, Thomas & Mead, 1991).

Reliability
It is also thought that the test's reliability can depend substantially on details of the testing procedure, such as where the tester and subject are seated, any introductory words, verbal and nonverbal responses to subjects' questions or comments, and how responses are recorded. Exner has published detailed instructions, but Wood et al. (2003) cites many court cases where these had not been followed. Similarly, the procedures for coding responses are fairly well specified but extremely time-consuming leaving them very subject to the author's style and the publisher to the quality of the instructions (such as was noted with one of Bohm's textbooks in the 1950s as well as clinic workers (which would include examiners) being 1975).
United States Courts have challenged the Rorschach as well. Jones v Apfel (1997) stated (quoting from Attorney's Textbook of Medicine) that Rorschach 'results do not meet the requirements of standardization, reliability, or validity of clinical diagnostic tests, and interpretation thus is often controversial' (Gacono & Evans, 2007:83). In State ex rel H.H. (1999) where under cross examination Dr Bogacki stated under oath 'many psychologists do not believe much in the validity or effectiveness of the Rorschach test' and US v Battle (2001) ruled that the Rorschach 'does not

have an objective scoring system' (Gacono & Evans, 2007:83).

Population Norms

Another controversial aspect of the test is its statistical norms. Exner's system was thought to possess normative scores for various populations. But, beginning in the mid-1990s others began to try to replicate or update these norms and failed. In particular, discrepancies seemed to focus on indices measuring narcissism, disordered thinking, and discomfort in close relationships (Lillenfeld, Wood & Garb, 2000). Lillenfeld et al. (2000), who are critical of the Rorschach, have stated that this proves that the Rorschach tends to 'overpathologise normals'. Although Rorschach proponents, such as Hibbard (2000), suggest that high rates of pathology detected by the Rorschach accurately reflect increasing psychopathology in society, the Rorschach also identifies half of all test-takers as possessing 'distorted thinking', a false positive rate unexplained by current research (Radford, 2009).

The accusation of 'over-pathologising' has also been considered by Meyer, Erdberg and Shaffer (2007). They presented an international collaborative study of 4 704 Rorschach protocols, obtained in 21 different samples, across 17 different countries, with only 2% showing significant elevations on the index of perceptual and thinking disorder, 12% elevated on indices of depression and hyper-vigilance and 13% elevated on persistent stress overload—all in line with expected frequencies among nonpatient populations.

Albert Binet considered including inkblots in his famous intelligence test (Zubin, Eron & Schumer, 1965). Although he eventually abandoned the idea, his original intuition turned out to be correct. As research has shown, several Rorschach variables are correlated with intelligence test scores (for reviews, see Meyer, 1992; Wood, Krishnamurthy & Archer, 2003). The highest correlations, which range from .30 to .40, have been found for Developmental Quality and Organizational Activity, scores that measure the degree to which responses synthesize diverse parts of a blot into a unified image. Lambda and the closely related F%, which reflect a tendency to give responses based on colour and shading rather than form alone, also appear to correlate above .30 with intelligence test scores. Somewhat lower (.20 to .30) are the correlations for Form Quality, Human Movement responses, and R (the total number of responses given to the blots).

However, the best Rorschach indicator of intelligence is to be found not among these scores but in the vocabulary that the respondent uses to describe the blots (Davis, 1961; Hauser, 1963; Trier, 1958). For example, Thomas Trier of the University of California at Berkeley asked clinicians to read a group of Rorschach protocols and identify the seven most sophisticated words used by each respondent. Then, by consulting a commonly available word book, he estimated the average grade level of these words for each respondent. This simple Rorschach-based estimate of vocabulary level correlated .77 with intelligence test scores.

Although such results demonstrate that Rorschach responses can be used to estimate intelligence, modern standardised intelligence tests are definitely superior for the purpose (Davis, 1961). However, when intelligence testing is impossible, for example with an uncooperative child, inkblots may provide an acceptable substitute. The use of Rorschach-based vocabulary as an index of intelligence has been virtually ignored in the assessment literature since the 1950s, so that standardised procedures and norms are unavailable. With some scientific groundwork, however, the Rorschach might well be put on a solid footing as a rough intelligence measure, to be pulled out of the psychologist's briefcase under pressing circumstances.

There is abundant evidence that two kinds of Rorschach scores are related to psychotic disorders. First, as Hermann Rorschach (1921,1964) noted, the inkblot responses of patients with schizophrenia often exhibit poor form quality (Rieman, 1953; Sherman, 1952; see reviews by Frank, 1990; Goldfried, Stricker & Weiner, 1971). That is, the images reported by these patients often do not 'fit' the shape of the blots. Form quality is also poor among many patients with bipolar disorder (Frank, 1990).

Second, as David Rapaport and his colleagues (1946) first noted in their famous book Diagnostic Psychological Testing, the Rorschach can be used to identify thought disorder, the disorganised cognition and peculiarities of language exhibited by many patients with schizophrenia. Several scoring methods have been developed to measure thought disorder on the Rorschach (for reviews, see Aronow & Reznikoff, 1976; Goldfried, Stricker & Weiner, 1971; Kleiger, 1999), the most prominent being the Thought Disorder Index (Johnston & Holzman, 1979; Solovay, Shenton, Gasperetti, Coleman, Kestnbaum, Carpenter & Holzman, 1986), the TETRAUT of the Logical Rorschach (Wagner, 2001), and the Weighted Sum (WSum6) of the Comprehensive System for the Rorschach (Exner, 2003). The Comprehensive System's Schizophrenia Index (revised recently as the Perceptual Thinking Index) combines scores for thought disorder and form quality (Exner, 2003). Research has shown that all these scores are related to schizophrenia (Greaves, 2000; Johnston & Holzman, 1979; Jorgensen, Andersen & Dam, 2000; Kleiger, 1999; Wagner, 1998; 2001). Many patients with schizotypal personality disorder and bipolar disorder in the manic phase also apparently exhibit thought disorder on the Rorschach (Coleman, Levy, Lenzenweger & Holzman, 1996; Singer & Brabender, 1993).

The Rorschach—particularly the Thought Disorder Index—has proven useful to researchers who examine genetic and familial patterns of schizophrenia (e.g., Knight & Silverstein, 1998; Lenzenweger, 1998). These various scales are also potentially useful in clinical settings, although it is unclear whether Rorschach indices of thought disorder are necessary if a clinician has already had an opportunity to observe a patient's thinking and language during an interview (for example, see Whitehead, 1985).

indexes of John Exner's (2003) Comprehensive System, currently the most popular method for scoring and interpreting the Rorschach. Exner's indexes (e.g., the SCZI, WSum6, Level 2 scores, and Conventional Form) presently have only limited clinical usefulness because their published norms appear to be seriously in error (Wood, Nezworski, Garb & Lilienfeld, 2001a, 2001b; see Shaffer, Erdberg & Haroian, 1999; also see Exner 2001, Meyer, 2001). Clinicians who rely on the Comprehensive System and its norms are likely to significantly overdiagnose thought disorder and psychotic symptoms.

Applications

The test is also controversial because of its common use in court-ordered evaluations. This controversy stems, in part, from the limitations of the Rorschach, with no additional data, in making official diagnoses from the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association, 1994). Irving B. Weiner (co-developer with John Exner of the Comprehensive system) has stated that the Rorschach is a measure of personality functioning, and that it provides information concerning aspects of personality structure and dynamics that make people the kind of people they are. Sometimes such information about personality characteristics is helpful in arriving at a differential diagnosis, if the alternative diagnoses being considered have been well conceptualised with respect to specific or defining personality characteristics' (Weiner, 1999). In the vast majority of cases, anyway, the Rorschach test wasn't singled out but used as one of several in a battery of tests, and despite the criticism of usage of the Rorschach in the courts, out of 8,000 cases in which forensic psychologists used Rorschach-based testimony, the appropriateness of the instrument was challenged only six times, and the testimony was ruled inadmissible in only one of those cases (Gacono & Evans, 2007; Gacono & Kaser-Boyd, 2007; Weiner & Greene, 2007). One study has found that use of the test in courts has increased by three times in the decadebetween 1996 and 2005, compared to the previous fifty years (Gacono & Evans , 2007). Others however have found that its usage by forensic psychologists has decreased (Garb, Wood, Lilienfeld & Nezworski, 2005).

Several Rorschach scores have repeatedly demonstrated their validity in research. The Elizur Anxiety and Hostility scales, which are based on the emotional content of patients' responses, have a well-demonstrated relationship to anxious and hostile behaviors (Aronow & Reznikoff, 1976; Goldfried et al., 1971). The Rorschach Oral Dependency scale (ROD), based on responses

that involve eating, mouths, or other 'oral' imagery, appears to be a valid measure of normal variations in dependency (Bornstein, 1996), although it has been less successful as a measure of pathological dependency (Bornstein, Hilsenroth & Padawer, 2000; see also Garb, Wood, Nezworski, Grove & Stejskal, 2001).

Rorschach signs identified by Piotrowski (1937) differentiate what used to be called 'organic' from 'functional' brain disorders (Goldfried et al., 1971). For instance, Piotrowski found that many patients with 'organic' brain disorders take a long time to react to the blots and often give repetitious responses. Finally, Klopfer's Rorschach Prognostic Rating Scale (RPRS) has a well-demonstrated relationship to treatment outcomes, for example, patients who report imagery involving animals or humans in movement receive higher scores on Klopfer's scale and have somewhat better outcomes in psychotherapy (Meyer & Handler, 1997).

Despite their respectable performance in research, these Rorschach scores are currently unsuitable for clinical applications. Most important, they lack adequate norms and involve elaborate scoring procedures that many clinicians may find impractical. In addition, some of these scores (e.g., the RPRS and Elizur scales) were validated using administration or scoring procedures from Beck and Klopfer that are now obsolete. Thus, these Rorschach scores are far more attractive as research instruments than as clinical tools.

Psychotherapy

Aronow and Reznikoff (1976) have long argued that the Rorschach, though arguably a failure as a psychometric test, has considerable value as an adjunct technique in psychotherapy. These authors approach the patient's responses to the blots analogously to dream interpretation, asking the patient 'What does this image make you think of?' or 'What does it bring to mind?' Such an approach seems compatible with some forms of psychotherapy and the Rorschach as a psychotherapeutic technique has not yet been demonstrated. Furthermore, therapists who use the test to generate symbolic interpretations must beware of the potential influence of confirmation bias, and should actively seek evidence that disconfirms their Rorschach interpretations, as well as evidence that confirms them (Nisbett & Ross, 1980).

Measurement of change in psychotherapy

The importance of measuring change through psychotherapy is essential to access the effectiveness of particular psychotherapeutic strategies and interventions. Accurate measurement of change assists in the development of further strategies and techniques in service of improved psychotherapy. Weiner and Exner (1991) evaluated patients in both long-term and short-term psychotherapy using the Rorschach Inkblot Test (Comprehensive System). Their findings demonstrated the effectiveness of long-term therapy, and the validity of the Rorschach in assessing the effects and changes in therapy.

Weiner and Exner (1991) also identified a number of indicators for successful psychotherapy. These were the patient's ability to manage stress more adequately, to deal with problematic situations in a specific coping style, and to be more aware of their experiences, to be involved in positive self-examination, and to be more comfortable in interpersonal situations. Improvement and change in psychological functioning through therapy can therefore be reflected in these psychological activities.

In the study of Weiner and Exner (1991), part of the indices that could indicate psychotherapeutic change included specific variables. These affect variables are related to underlying personality structures that influence the use and expression of affect in individuals. These Comprehensive System indices are D, Adjusted D, Lambda, Affect Ratio, Shading responses, EA, Texture responses, EB and Colour responses.

Weiner and Exner (1991) found a general improvement when measuring change in psychotherapy subjects, after one year of treatment. The general improvement in functioning was consistent with identified indicators for successful psychotherapy (e.g. the ability to manage stress more

adequately) in the functioning of psychotherapy subjects. Generally, the depressed, enjoying experiences and modulating affect more effectively, being more realistic as opposed to escapist, and improved interpersonal relationships. The measured changes perpetuated over the period of testing, and up to four years after treatment commenced. After one year of therapy there were areas of functioning that indicated little change, as indicated by Rorschach tested variables (Adjusted D, D, and EA). According to Weiner and Exner (1991) this indicated the subjects as experiencing subjectively felt distress. This relates the finding of Weiner and Exner (1991) in a significant increase of the Form Dimension (FD) responses after one year of therapy, and up to two years after therapy commenced, which indicates increased self-examination during this period of therapy. The results of Weiner and Exner's study (1991) demonstrates change in six areas of personality functioning, namely, stress management, a conventional and consistent manner of dealing with experiences, being more capable of taking enjoyment from emotional experiences and modulating affect, more effective ideation, being less preoccupied with themselves, and having and desiring better interpersonal relationships.

The Weiner and Exner (1991) study demonstrates the beneficial effects of psychotherapy through improved functioning of the subjects in the six identified dimensions of personality, as previously mentioned. The long-term patients displayed greater beneficial personality changes in comparison to the short-term psychotherapy patients. These changes were improvement in the frequency of loose and arbitrary thinking, excessive intellectualisation, excessive self-focusing, and the lack of expecting close and interpersonal relationships. The accuracy of the Rorschach is demonstrated though the research of Weiner and Exner (1991:464), as they state, 'the successful measurement of these expected measurement by Rorschach variables lends construct validity to their use for this and related purposes'. This lends validity to changes through psychotherapy, as assessed by the Rorschach. As stated by Weiner and Exner (1991:464), changes seen in psychotherapy through Rorschach assessments may not be expected unless '(a) psychotherapy makes a difference and (b) the Rorschach can validity measure this difference.' This demonstration of the accuracy of Rorschach assessment of change through therapy in the Weiner and Exner (1991) study gives validity to Rorschach assessment in this case study of change in psychotherapy.

Paradoxically, although the Rorschach is held in disrepute by many research psychologists, it has perhaps achieved its greatest successes as a research tool. Its value as a measure of thought disorder in schizophrenia research is well accepted. It is also used regularly in research on dependency, and, less often, in studies on hostility and anxiety. Furthermore, substantial evidence justifies the use of the Rorschach as a clinical measure of intelligence and thought disorder. Although clinicians should normally rely on well-established tests such as the Wechsler Adult Intelligence Scale–Third Edition (Wechsler, 1997) to measure intelligence, and on clinical interviews to assess thought disorder, there may be times when the Rorschach can usefully supplement these 'front-line' methods. In addition, the Rorschach may be useful as an exploratory technique in some forms of insight-oriented psychotherapy.

The virtues of the Rorschach are modest but genuine. If, over its long history, the test had been promoted solely for the uses identified here, it probably would have been less popular among psychologists, but also far less controversial. It remains to be seen whether clinical psychologists of the future can learn to accept the limitations of the Rorschach while respecting its strengths, otherwise, it will continue to be promoted for purposes for which it has no usefulness and will inevitably be a flashpoint for controversy.

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